WHETHER THE POVERTY OF WOMEN IN CHILDHOOD AND ADULT AGES AFFECT THEIR HEALTH STATUS IN LATER YEARS?

Extended Abstract

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I. Rationale

With the ageing of societies, quality of additional years gained in the 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 are likely to carry burden of childhood infections and poor adult health status into the old age. Further, in most of these countries, women generally have unequal and inadequate access to basic services, food and nutrition throughout their lives. In poor households and communities, women work harder than men, but eat less. The situation of women has changed very little in spite of several decades of development efforts. Then there is evidence that the behaviour of particular biological factors that lead to higher disease and disability burden among women in old age are 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, the gender gap in life expectancy (in developing countries) will widen again, but with an advantage for women.

Against the above backdrop, an obvious question arises, whether the men and women have different experiences of aging in these societies? Though the initial

gains in expectancy of life are generally due to lowering of childhood mortality, the further gains are attributable to the rise in old age life expectancy only. If despite of relative deprivation in childhood and adult age and poverty conditions, women are living longer than men, is it a quality life? How it is different than men?

II. Objectives

This research is an attempt to answer some of these questions taking India as a case. It carries out a comparative analysis of disease and disability burden of men and women in old age and investigates relationship between relative deprivations in nutrition, health care, education etc. in childhood and adult age and health status of women in old age.

III. Data Sources and Methods

The analysis is based on secondary data culled out from Indian census (1981,1991 and 2001) large scale surveys (NFHS: 1993 and1998, 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 depicting linkage between quality of life in old age and access to necessities of life in childhood and adult ages. The old age is defined as people above 60 years of age. 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, prevalence of pain in joints, tuberculosis, cough, blood pressure and heart problems are considered. Level 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 in adult ages 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 indicates that the proportion of women in 60+ years age group is rising more rapidly than males. In the year

1996 the proportion of males and females in 60+ category was almost equal (6.67 percent each). Twenty years later in 2016 this proportion will become 9. 05 for females and 8.84 for males. It closely corroborate with a relatively rapid rise in the expectancy of life of women at birth that in recent years has surpassed men (for many decades in the past, women have had a lower life expectancy). The expectancy of life at age 60 is 18 years for women and 16 years for men. 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. It has been largely attributed to relatively lower public health attention on the elderly.

IV.2: There are significant regional variations in the mortality experience of women. With an expected length of life at birth of 75.6 years, Kerala women aged 60 on an average can expect to live for 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 Indian 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 the trend).* The analysis indicates that the overall reporting of illness has increased during 1986-96. The gender specific difference in the prevalence of chronic diseases in old age is however, minimal.

More than one third of elderly were reportedly suffering from one or other disability. Poor eye sight followed by hearing impairment are the largest reported disabilities. Locomotion and amnesia (senility) were reported by 6 to 12 percent elderly persons. Speech impairment was relatively less. 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 multiple regression 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 old ages. Not only women are living longer, their health status is also at par with men.

The explanations are found in the socio-cultural domain of the Indian society. In spite of discrimination and neglect, the family institutions provide protection, care and respect to old women. In the Indian society, transition to old age provides new opportunities and status to women. They exercise more power in the household as mothers-in-law or grandmother 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 addressed.