"Health care of elderly and Gender disparity: with reference to Indian Society"

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Abstract

The health needs and the use of health services are greater among older age groups. The elderly population faces number of health problems in their mundane life. As people get older, they need more intensive and long-term care, which in turn may increase financial stress in the family and on its members. Inadequate income and financial insecurity are major problems faced by the elderly in India. Some studies reveals that older people have tended to be neglected in research on health inequalities compared with people in other stages of life. Similarly, there has been a lack of research on how the gender disparity, social inequity contribute to the deterioration of health in elderly. Gender disparity in health care services of elderly due to poverty will also results in poor health status, because poverty and gender differences among elderly are related with each other. In the present article an attempt had been made to find out the gender differences in health and healthcare among older people.
KEYWORDS: Gender disparity, health care of elderly, poverty and elderly.

Introduction:

Gender inequalities in health have been a major area of sociological research interest since the early 1970s. The Ministry of Social Justice and Empowerment, Government of India in its document on the National Policy for Older Persons (1999), has relied on the figure of 33% of the general population below poverty line and has concluded that one-third of the population in 60 plus age group is also below that level - 23 million. It also looks at the gender disparities among the Poverty target Programs for the Elderly in India.

The Global Report on Ageing in the 21st Century (2012) reinforces the observations made in India that there is multiple discrimination experienced by older persons, particularly older women, including in access to jobs and health care, subjection to abuse, denial of the right to own and inherit property, and lack of basic minimum income and social security (UNFPA & Help Age International, 2012).

Women and men have different health care needs. Compared with men, women's health needs are more complex and change over their life's course, often requiring multiple providers and specialists (Bierman and Clancy 1999). Women also have fewer resources to address their health care needs. Rising health care costs have a disproportionate impact on women even those with health insurance because of their lower socio-economic status.

Objectives:

1. To introduce the concept of gender disparity in health.

2. To study the impact of gender disparity on healthcare of elderly.

Materials and Methods: Considering the available literature on health disparity and inequalities among the elderly, the researcher has used the secondary sources that are reference books and journals, articles and reports of scholars, NSS, WHO.

Concept of gender disparity in health:

Health disparity has been defined by the *World Health Organization* as the "differences in health care received that are not only unnecessary and avoidable but are also unfair and unjust. The existence of health disparity implies that there is no health equity. Equity in health refers to the situation whereby every individual has a fair opportunity to attain their full health potential, and if avoidable, no one should be disadvantaged from achieving this potential. Overall, the term "health disparities," or "health inequalities," is widely understood as the differences in health between people who are situated different positions in a socio economic hierarchy."

Advocating gender equity in health does not mean insisting that women and men receive equal quotas of resources and services. On the contrary, it means that resources are assigned and received differentially, according to the needs of each sex within their socioeconomic context. Equity in health status does not imply equal levels of mortality and morbidity among women and men, but the elimination of avoidable differences between them with respect to opportunities to enjoy health, vulnerability to illness or disability and premature death.

The most important access difficulty is due to gender related distance. It is said that health of society is reflected from the health of its female population. That is completely disregarded in many of the south Asian countries including India. Gender discrimination makes women more vulnerable to various diseases and associated morbidity and mortality. From socio-cultural and economic perspectives women in India find themselves in subordinate positions to men. They are socially, culturally, and economically dependent on men. Women are largely excluded from making decisions, have limited access to and control over resources, are restricted in their mobility, and are often under threat of violence from male relatives. Sons are perceived to have economic, social, or religious utility; daughters are often felt to be an economic liability because of the dowry system. In general an Indian woman is less likely to seek appropriate and early care for disease, whatever the socio-economic status of family might be. This gender discrimination in healthcare access among aged becomes more obvious when the elderly women are illiterate, unemployed, widowed or dependent on others. The combination of perceived ill health and lack of support mechanisms contributes to a poor quality of life.

Another dimension of aged women is, they are more in number in the aged population in comparison with their male counterparts, but old age social security and benefits are fewer for women. This is mainly due to non availability of old age income security programs for the workers in the large informal sector and coverage gap in the formal sector.(P. Madhava Rao, Social Security for the Unorganised in India) That is why there are poorer and needy among the female aged widows than among the male aged. They also suffer from more chronic diseases more intensely and also from disabilities. The situation has heavy financial implications for the health and social service sectors. Therefore, it will be a challenge for the welfare state to find a viable social security system for women that will meet their health and other old age needs.

The problems faced by the elderly generally arise from inequality of opportunity for employment; inadequate income; unsuitable housing; lack of social services and of provisions for sustaining physical and mental health; stresses and

strains produced by changing family patterns and family relations; and lack of meaningful activities in retirement.

Review of Literature:

Kenzie A. Cameron, M.P.H, Jing Song, M.S, Larry M. Manheim, and Dorothy D. Dunlop (2010) in their work *Gender Disparities in Health and Healthcare Use among Older Adults Health needs* says that health needs were substantially greater among older women compared with men, but women had fewer economic resources. Controlling for health needs did little to explain gender differences in preventive care and increased gender differences in the use of hospital services. Women were less likely to have hospital stays (adjusted odds ratio [OR] = 0.79) and had fewer physician visits (3.07 vs. 3.30 median visits within 2 years) than men with similar demographic and health profiles. In contrast, the greater use of home healthcare among women was almost entirely explained by their greater health needs.

Subhojit Dey, Devaki Nambiar, J. K. Lakshmi, Kabir Sheikh, and K. Srinath Reddy. (2012) in their work *Health of the Elderly in India: Challenges of Access and Affordability* they opines that the growth of the elderly population in the coming decades will bring with it unprecedented burdens of morbidity and mortality across the country. As they have outlined, key challenges to access to health for the Indian elderly include social barriers shaped by gender and other axes of social inequality (religion, caste, socioeconomic status, and stigma). Physical barriers include reduced mobility, declining social engagement, and the limited reach of the health system. Health affordability constraints include limitations in income, employment, and assets, as well as the limitations of financial protection offered for health expenditures in the Indian health system.

Disparity among Aged due to inequity: Inequalities in health and longevity are reflected in stratification within our society based on factors, such as Education, Income, and Gender. The heaviest burden of ill health is carried by the deprived section of society; aged, especially women. Due to poverty and poor economic sources the disparity among elderly occurs. The health status of aged women is not satisfactory when compared with men, their male counterparts. As women works much longer hours than men do. They sacrifice nutrition, healthcare and leisure for themselves most of the times. Women work even after getting old, sick. It's inevitable to do so. They have to look after their family affairs and take care of aged spouse, children and grandchildren. So, aged women play multiple roles in family and society.

Some of the healthcare aspects arise due to inequity among aged women

- Women, who tend to live longer, are generally found to be less healthy and report more severe disability.
- Women report more multiple health problems associated with chronic conditions (e.g., arthritis, rheumatism, high blood pressure, back problems, and allergies)
- Women are more likely to report limitations in activities of daily living or disability in later life. (although likelihood of disability increases with age for both sexes)
- More than four-fifths of the population, the elderly persons live in rural areas, and female elderly outnumber the men. Factors in women's lower mortality

possibly biological/genetic component, but also determined by social and economic factors.

- The most vulnerable are those who do not own productive assets, have little or no savings or income from investments, have no pension or retirement benefits, and are not taken care of by their children, or live in families that have low and uncertain incomes and a large number of dependents. Nearly half of the elderly are fully dependent on others.

Implications of gender differential and poverty on elderly:

- Women more likely than men to be widowed, not remarry, live alone, and are poorer; but also more likely to maintain social support networks into old age.
- We actually can afford better social services for the elderly because of economic activity, which continues to increase over time nearly half of elderly women without a spouse live in poverty.
- Although equation of old age with declining health is valid with regard to physical health, is less true of psychological and emotional health and social well-being. With advancing age, about 77% of men and 85% of women aged 65+ suffer from at least one chronic condition; i.e. persistent physical or mental health problem.
- An analysis of systematically ascertained chronic conditions demonstrated that women reported more arthritis, hypertension, and poor vision than did men, whereas men reported a higher incidence of cancer, diabetes, and heart disease. No gender difference was identified for obesity, pulmonary disease, or stroke. Women also reported fewer economic resources in terms of income and wealth than men. Although similar proportions of men and women had health insurance coverage through Medicare, Medicaid coverage was more frequent among women. But the chronic conditions do not necessarily interfere with day-to-day functioning…
- The most common chronic conditions are arthritis and rheumatism, eye problems such as cataracts or glaucoma, back problems, heart disease, and diabetes
- Family roles and the persistence of sexual division of domestic work at older ages can be important determinants of health status and gender inequalities in health.
- Health needs were substantially greater among older women compared with men, but women had fewer economic resources. Controlling for health needs did little to explain gender differences in preventive care and increased gender differences in the use of hospital services. Women were less likely to have hospital stays than men with similar demographic and health profiles. In contrast, the greater use of home healthcare among women was almost entirely explained by their greater health needs.
- Among adults >age 65, women tended to be older than men and were more likely to live alone. Women reported more health needs in terms of functional limitations (mobility, stair climbing, upper extremity difficulty) and disability than men. An analysis of systematically ascertained chronic conditions demonstrated that women reported more arthritis, hypertension, and poor vision than did men, whereas men reported a higher incidence of cancer, diabetes, and heart disease. No gender difference was identified for obesity, pulmonary disease, or stroke.

Findings:

The chief underlying cause of health disparities is increasingly understood to be social and economic inequality; i.e., social bias, racism, limited education, poverty, and related environmental conditions that either directly produce ill health or promote unhealthy behaviors that lead to poor health. In order to reduce the occurrence of health disparities, instead of just treating already high rates of disease, preventive action must also occur at the systems level.Women are frequently caught in a vicious cycle of poverty and starvation where low nutrition early in life reduces learning potential and productivity and increases health risks at older age. Women generally live longer than men; however this means that women over 60 live more years in ill-health than men over 60.[i] Healthcare is too expensive for many poor older women to access.

Sexual and reproductive rights of post-menopausal women are rarely considered in reproductive health programmes. Lack of medical staff trained in age-related illnesses and basic gerontology is a common barrier to appropriate healthcare for older people.

The stigma of aging, as well as the health and social conditions the elderly commonly face (such as dementia, depression, incontinence, or widowhood), is another social barrier to access of health, manifest in the Indian case in unique ways (World Health Organization [WHO], 2002)

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Conclusions:

Family roles and the persistence of sexual division of domestic work at older ages can be important determinants of health status and gender inequalities in health. A comprehensive care package that includes promotive, preventive, curative and rehabilitative services in the area of health needs to be worked out for holistic promotion of health among the older persons. The socio-economic profiles of the elderly population are undergoing a change and many elderly persons want to lead an active life of fulfilment for themselves, their families and the community. The Government and NGO's strive hard for the upliftment of the existing conditions of elderly. These policies and programmes can act only as an instrument for bringing some changes in the conditions of elderly but the youngsters should change their attitude in take caring of their elderly parents. In spite of the poverty the family of aged should give the minimum healthcare rather than depending on the government or NGO. The social inequity and gender disparity among the aged in terms of health care should be minimized and reduced.

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