Gender Differential in Health and Treatment Seeking Among Elderly in India: Does Living Condition Matters?

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Extended abstract:

By 2020, the number of elderly people is projected to reach more than 1000 million, with 70 percent living in developing countries, especially in China, India, Indonesia, Brazil, and Pakistan. India has the second largest elderly population in the world after china. Our understanding of the determinants of living alone has been limited because of paucity of large, representative data sets including detailed information on their socio-economic, and health status of the elderly. The gaps in research also include the lack of information on income and wealth of the elderly in developing countries, the interaction between the wealth of the elderly and their social dependency and the relationship of the elderly's living arrangements to health and housing for young people. There are also gaps in knowledge about the effects of socioeconomic conditions on the health of the elderly, changes in risk factors and morbidity, and the needs of the elderly.

The impact of old age on women is different from that of men because of differences in their status and role in society. This is specially so because proportion of widows in 60+ age group is considerably higher than of widowers. In view of the above discussion this paper explores the gender differential in the health status, health risk and treatment-seeking behavior of elderly according to living condition in India. Data has been taken from second national family health survey (NFHS-2) conducted in 1998-98. Paper is based on 39694 elderly in India residing in a random population of about half million.

Findings

Relatively more older person are living alone than with family (42.3 and 37.6 percent respectively). Among elderly living alone, majority are females. Sixty-two percent elderly are married and 37 percent are widow/widower. However, a majority of the

elderly living alone are widow/widower. Relatively more proportion (76 percent) of elderly living alone are illiterate than elderly living with family (65 percent). A majority (75 percent) of the elderly living alone belongs to a lower standard of living (SLI). Thirty-five percent of the total elderly are working. However, almost half of the elderly living alone are working in comparison to 35 percent of the elderly living with family. Further, 92 percent of the elderly are working for cash. Here also relatively more percentage of elderly living alone are working for cash than elderly living with family.

A gender differential in the socio-economic status of the elderly has been found. More than half of the female elderly are widowed whereas majority of the male elderly are married. However almost all female elderly who are living alone are widow as compared to 65 percent widower00 male elderly living alone. A majority (82 percent) of the female elderly are illiterate compared to 50 percent male elderly. A negligible proportion (2 percent) of the female elderly are educated high school and above compared to 13 percent of male elderly. According to living arrangement, situation of the female elderly living alone worsened. Eighty-eight percent of the female elderly living alone are illiterate compared to 47 percent of the male elderly. There exist significant gender differential in the working status of the elderly. About 55 percent of the male elderly are working compared to only 14 percent female elderly. However, the gap between the working status of the male and female elderly gets minimized according to the living arrangement. About 61 percent of the male elderly living alone are working compared to 41 percent female elderly living alone.

Health status and health risk among elderly according to living condition

A significant differential has been found in the health status of the elderly according to living condition. More proportion of elderly living alone (15 percent) are suffering from asthma than elderly living with family (10 percent). Almost double proportion of elderly living alone (2.7 percent) is suffering from TB than living with family (1 percent). A huge differential regarding the treatment of TB has been found among elderly according to living arrangement also. Only half of the elderly living has received treatment

compared to 84 percent living with family. In case of malaria and jaundice also a remarkable differential is found according o living arrangement of elderly. Elderly living alone have been found more prone to malaria and jaundice than elderly living with family which indicates lack of care and support towards elderly living alone which results in their proneness to infectious diseases.

On the other hand, looking towards the health risk behaviour, in all the risk behaviours like drinking alcohol, tobacco chewing and smoking, elderly living alone are behind the elderly living with family except for chewing tobacco. But other health risk factors related to environment and nutrition are found more among elderly living alone. Significantly more proportion of elderly living alone does not purify drinking water and use unclean cooking fuel, than elderly living with family.

Nutritional risk has been seen for salt use. In this risk also, a significantly higher proportion of elderly living alone are using coarse salt (70 percent) than elderly living with family (56 percent). Moreover, iodine content in salt has been found to be nil among 41 percent of elderly living alone than 30 percent of elderly living with family.

Thus the above discussion brings out the facts that elderly living alone are again more prone to environmental and nutritional risk factors and also their health status is poorer than elderly living with family.

Relatively more proportion of male elderly are found to suffer from asthma and TB than female elderly. A remarkable gender gap can be seen in treatment of TB. More proportion of male elderly (86 percent) has got treatment for TB compared to female elderly (74 percent). Moreover, if female elderly are living alone, almost two third of them did not get any treatment for TB. On the other hand, in case of malaria and jaundice, gender differential is found. However, male or female living alone are found to be more prone to malaria and jaundice than they live with family.

Looking to the health risk behaviour, a huge gender differential has been found in all the health risk behaviour. Male elderly are significantly more indulge in drinking, smoking and chewing tobacco than female elderly. Moreover, male elderly living alone are found to be more indulged in drinking, smoking and chewing tobacco habits than elderly living with family. Also, female elderly living alone are found to be chewing tobacco more than elderly living with family.

Looking at the environmental risk factors like drinking water and fuel, no gender differential exists. However, according to their living arrangement, significant differential is found. More proportion of male as well as female elderly living alone do not purify drinking water. Also, more proportion of female (84 percent) elderly living alone use unclean fuel than 74 percent of female elderly who lives with family. But less proportion of male elderly living alone (73 percent) uses unclean fuel than living with family (76 percent).

In case of nutritional risk, also gender differential has not been found. However, it is their living arrangement, which makes difference in nutritional risk. More proportion of male and female elderly living alone uses coarse salt than elderly living with family. Also, more proportion of female and male elderly living alone uses salt with zero iodine content than elderly living with family.

Thus the above discussion indicates that, there exists a gender differential in the health status of the elderly and male elderly have worst health condition. It may be because of the fact that male elderly indulge in significantly high health risk behaviour such as drinking alcohol, smoking and chewing tobacco than female elderly. Further, both male and female elderly living alone have significantly more health problems, risk behaviour and also have environmental and nutritional risks.

Gender differential in treatment seeking behaviour by living arrangement

Though there does not exist any gender differential in the treatment seeking behaviour of the elderly, but differential can be found according to their living arrangement. Relatively

more proportion of male elderly living alone are taking treatment in the public sector/NGO/trust/shops, homes or other places than male elderly living with family. Similar situation has also been found in case of female elderly even with more gaps according to the living arrangement. Forty-three percent of female elderly who are living alone are taking treatment in the public sector/NGO/trust compared to 29 percent female elderly living with family.

Thus the above discussion shows that living arrangement makes a significant difference in the treatment seeking behaviour. More proportion of elderly of either sex who are living alone are seeking more treatment from shop, home or other places than elderly living with family which makes them more vulnerable to diseases. It is a general practice that, weaker section of the society seeks treatment mostly from public sector/NGO/trusts, shops, homes and other places because of paucity of money. This finding also commensurate with finding from NFHS-2 for all India, which shows that use of health-care services, is strongly influenced by the standard of living of the household. As the standard of living increases, use of private sector services increases (IIPS and ORC Macro, 2000).

Logistic regression results for different morbidity conditions among elderly

Logistic regression has been restored to show the adjusted effects of living arrangement and other background characteristics on different morbidity conditions among elderly. Considering asthma, living arrangement, age, sex, education, working status, type of coking fuel used and quality of drinking water ha a significant impact on asthma among elderly. The most important factors found are living arrangement and type of cooking fuel used. Elderly living alone are found to be 1.7 times more likely to suffer from asthma with reference to elderly living with family. Elderly who do not use clean fuel for cooking are one a half times more likely to suffer from asthma with reference to elderly who uses clean fuel for cooking. Also higher the age of the elderly the likelihood of asthma is significantly more. Female elderly has almost half time less likelihood of suffering from asthma. Also, higher the education status of the elderly, the likelihood of

suffering from asthma is found to be less. Further, the likelihood of suffering from asthma is significantly less among not working elderly (OR-0.62).

Considering TB, again living arrangement, sex, ethnicity, types of house and working status has been found to be significant factors for TB among the elderly. Elderly who are living alone are found to be more than two times lore likely to suffer from TB than elderly living with family. Again female elderly are less likely to suffer from TB than their male counterparts. Elderly belonging to scheduled tribes are one and half times more likely to suffer from TB with reference to scheduled castes. Also, elderly residing in *kachcha* houses are one and half times more likely to suffer from TB with reference to elderly residing in *pucca* houses. Again, not working elderly are less likely to suffer from TB.

In case of malaria, living arrangement, ethnicity, types of house, working status, types of cooking fuel used and quality of drinking water has emerged a significant predictors. Elderly living alone are found to be more than two and half times more likely to suffer from malaria than elderly living with family. Also, the likelihood of malaria is found to be more than two times significantly higher among elderly who does not use clean fuel for cooking with reference to elderly who uses clean fuel for cooking. Moreover, elderly residing in *semi-pucca* and *kachcha* houses are about one and half times more likely to suffer from malaria with reference to elderly living in *pucca* houses. Also, scheduled tribe elderly are more likely to suffer from malaria (OR-2.2) with reference to scheduled caste elderly whereas, elderly belonging to other ethnic group are less likely to suffer from malaria. However, elderly educated high school and above, elderly belonging to Muslim and Sikh religion are significantly less likely to suffer from malaria with reference to elderly who are illiterate and elderly belonging to Hindu religion. On the other hand in contrast, not working elderly were found to suffer more from malaria (OR-1.2) than working elderly.

In case of jaundice, living arrangement, type of house, ethnicity, type of cooking fuel used and quality of drinking water have been found as significant factors. Elderly living

alone are found to be almost three times more likely to suffer from jaundice than elderly living with family. Also, elderly belonging to scheduled tribes are found to be one and half times more likely to suffer from jaundice. Elderly living in semi *pucca* and *kachcha* houses are again significantly more likely to suffer from jaundice than elderly living in *pucca* houses. Environmental factors like type of cooking fuel used and quality of drinking water both has been found to be significant factors for suffering from jaundice. Elderly who does not use clean fuel for coking are found to be 1.6 times more likely to suffer from jaundice. However, elderly who purify their drinking water are significantly less likely to suffer from jaundice (OR-0.73) than elderly who does not purify drinking water.

Thus the above four models for different morbidity conditions show that in all the morbidities, living arrangement of the elderly emerged out as the most predominant factor even after controlling for the socio-economic, demographic and other environmental factors. Elderly living alone are significantly more likely to suffer from all the diseases than elderly living with their family.

Conclusion

The paper comes out with an important policy implication that elderly living alone should be taken more care with strong public support system especially those elderly who belongs to the weaker section of the society. Findings from the study show elderly living alone are the most vulnerable group in their health status, health risk behaviour and also in environmental risk and nutritional risk. Even after being much old, a majority of elderly are working and also for cash. Further, majorities of female elderly are widow. Moreover, who are living alone, almost all the female elderly are widow. Thus, public support for widow elderly should be strengthened more rationally. Elderly living alone not only are in risk in terms of health and health behaviour but also in terms of environmental as well as nutritional risk.