Whether the Poverty of Women in Childhood and Adult Ages Affect Quality of their Health in Later Years?

Extended Abstract

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Rationale and Objectives

With the ageing of societies, quality of additional years gained in life of individuals becomes a crucial issue. Are these healthy and productive years, or spent with disability, ill health, misery and mental disorder? In many developing countries, population ageing has begun in the midst of epidemiological transition where in, the prevalence of infectious diseases continues to be large. Several people in these societies carry burden of childhood infections and poor adult health into the old age. Further, in most of these countries, women generally have unequal and inadequate access to basic services, food and nutrition from throughout their lives. It is natural to have adverse outcome in later years. Then there is evidence that the behaviour of particular biological factors that lead to higher disease and disability burden among women in old age is further exacerbated by life-long discrimination against them.

On the other hand, female life expectancy is rising. In several countries (mostly in the developed world), where male and female life expectancy was equal, females have acquired an edge. In countries where females had a lower life expectancy than men (largely in developing countries), gender gaps have narrowed. Demographers have anticipated that with the continuation of the current trend, in developing countries the gender gap in life expectancy will widen again, but with an advantage for women.

Against the above backdrop, several questions arises, if despite of relative deprivation and poverty conditions in childhood and adult ages, women are living longer than men, is it a quality life? How it is different than men? This research is an attempt to answer some of these questions by taking India as a case. It carries out a comparative analysis of disease and morbidity burden of men and women in old age

and vis a vis relative deprivation experienced by women in nutrition, health care, education etc. in childhood and adult ages.

Data Sources and Analysis

The analysis is based on secondary data culled out from Indian census (1981, 1991 and 2001) large scale surveys (NFHS: 1993,1999, 2006; NSS: 1991 and 2000) and other sources. The reference period of the study is last two decades of the 20th century. The study variables are identified through a correlation analysis on the basis of their predictive value for quality of life in old age and access to necessities of life in childhood and adult age. People above 60 years of age are considered as old. Population under 15 years is considered as children and between 15 to 49 years as adult. The variable chosen for studying the old age disabilities are; blindness, locomotion, amnesia, hearing and speech impairment. For studying the morbidity pattern in old age, prevalence of pain in joints, tuberculosis, cough, blood pressure and heart problems are considered. Levels of nutrition, immunisation coverage, access to health care and primary education are chosen to depict the relative access of men and women to necessities of life in childhood. The variables chosen to depict the quality of life of women in adult years are; domestic violence against women, proportion of men and women employed in organised sector, access to health care services, and household income/assets. It is a macro level analysis taking state as a unit of analysis.

IV. Major Findings

IV.1: The projected figures of Indian population indicate that the proportion of women in 60+ year age group is rising more rapidly than males. In the year 1996 the proportion of males and females in 60+ categories was almost equal (6.67 percent each). It is projected that in twenty years (in 2016) this proportion will become 9. 05 for females and 8.84 for males. It closely corroborate with the relative rise in the expectancy of life at birth of women which in recent years has surpassed men (for many decades in the past women have had a lower life expectancy). Further, though the expectancy of life at birth for Indian people has increased from 41.3 years in 1960 to 62.9 years in 1999, the gains have largely been in childhood years. Persons above the age of 60 years did not gain many years in life. The expectancy of life at

age 60 is was 18 years for women and 16 years for men (though women have had advantage here also).

IV.2: There are significant regional variations. States like Kerala with an expected length of life at birth of 75.6 years are at the top of the list. At the age 60 years also, women in Kerala are expected to live 20.6 additional years. However, most other Indian states lag far behind. This phenomenon closely corroborate with the socio-economic and demographic profile of women across the states.

IV.3: A time series analysis of prevalence of chronic diseases (pain in joints, tuberculosis, cough, blood pressure and heart problems) among elderly men and women at two points of time that is, 42nd (1986) and 52nd (1996) rounds of NSS, with respect to self-reported prevalence of diseases was attempted. (*Though in self-reporting of symptoms, a tendency of over-reporting has been noted, comparison at different points of time or across sub-groups of population may neutralize this phenomenon and reflect on trend).* The analysis indicates that the overall reporting of illness has indicated an increasing trend during 1986-96. Among men it has increased form about 45 percent in 1986 to 53 percent in 1996. The gender specific difference in the prevalence of chronic diseases in old age was minimal.

More than one third of elderly were reportedly suffering from one or other disability. Poor eye sight followed by hearing impairment is the largest reported disabilities. Locomotion and amnesia (senility) were reported by 6 to 12 percent elderly persons. Speech impairment was relatively less. Overall, more than one third of elderly were reportedly suffering from one or other disability. Though the reporting of physical impairments was somewhat higher among females than males, the difference between the two was not significant. Only in case of visually handicapped, women's disadvantage was noteworthy.

IV. 4: A rank correlation coefficient analysis between disease and disability burden of men and women and variables depicting deprivation to quality of life in

childhood and adult ages was carried out. The data from 14 major states were used for the analysis.

The analysis did not show any significant effect of deprivation in childhood and adult ages on health status of women in elderly ages. Not only women are living longer, their health status is also at par with men. The pattern observed for India is quite close to the one observed in the WHO study of 12 developing countries. It notes a longer healthy life expectancy for women in 10 out of 12 countries (except in Tunisia and Egypt) (Kensella: 1993). Several developed countries also depict a similar pattern.

In the context of India, possible explanations could be found in the socio-cultural domain of society. In spite of discrimination and neglect, the family institutions provide protection and care particularly, to elderly women. Further, in Indian society, transition to old age provides new opportunities and status to women. They exercise more power in the household as mothers-in-laws or grandmothers than they did as younger women. Data on living arrangements of the elderly endorse this point.

The analysis also shows that the quality of life (in terms of free from diseases particularly pain in joints and cough, two major diseases of old age) of the elderly in India has not shown much improvement during the decade 1986-96. Against a backdrop of continuously improving life expectancy of women (as compared to men) it means that quality of life during additional years gained should be studied and addressed.