Extended Abstract

Gender Differentials in Health Care Among the Older Population: The Case of India

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Gender gaps in health status are persistent throughout the world. Unequal access to health-care is seen as an important factor in explaining this disparity in health outcomes (He et. al, 2007). Interest in understanding gender differences in health in the developing world can be traced to research on child mortality. In trying to explain the unusual phenomenon of excess female child mortality in regions such as South Asia, North Africa and Middle East, demographers have investigated links to factors such as nutrition, health-care and other forms of care. However, there have been very few large scale studies in India that have explored the extent of gender differentials in health-care access among the older population (NSSO, 1998; NCAER, 1992).

While the literature on gender disparity in child health has been growing, research on the factors that result in adult women having poorer access than men is still at its nascent stage in South Asia. While some studies have shown that the disparity in access is closely associated with the overall disadvantage of females in society, few have examined the various parameters that are responsible for the disparity (Sen and Sharma, 2006). It is generally acknowledged that kinship systems, gender ideologies, lack of human capital, location, economic and social resources result in differential morbidity rates and access to care.

The recently released 41,000 household, nationwide, multi-topic India Human Development Survey: 2005 provides us with a unique opportunity to research this issue. In this paper we examine the extent of gender disparity in access to health-care among people aged 60 and over.

Gender Disparity in Access to Health Care

At the outset it must be noted that research on gender disparity in access to health-care is extremely limited. Most of the research on gender differentials in the area of child and adult health relates to examining morbidity and mortality gaps and trying to understand why this is so (Case and Paxon, 2005; MacIntyre et. al. 1996; Verbrugge, 1985).

However, it is precisely studies of mortality that suggest that gender differential in terms of access to health-care seems to begin right from childhood. In many parts of the world, female children are more vulnerable to early death than male children due to

differences in the quality and quantity of nutrition, the degree of overall care, and the utilization of health-care services (Young et. al, 2006). Does this continue through the life span such that women 60 and above visit the doctor less than men of the same age or spend less on treatment?

Even when demographic characteristics such as the sex ratio do not show much or any anti-female bias, there are other ways in which women can have less than a square deal. In her study in the South of India, Iyer (2005) shows that married women in the reproductive age group, as well as older women, experience the greatest morbidity but have the poorest access to health-care. She argues that differentials in access to health-care service stems from the gender-biased normative structures that govern households. The major impediment she argues, seem to be economic. Comparing the cross-sectional data across age groups, she also finds that the access to health-care declines with age for both men and women, but the declines are greater for women from after puberty until the end of their reproductive years. On the other hand, the declines are more gradual among men compared with women and their access to care uniformly better at every interval. Women were held back from seeking treatment during their reproductive years by self-censorship and a lack of acknowledgement of their needs by their family. However, as women grow older their ability to exert power over other women and children in the house increases. Thus, she argues, their access to health-care gets better during subsequent years (Iyer 2005).

Much of the confusion in the literature stems from a lack of good data on short-term morbidity and health-care access for measuring gender disparity in adults. While there seems to be some degree of agreement in the literature that there is gender disparity in health-care access, most of the research has either focused on disparity at the early stages of life, or it has focused on women's access to maternal health (Desai and Rastogi, 2006).

There is some evidence that gender disparity seems to be greater among adults than other age groups. Women are not only twice as likely as men to fall sick with minor illnesses like fever, cough and diarrhea, but they are also less likely to seek treatment and less likely to be seen by a private practitioner when they do so (Sen and Sharma, 2006). In addition, Sen and Sharma also argue that there is a large disparity in medical

expenditures for girls and women as they age, however their paper did not examine the older population exclusively.

Data

The recent publicly released India Human Development Survey 2005, allows researchers the opportunity to examine gender disparity in health-care access, controlling for a host of significant parameters. In 2005, the University of Maryland and the National Council of Applied Economic Research designed and fielded a survey of over 41,000 Indian households. The India Human Development Survey (2005) was conducted throughout India in 33 states and Union Territories and included urban as well as rural areas.[1] This data collection was funded by grants from the National Institute of Health to the University of Maryland.

Over 17,900 elderly resided in the households interviewed. Apart from demographic details, information on household composition, caste, work, morbidity, activities of daily living, pension, and program participation are available.

Among other things, the survey collected data on short-term morbidity, viz., fever, cough and diarrhea for all household members-- children, men and women. The recall period was one month. In addition, data on long-term illnesses like hypertension, diabetes, etc. were also collected. In addition, whether they sought treatment, what kind of provider they used and expenses incurred, was also gathered. All these questions were generally answered by an adult female member in the household, often the mother of the household in nuclear families or a senior woman in multigenerational, extended households. For this paper we focus on studying the gender disparity in health and health-care access among people aged 60 and over.

Proposed Analysis

An appropriate multiple regression method will be used to analyze gender disparity in health-care of the older population. While the main independent variable of interest will be gender, the dependent variable of health and health-care will be measured in multiple ways, using constructs from information on morbidity and treatment. The

[1] Only the small island Union Territories of Lakshadweep and the Andaman and Nicobar Islands are excluded.

final model will control for all other major factors that have been shown to affect health-care--education, income, caste, urban-rural location, marital status, region effects, etc.

Table 1. Preliminary Descriptives of Population Aged 60 and Over

	Mean	Std. Dev.	Min	Max
Dependent Variables				
Sick in last 30 days	0.12	0.32	0	1
Treatment sought*				
Mean Expenditure per Episode*				
Independent Variables				
Age	67.65	7.38	60	100
Married	0.62	0.49	0	1
Female	0.49	0.50	0	1
Asset Index	8.30	4.42	0	23
Highest Adult Education	2.37	1.70	0	5
Living Arrangement				
Living Alone	0.02	0.16	0	1
Living with Spouse	0.10	0.30	0	1
Living in Nuclear Family	0.11	0.31	0	1
Living in Joint Family	0.77	0.42	0	1
Social Groups				
High Caste	0.24	0.43	0	1
Other Backward Castes	0.37	0.48	0	1
Dalit	0.19	0.39	0	1
Adivasi	0.06	0.23	0	1
Muslim	0.10	0.30	0	1
Sikh, Christian, Jain	0.04	0.19	0	1
Urban	0.23	0.42	0	1

*To be described and analyzed in the paper.
Source: Weighted IHDS 2005

Conclusion:

In a country where social security systems and affordable health-care for the older population is largely lacking or severely restricted, access to it may be dependent on the relative status of the members in a household. This paper expects to find an association between gender and health-care among the older population, wherein older women are less likely to seek treatment when sick, as well as spend less on treatment overall compared to older men, controlling for a host of significant factors.

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