

A fair innings between the sexes: What men say and what women say

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Abstract

An earlier HESG/Norwich paper (Tsuchiya, Williams, 2002), examined whether the fair innings argument is applicable to inequalities in life expectancy between the sexes. Its application implies that (*ceteris paribus*) health improvements for men should be given priority over those for women. However, existing data indicate that, while people support the fair innings argument when it is applied to the social classes, they do not when it is applied to the sexes. The aim of the current study is to examine the attitudes of men and of women towards differences in lifetime health between the sexes. 25 members of the public were recruited for focus group discussions. The sample was divided into four sex-segregated groups. Each group participated in two, separate, hour-long sessions, each of which finished with a questionnaire. Qualitative analysis of the transcripts suggests that women and men mostly highlight the same issues in accounting for the differences in health between the sexes. Quantitative analysis of the questionnaires indicates that when life expectancy is considered in isolation women are more inequality averse than men. Furthermore, when inequality in annual income (which favours men) is brought into the picture, women prefer a generally egalitarian outcome between the sexes in both domains, while men are predominantly Paretian, in that they would prefer the scenario in which men have even more income and women have even more life expectancy (so both sexes are better off), despite the fact that this makes both inequalities greater.

Acknowledgements

Special thanks are due to Rebecca Shaw for her input for the design of the study and recruitment. We would also like to thank all our participants. The usual disclaimer applies.

1: Introduction

An earlier HESG/Norwich paper (Tsuchiya, Williams, 2002), examined whether or not the fair innings argument (Williams, 1997) is applicable to inequalities in life expectancy between men and women. The fair innings argument prescribes giving larger weight to marginal health improvements for those whose expected lifetime health without intervention is lower. It is based on the notion that people are entitled to a specific level of health over their lifetime, and the fact that some groups within the population die without achieving this is regarded as unfair. In most modern societies, those in the more advantaged socio-economic classes live longer than those from the less advantaged classes; also, women live longer than men. Therefore, the application of the fair innings argument implies that (*ceteris paribus*) health improvements for those from social class 5 should be given a larger weight than for those from social class 1; and that health improvement for men should be given a larger weight than health improvements for women.

However, existing data (Dolan et al, 2002) indicate that, while people support the fair innings argument when it is applied to the social classes, they do not when it is applied to the sexes. In the above study, when respondents were informed that there is a 5-year difference in life expectancy at birth between men in social class 1 and those in social class 5, the median respondent was willing to trade-off 1 year of life expectancy on average for an equal distribution of life expectancy across social classes 1 and 5. On the other hand, when the respondents were informed that there is also a 5-year gap in life expectancy at birth between men and women, the median respondent was not willing to trade off any efficiency for equality. Furthermore, both male and female respondents were inequality averse over health inequality across the social classes, but inequality neutral over health inequality across the sexes.

The aim of the HESG/Norwich paper was to explore possible reasons why people who are averse to inequality in health between the social classes may be neutral to comparable inequality in health between the sexes. It reached the following conclusions:

- (1) The evidence on lifetime health prospects between men and women indicates that women are still better off than men even when male advantage in HRQOL is taken into account. Thus, there is a potential case for the fair innings argument.
- (2) Arguments in support of regarding men and women as members of separate communities based on their different natures and roles are dubious, and do not undermine the applicability of the fair innings argument.
- (3) Arguments denying the inequity of the inequality based on the fact that it is biological/natural/normal fail, and do not justify a rejection of the fair innings argument.
- (4) Arguments assigning responsibility for the inequality to men's own behaviour have some (but not complete) relevance, and therefore the force of the fair innings argument is diminished, but it still remains applicable.
- (5) The argument that, given the recent trends, the issue will eventually go away, is not satisfactory, and does not undermine the applicability of the fair innings argument to present generations.
- (6) The argument that health should not be considered in isolation from other inequalities between the sexes has reasonable appeal, and questions the

applicability of the fair innings argument to health prospects alone (but not its applicability to some indicator of overall well-being).

The aim of the current study is to examine empirically the attitudes of men and of women towards differences in lifetime health between the sexes. Throughout, attention was paid to whether or not men and women respond differently. There are theories in developmental psychology that suggest men and women have different “moral orientations” (Gilligan, 1993, is a classic). It has been found in various empirical studies that while boys and men tend to base their moral arguments on concepts of justice and rights, girls and women tend to appeal to notions of care and to a desire minimise harm to others. Furthermore, in social and developmental psychology, empirical work has suggested that women display a greater ability to see things from the perspective of others (Davies 1983), women are more likely than men to display positive social behaviours in groups, acting to relieve tensions and displaying greater group solidarity (Beutel and Marini, 1995) and that girls are more likely than boys to show consideration for the feelings of others in expressing their own emotions (Saarni, 1984). Further work has been carried out in the context of policy preferences (Shapiro and Hanajan, 1986) and more fundamental value orientations (Beutel and Marini, 1995), confirming differences across the sexes. However, note that there is also a great deal of conflicting evidence (see for example Jaffee and Hyde, 2000), and this intriguing issue is far from settled

In what follows, Section 2 will describe the empirical study and Section 3 will report the results. Section 4 will summarise the results of other similar empirical studies. Section 5 offers a brief discussion and some tentative conclusions.

2: Methods

2.1. The objectives of the study

The first objective of the study was to explore why people seem to think the fair innings argument is not applicable to the inequality in life expectancy at birth between the sexes. This led to a qualitative study design, where participants were invited to take part in discussion groups covering the causes, possible remedies, and ethical acceptability of the inequality. In order to encourage free discussion, and to investigate the difference, if any, between the views of men and of women, it was judged that groups should be segregated by respondent sex. Furthermore, given the amount of information which we wanted the respondents to have time to digest and form views on, each group was scheduled to meet on two consecutive occasions, one week apart. The actual schedule is presented in more detail in the next section.

The second objective of the study was to examine whether or not, after deliberation about the relevant issues, people still think the fair innings argument is not applicable to the inequality. This was tested by using a revised version of the quantitative questionnaire developed by Dolan et al (2002). The questionnaire consists of three pages, one of which was a new addition for the present study. The first page illustrates the difference in life expectancy at birth between men (73 years) and women (78 years), and offer two options: programme A, which will increase the life expectancy of both sexes by 2 years, and programme B, which will increase the life expectancy of men by 4 years, but leave the life expectancy of women unchanged. The original questionnaire had an additional page for those respondents who choose

programme B over A in the first incidence, which we refer to as “Sheet B”. Here, they are shown four pair-wise choices, where programme A is always the same (2 years to both) and programme B becomes increasingly less attractive (3 years to men and 0 years to women; 2.5 years to men and 0 years to women; and so on). The task is to identify the point at which the respondent switches from programme B to programme A, thus enabling the inference of an indifference point (which can be used in the calculation of the degree of their inequality aversion). The new page of the questionnaire, called “Sheet A”, is for those who choose programme A on page one, and is inserted between the first page and sheet B. Again, there are four pair-wise choices, and programme A is held constant throughout (2 years to both). Programme B in the first pair gives 1 year to men and 3 years to women. This pair is designed to pick out those who favour an even greater inequality. In the second pair, programme B offers 3 years to men and 1 year to women, and in subsequent pairs the gain to men is gradually reduced as on Sheet B. The rationale for this new Sheet A was to distinguish between three types of respondents amongst those who choose programme A on the first page: those who want more inequality, those who are neutral, and those who want to reduce the inequality in health but also to reduce the inequality in the gains. The questionnaire is reproduced in Appendix 1. It was administered at the end of the first group session, and the results were fed back to the respondents at the beginning of the second session.

The third objective was to test the relevance of observation (6) of the HESG/Norwich paper mentioned above: *viz.* the acceptability or otherwise of the inequality in health cannot be determined without reference to other aspects of life in which the inequalities favour men. This was done through a single pair-wise choice question, developed for this study. The exercise described the current situation between men and women in two bar charts: one for life expectancy at birth (73 for men and 78 for women) and another for average annual income (18K for men and 13K for women). Then, it asked respondents to indicate which of two possible states of a future world, X or Y, they preferred:

	<u>life expectancy</u>		<u>annual income</u>	
	men	women	men	women
Current state:	73	78	18K	13K
Forecast X:	76	79	20K	20K
Forecast Y:	76	80	25K	20K

Assuming selfish behaviour, male respondents will be indifferent between X and Y with respect to life expectancy, but will prefer Y over X with respect to income, while female respondents will prefer Y over X with respect to life expectancy, and will be indifferent between the two forecasts with respect to income. Therefore all selfish respondents will prefer Y over X. Further, if they were unselfish but inequality-neutral maximisers, they will again prefer Y over X, because Y dominates X (the move from X to Y is a Pareto improvement). The only reason why X may be preferred to Y is the smaller inequality in both life expectancy and income, which suggests an unselfish perspective with inequality aversion. This questionnaire is reproduced in Appendix 2. The results of this second questionnaire were not fed back to respondents, since there was no opportunity to do so.

2.2 The sample

Two hundred individuals, living in the city of York and chosen at random from the electoral register, were invited to take part in focus group discussions. The aim was to convene four single-sex groups, with a maximum of 8 individuals per group, which would meet on two consecutive occasions, one week apart. Respondents were also asked to indicate their age group as follows: 30 or younger; 31 – 49; 50 or older. Other than sex, age was the only personal information sought from respondents at this stage. We felt that it was important to achieve a balance of age groups within each focus group, in case there were strong differences of view between the generations. Potential participants were given the choice of afternoon or evening focus groups, to ensure that those with work commitments were not prevented from taking part in the study. A fee of £30 was offered, payable at the end of the second meeting.

2.3. The session schedules

The focus group meetings took place at a public venue in the centre of the city of York and were scheduled to last for one hour 10 minutes. All sessions were facilitated by WM. The first 10 minutes at each session was intended as an ‘ice-breaker’, giving participants an opportunity to meet in an informal setting (the reception area of the building) before the business of the group began. 50 minutes were allocated for the actual discussion and a final 10 minutes for the administration of the questionnaire. With participants’ consent, sessions were tape recorded for transcription at a later date.

In the first session, two pieces of information were introduced. First, that the expected age at death of the average male and the average female living in the UK today is 73 years and 78 years respectively. Second, that although the average female will live 5 years longer than the average male, she will not be as healthy in the later years of her life as will be the surviving males of the same age. In each case, participants were asked whether they were aware of the situation, what they thought of it, and what they thought its causes might be. In both cases the researcher introduced the topic and then encouraged the participants to offer their views, using pre-agreed prompts as necessary to stimulate discussion. The session ended with the administration of the first questionnaire.

At the beginning of session two participants were given a brief résumé of the outcome of the analysis of the questionnaires distributed in session one. This was in the form of a general statement about the overall view of male groups and female groups, the specific position of the median person in each case and the implications of that position in terms of male vs female life expectancy trade offs and the value attributed to extra life years for each sex. They were then asked to consider the various reasons put forward in the first session for the difference in life expectancy between men and women and to discuss whether each of these made the inequality more or less important. Next, they were given data on inequality of life expectancy between social classes and asked to consider whether this inequality is more or less serious than that between men and women. The final part of the discussion went back to the inequality between the sexes, and encouraged them to consider factors beyond health which might affect whether it is men or women who are doing better overall. Again the researcher introduced each of the topic areas and invited participants’ comments

on it, prompting if necessary to stimulate discussion. The session ended with the administration of the second questionnaire.

2.4. The analyses

2.4.1 Qualitative Analysis

Tapes from the group discussions were transcribed and analysed qualitatively, using content analysis. ATLAS.ti V4.2 was used to manage the data. The analysis broadly consisted of three stages. In the first stage, words and phrases which seemed significant, or which recurred across the groups were highlighted. In the second stage, provisional themes and issues were identified from these highlighted pieces of text. Finally, these emergent themes were organised into key themes and issues (ie those raised most frequently) grouped under a number of headings, for example reasons for the difference in life expectancy between men and women; reasons for the inequality in 'healthiness' between the sexes in later life.

2.4.2 Quantitative Analysis

Results of the first questionnaire are summarised in terms of the distribution of respondents by sex and by the choice at which they switched to programme A. The position of the median respondent, in terms of the implied degree of inequality aversion, will be indicated. (For details regarding the assumed social welfare function and the derivation of the inequality aversion parameter, see Dolan et al 2002.)

Results of the second questionnaire are presented in a cross tabulation between the choice over options X and Y, and respondent sex. A χ^2 -test is performed to examine whether the distribution of responses is different depending on respondent sex. A 10% significance level is used.

3: Results

3.1. The respondents

Two hundred people received an initial letter, inviting them to participate in the focus group study. 55 (26 males and 29 females) agreed to do so. Of these 55 respondents, 23 were subsequently excluded from the study, either because they were not available at the same time on two consecutive dates or because of the need to achieve single sex groups with a relatively balanced age profile. A further 7 dropped out of the study after recruitment was complete. Two participants (one male, age 50+ and one female, age 31-49) attended the first group session but not the second. Detailed breakdowns by sex and age of initial acceptance, exclusions, drop outs and final group composition are given in Tables A and B below. It will be noted that both males and females in the <30 age group are underrepresented.

3.2. The first discussion session

Qualitative analysis of the first focus group transcripts lead to the identification of the themes listed in Table C. Men and women highlight substantially the same issues when accounting for the inequalities in life expectancy and health between the sexes. Two differences may be noted however. Males more often mentioned work-related issues when discussing life expectancy, and females more often mentioned nature/biological differences when discussing health in general. The main focus of

discussion in all groups was around the causes of inequalities in life expectancy and health.

Participants spent a significant amount of time discussing differences in behaviour between men and women and their effects on health and longevity. The consensus seemed to be that men are likely to be more risk taking than women:

“a lot of young men, particularly, ride motorbikes and drive extremely fast, you know they enjoy taking risks” (Focus Group 2, Person G, Female, 31-49)

and that women are likely to be more receptive to health education and to adopt healthy lifestyles and behaviours:

“One thing that has always come through for me is diet, women are more likely to make positive changes in their diet, men are neglectful of such things” (3/B/M/31-49)

Men were seen as being more at risk in the workplace, (industrial diseases such as asbestosis and dangerous occupations such as coal mining were mentioned) and subject to greater stress because of their traditional role as breadwinners and providers:

“we have mortgages to maintain, bank overdrafts probably, credit cards, responsibility at work”(3/A/M/50+).

There was general agreement, however, that this is changing. The decline of heavy industry, such as mining, the advent of more stringent legislation for the regulation of health and safety at work and the increase in the numbers of women working outside the home were cited as examples of developments which might have an effect on inequalities in life expectancy and health between the sexes in the future.

Most group members agreed that, in families where both adults worked outside the home, women took the greatest responsibility for childcare and domestic chores and that this was a significant source of physical and psychological stress:

“these days you get a lot of women out to work, often soon after having a child. Our mum were there all the time, its more stressful to work and have children” (3/C/M/50+).

Women were also seen as being subject to additional physical stress, because of their childbearing role.

The fact that women are less healthy than surviving males in later life tended to be seen as rather surprising, given that most participants felt that women were more likely to exhibit healthy behaviours, such as better dietary habits etc. They were also generally seen as more able to cope alone after the death of a partner than men:

“ if my grandma had died first, I don't think my granddad would have lasted longperhaps in later life men need to be cared for more” (2/E/F/31-49).

Participants tended either to attribute this health inequality to health factors related to sex, such as women suffering from breast cancer or osteoporosis, or to suggest that men who are elderly today are more likely to have been physically fit in their youth than women:

“men are much more physically active than women in general, therefore he ought to be fitter, have better lung capacity et cetera, if he looks after himself” (3/D/M/50+).

Again, however, there was general acknowledgement that the situation is changing and that these changes may have implications for health inequality in later life. For example, participants cited increasing female involvement in sport and fitness regimes and the fact that modern work patterns do not involve physical labour to the same extent as in the past.

3.3. The first questionnaire

The results of the first questionnaire are shown in Table D. The first row “A + 3&1” is for those respondents who initially chose programme A on the first age, chose programme B on Sheet A when this was 3 years to women and 1 year to men. The next row “A + A + A” is for those who choose programme A throughout (on the first page and then on Sheet A). The next four rows “A + A + 1&x” are for those respondents who choose programme A on page 1, and programme A on the first option on Sheet A: the last option where they chose programme B is where life expectancy of women was increased by 1 year and that of men by x years. The last group of six rows is for those who choose programme B on page 1 and go on to the trade off exercise on Sheet B. It will be seen that there was a clear divergence of views between the male and female respondents but it was the opposite of what would have been predicted had each sex been acting in a self-interested manner. The median male would not attempt to change the inequality at all, voting always for each sex getting 2 extra years of life expectancy. But the distribution is skewed, with more males wishing to go for some reduction of the inequality than wishing to make it larger (which 2 favoured!). The median female, on the other hand, would be prepared to sacrifice 2 years of life expectancy for her own sex even if it meant that the males gained only 0.5 of a year, which represents quite a strong efficiency trade-off. Only one female went for neutrality, and none wished to make the inequality any greater. So there appears to be a stronger inequality aversion here amongst the females than amongst the males.

3.4. The second discussion session¹

When the results from the first questionnaire were presented to each group at the beginning of the second session, most participants expressed a degree of surprise at the divergent positions taken by the median male and the median female, but offered little else by way of comment. There was, however, some attempt to explain the lack of self interest demonstrated by the female respondents. One theory was that this was linked to women’s nurturing instinct and therefore to be expected:

“ I think that’s the mother instinctwomen are protecting the lives of their families, she’s protecting everyone, including the man” (3/D/M/50+)...

Alternatively one participant suggested that women might indeed be acting out of self interest in attempting to prolong male life expectancy:

¹ Detailed analysis of the transcripts of the second session has yet to be fully completed, therefore we are unable to include a table of themes for this session

“Well, you look at it and you think, if you had a partner, then you’d want to spend more time with your partner” (2/E/F/31-49)

However, this was combined with the instinct to nurture and protect.

“If you have children and if you have boys, you think, well, what do boys do....”(2/E/F/31-49).

In general, however, participants did not seem able to articulate exactly why they were surprised and talked instead of their own thoughts and motives when completing the questionnaire:

“in my own personal case, I’m 57 and my wife is 4 years older than me. I tried to choose the option which boosted up my own life expectancy and slightly reduced hers and might mean that we had more time together overall” (4/D/M//50+)

We will return to this point later in the concluding section.

When discussing inequality in life expectancy between the social classes, participants tended to agree that this was a more important issue than that of inequality between the sexes. However there was little consensus on why it was more important. Some participants felt that it was a situation that could and should be changed:

“Its more serious because you can do something about that, can’t youwhereas you can’t do much about the other, [ie inequality between the sexes] can you, because its genetics” (4/B/M/50+)

Others, however, saw an inevitability about it, either because it was part of a ‘natural order’ or because one class had the power and motivation to prevent change:

“ But its not as easy as that, the upper classes have got the power and the interest to make sure things don’t change” (4/F/M/31-49).

Participants were also asked about factors, other than health, which might determine whether it is men or women who are doing better overall. In general, they did not have strong opinions on this subject, and the results of the discussions were not conclusive. One issue raised was that of economic power and its effect on the relative social and political influence of men and women. A common perception was that more men than women are employed in highly paid positions affording them higher status and therefore a greater degree of influence, both inside and outside the workplace. However, this was countered by some who considered that economic power is the preserve of the minority, regardless of sex.

There was disagreement as to whether this situation would change. A number of participants felt that the gap in earnings between men and women would close eventually, suggesting that young women today have higher expectations and are more career orientated than their mothers and grandmothers were. Others, however, expressed the view that women would continue to be the majority in low paid, low status work, because of their greater commitment to and involvement in childcare and childrearing:

”You’ll find in a lot of instances, women, because they’ve got a family are more willing to work shifts, odd hours, because they’ve got a family to look after You ask why they have

applied, its because the hours mean I can take the kids to school, do the housework".
(4/F/M/31-49)

Some suggested that men's economic advantage was balanced by women having greater influence in the home.

Finally there seemed to be a feeling that women were advantaged in that they could choose to take on a domestic role, or pursue a career, without attracting censure:

"do you think that women are more empowered in that they have more choice in their lifestyles? These days they have the choice to occupy either role (domestic or working outside the home) more easily than a man" (4/E/M/<30)

3.5. The second questionnaire

The results of the second questionnaire are shown in Table E. The median respondent for males marginally chose Y, while the median respondent for females chose X (by a much wider margin). It will be seen once more that the females are more inequality averse than the males. This result is not statistically significant however ($p > 0.31$). There was no opportunity to present feedback from this questionnaire to Focus Group participants or enter into discussions about it.

4: Results from other empirical studies

With the addition of one extra option on each follow up page of the group questions, the same two questionnaires that were first used in this study have since been used with various convenience samples to see whether economists and other professionals with a special interest in health care manifest similar views to our very small sample of the general public. Some comparative results are presented in Table F for the first questionnaire and Table G for the second questionnaire. In this larger group of health care professionals, for the first questionnaire the median male and the median female are to be found in the same response group², which shows both to be mildly inequality averse. But the distribution of responses manifests a rather problematic property, namely that within each sex there is a bimodal distribution of responses, with the median falling in between (and closer to the larger mode)! So although there is less difference between the sexes, there is more difference within them! Unfortunately it is not possible for us to say whether this is due to the heterogeneity of the various pooled data, the characteristics of the two study populations (professionals versus the public) or whether it is the result of the focus group discussions themselves (which might have pushed the males towards a consensus at the one mode and the females towards a consensus at the other!).

In Table G the results from the second questionnaire have not simply been aggregated across all samples but also presented separately for each. They are ranked in ascending order of the percentage choosing X rather than Y (ie rejecting Pareto in favour of more equality). Generally speaking the women are more egalitarian than the men, but within each sex our focus group members have virtually identical responses to the average for their respective sexes (highlighted in bold in the table).

² The exact location of the median is somewhat problematic here, however, since those who would favour males but want females to have some gains too, cannot have indifference curves that have the same inequality aversion properties as those who would target without reservation.

But of greater anecdotal interest is the ranking of the samples, with the academic economists (but not their students!) more likely to be Paretian than Egalitarian, and the medical profession closer to the general public than the economists are!

Also of possible interest is a comparison of the way the men and women from the same group differ. Amongst the seven groups, six groups have a higher proportion of women choosing X than Y: the Spanish public health specialists is the only group where a higher proportion of men choose X than women do. Of the six remaining groups, female excess in choosing X ranges from 17 to 33 percentage points for five of the six groups, with the York International Course participants an outlier at 65 percentage points difference. This may have been affected by the heterogeneous nature of this particular group.

5: Discussion and conclusion

This study had three objectives: to explore why people seem to think that the fair innings argument is not applicable to the inequality in life expectancy between the sexes; to examine whether discussion of the possible reasons for this inequality has an effect on this view; and to test whether the acceptability of this inequality can be determined without reference to other inequalities in society which favour men.

The York citizens who participated in the study appear to be divided on the applicability of a fair innings argument to inequalities in health between the sexes, despite largely agreeing on their causes. In general, women were willing to sacrifice life expectancy for their own sex, to achieve gains for men, suggesting that they value health improvement for men over that for women, whereas men appeared willing to accept the inequality. This pattern was repeated in the results of the second questionnaire, which again showed females as more inequality averse than males.

The qualitative analysis of the data indicates that the reasons for these findings are complex. There is some suggestion that women are motivated by altruism in opting to reduce the inequality of life and health expectancy between the sexes and giving up life years themselves, so that men's lives can be prolonged. In doing so they are acting against their own self interest, a stance which, on the surface, could be consistent with the view that women and men have different moral orientations and that women display greater empathy with the situation of others than men do.

However, in attempting to explain why they had completed the questionnaire in a particular way, some of the York citizens (both male and female) indicated that they had, in fact, been motivated by a different self interest when completing the questionnaire. Amongst both sexes respondents articulated a desire to prolong the length of time that partners would have together, an objective that would be served by reducing the inequalities in life expectancy between the sexes. The quantitative data appears to show that this desire is however stronger amongst the women than amongst the men, unless it is being swamped by other reasons for inequality-aversion.

The additional results reported in section 4 found a bimodal distribution for the first questionnaire and a variation in female excess for choice X in questionnaire two. These observations suggest that different populations are likely to have different

views on this issue, and that the difference in the male and female views is also likely to depend on the population studied.

A final observation, which it is hard to resist making in the context of a HESG Meeting, is that there seems little support for a Paretian stance when it comes to this particular policy problem, despite the resistance of the economics profession generally to adopting a non-welfarist stance rather than a welfarist one. In this respect the medical profession seems more closely attuned to the views of the general public, though perhaps this impression is too hastily conceived given the small number and unrepresentative nature of our respondents. For now, let it be a speculation to be tested more rigorously one day

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TABLE A: RECRUITMENT TO THE STUDY

	Potential Invitees	Actual Invitees	Attendees
Males			
<30	7	2	2
31-49	7	4	4
50+	11	7	6
Age not declared	1	0	0
Total Males	26	13	12
Females			
<30	9	6	2
31-49	12	8	7
50+	8	5	4
Total Females	29	19	13

TABLE B: FINAL GROUP COMPOSITION*

Focus Group	Age Group		
	<30	31-49	50+
1 (Female)	2	1	2
2 (Female)	0	6	2
3 (Male)	0	2	3
4 (Male)	2	2	3

* Note: 1 male aged 50+, in group 4 and one female aged 31 to 49 in group 2 attended session 1 but did not attend the second session.

TABLE C: DISCUSSION THEMES – SESSION 1

	Main discussion theme	No of times this theme appeared in the discussion	
		Males	Females
Causes of inequality in life expectancy	Nature/biological differences between the sexes	11	12
	Stress	7	4
	Lifestyle/behaviour and expectations	20	21
	Health education/awareness	4	2
	Work related issues	10	4
Causes of inequality in health	Nature/biological differences between the sexes	4	10
	Stress	1	0
	Lifestyle/behaviour and expectations	11	12
	Work related issues	3	2

**TABLE D: INEQUALITIES IN LIFE EXPECTANCY
BETWEEN THE SEXES**

Results from York Focus Groups

Respondent	Male	Female
WOULD FAVOUR FEMALES		
A + 3&1	2	0
NEUTRAL		
A + A + A	5	1
WOULD FAVOUR MALES BUT FEMALES SHOULD BENEFIT TOO		
A+A+1&3	1	0
A+A+1&2.5	1	0
A+A+1&2	1	0
WOULD FAVOUR MALES EVEN IF FEMALES GET NOTHING		
B+A	1	1
B+0&3	1	3
B+0&2.5	0	5
B+0&2	0	1
B+0&1.5	0	2
TOTAL	12	13

Median respondent is in the shaded cell

**TABLE E: COMPARING FEMALE ADVANTAGE IN LIFE EXPECTANCY
WITH MALE ADVANTAGE IN COMMAND OVER RESOURCES**

SUMMARY TABLE OF RESULTS

by the sex of the respondents

	Chose X	Chose Y	Total
Males	5	6	11
Females	8	4	12
Total	13	10	23

Compared with X, Y offers females more life expectancy
and males more command over resources.

To choose X is therefore to forego these benefits
in favour of greater equality

**TABLE F: INEQUALITIES IN LIFE EXPECTANCY
BETWEEN THE SEXES**

By the sex of the respondents

RESULTS FROM VARIOUS CONVENIENCE SAMPLES

Respondent	Male	Female
WOULD FAVOUR FEMALES		
A + 3&1	1	7
NEUTRAL		
A + A	41	40
WOULD FAVOUR MALES BUT FEMALES SHOULD BENEFIT TOO		
A+1&3	11	8
A+1&2.5	6	1
A+1&2	0	1
A+1&1.5	1	5
WOULD FAVOUR MALES EVEN IF FEMALES GET NOTHING		
B+A	11	5
B+0&3.5	6	2
B+0&3	15	21
B+0&2.5	11	14
B+0&2	4	2
B+0&1.5	5	2
TOTAL	112	108

Median respondent is in the shaded cell, but the median falls
between two modes **each in larger bold type**
in a bimodal distribution for both sexes!

Respondents:

British Medical Faculty	72 (M28 : F 44)
Spanish Health Care Personnel	48 (M 29 : F19)
Dutch MDM Forum	38 (M 15 : F 23)
ISPOR Workshop	31 (M 20 : F 11)
International Course 2003	18 (M 11 : F 7)
York Economics Dept	13 (M 9 : F 4)

TABLE G: INEQUALITIES BETWEEN THE SEXES

**Comparing female advantage in life expectancy
with male advantage in command over resources**

RESULTS FROM VARIOUS CONVENIENCE SAMPLES

by sex of the respondent

**Compared with X,
Y offers females more life expectancy
and males more command over resources.**

**To choose X is therefore to forego these benefits
in favour of greater equality**

	Chose X (%)	Chose Y (%)	Total Number
Males			
York International Course 2003	18	82	11
York academic economists	22	78	9
Dutch Forum for MDM	43	57	14
York Citizens (focus groups)	45	55	11
British Medical Faculty	46	54	28
Spanish Public Health Specialists	62	38	29
M Sc Students 2001/2	63	37	8
Total Males	46	54	110
Females			
York academic economists	40	60	5
Spanish Public Hlth Spec	50	50	20
York Citizens (focus groups)	67	33	12
British Medical Faculty	70	30	47
Dutch Forum for MDM	77	23	22
M Sc Students 2001/2	80	20	5
York International Course 2003	83	17	6
Total Females	68	32	117
ALL	57	43	227

Appendix 1: The first questionnaire

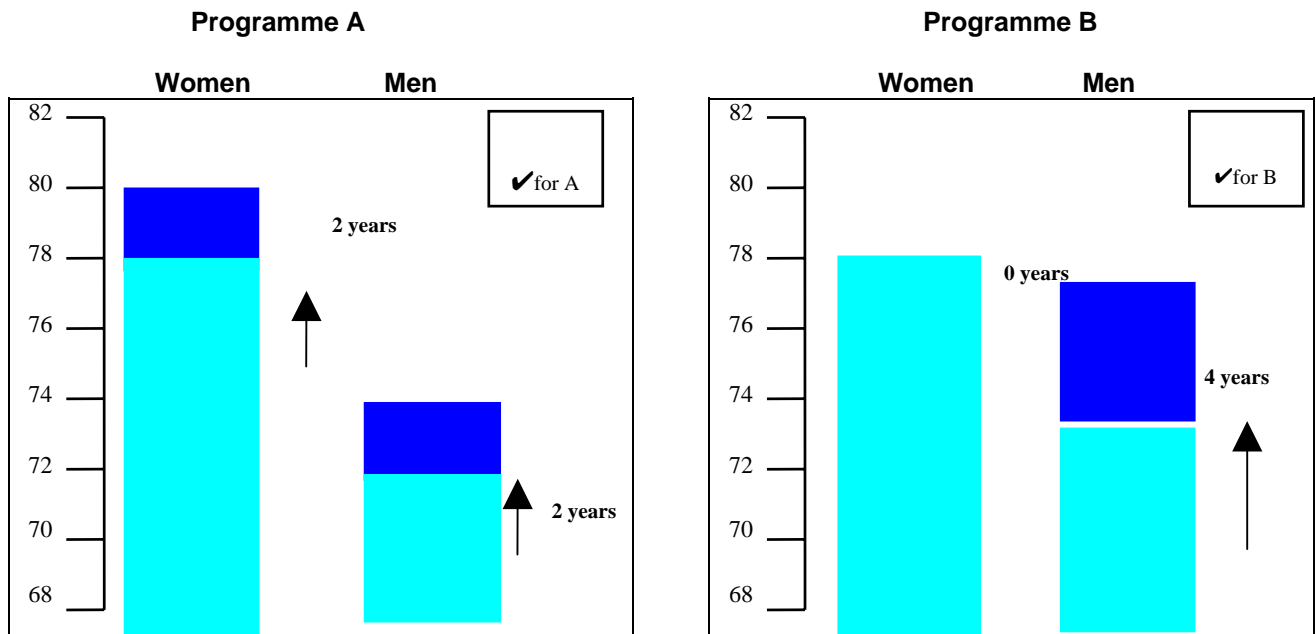
Average life expectancy differs for men and women.

Whilst actual life expectancy varies between individuals, on average, women live to be **78** and men live to be **73**.

Imagine that you are asked to choose between two programmes which will increase average life expectancy. Both programmes cost the same. In the two graphs below, the light grey part shows the average life expectancy and the dark grey part shows the increase in life expectancy. There is a separate graph for each of the programmes.

As you can see, Programme A is aimed at men and women equally and Programme B is aimed only at men.

Please indicate whether you would choose A or B by ticking one box.



If you chose A, please go to "Follow-up Sheet A".

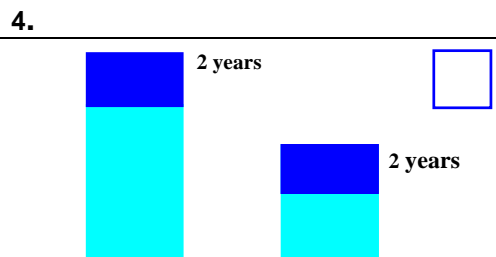
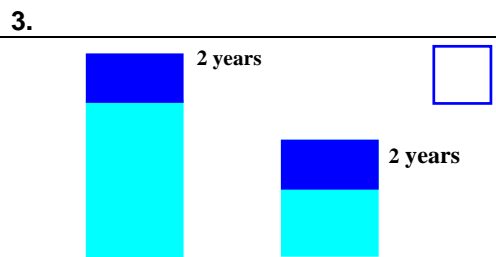
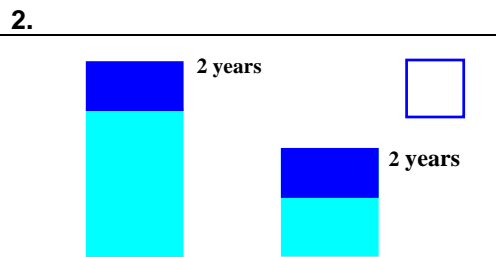
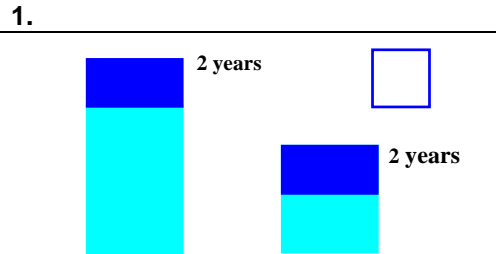
If you chose B, please go to "Follow-up Sheet B".

FOLLOW-UP SHEET A

For each of the five choices below, please tick on box to indicate whether you would still choose Programme A, or whether you would now choose Programme B.

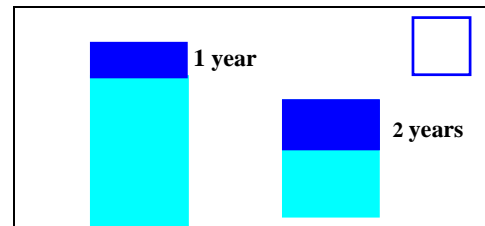
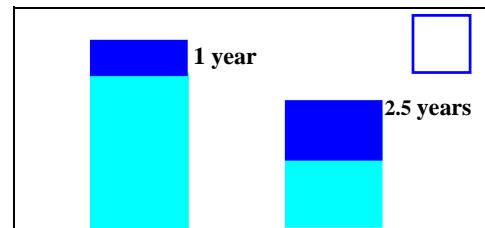
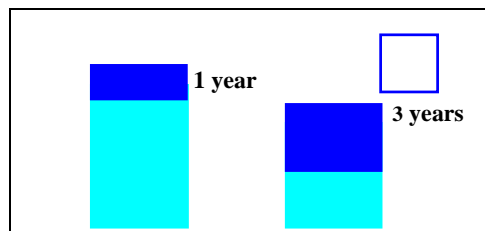
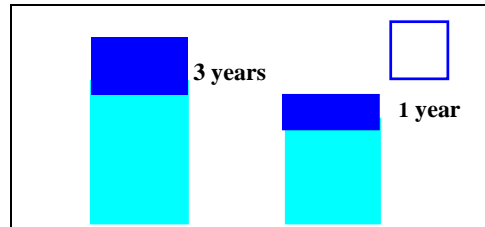
Programme A

Women Men



Programme B

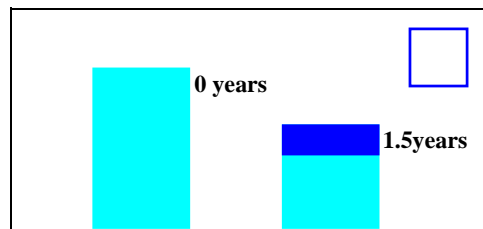
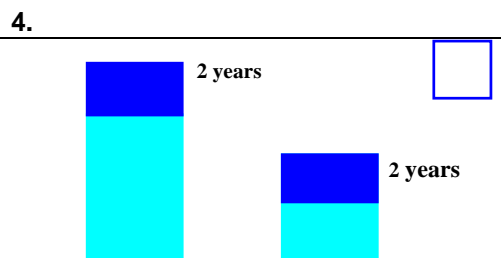
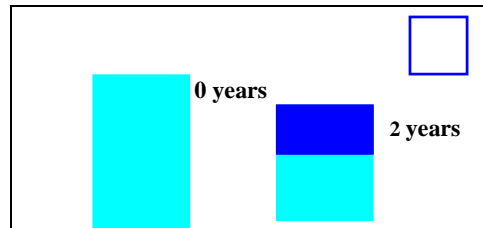
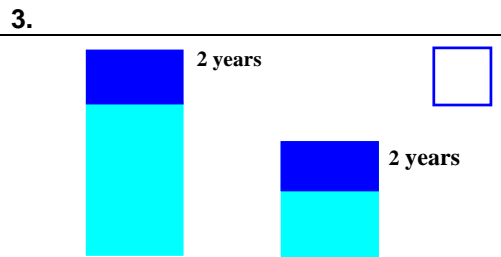
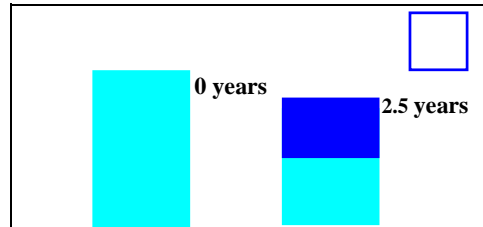
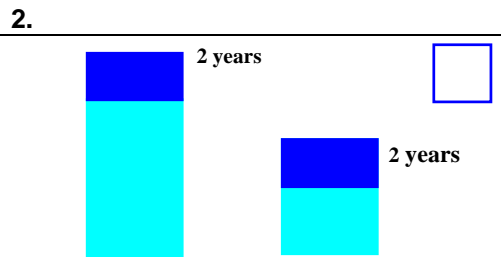
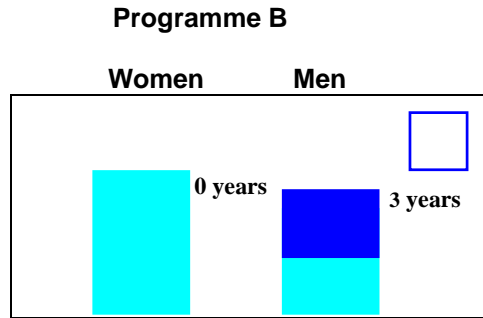
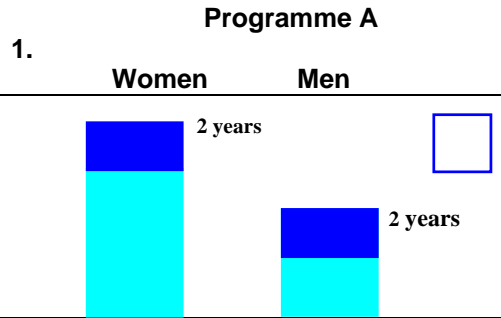
Women Men



FOLLOW-UP SHEET B

It may be that Programme B is less effective than we had first thought. This will mean that the increase in life expectancy is less overall.

For each of the **four** choices below, please tick one box to indicate whether you would still choose B or whether you would now choose A.



Appendix 2: The second questionnaire

HOW THINGS MIGHT GO IN THE FUTURE

The left-hand chart below indicates the differences that currently exist between males and females as regards life expectancy and command over resources. The two right-hand charts show two alternative predictions ('X' and 'Y') about how things might develop in the future.

Please study these three charts carefully and indicate which of the two forecasts ('X' and 'Y') you would like to come true, by ticking the box under the one you prefer.

Could you also please provide the following information about yourself:

Your age group:
 30 or younger 31-49 50 or older

Did your education continue after the minimum school leaving age?

 Yes No

Do you have a degree or equivalent qualification?

 Yes No

Indicate which forecast you prefer by placing a tick in the box underneath your preferred choice

