

Gender Differences among Old Persons Worldwide: Facts and Conclusions

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INTRODUCTION

It is well established worldwide that, women in comparison to men, are disadvantaged in almost all indicators of wellbeing including health, physical and mental functioning, as well as economic, educational, psychological and social aspects. The question addressed in this paper is, whether due to the biological selection, changes in social roles, and governmental pensions which are customary in old age in many countries, the gap in wellbeing between men and women narrows in old age. In other words, we aim to support one of two opposing hypotheses: the convergence or the divergence hypothesis, using international data sets as our basis.

Gender differences have been reported in several domains of life. Since the seventies, the biomedical literature showed that women suffer from higher morbidity than men due to acute and chronic physical and psychiatric illnesses (Nathanson, 1975; Waldron, 1983; Verbrugge, 1985, 1986, 1989). These differences in morbidity held even when conditions associated with reproduction were excluded (Nathanson, 1975; Verbrugge, 1985). The findings were similar whether they were based on self-reports or more objective measures.

Women also tend to be more moody than men (Dowdy et al., 1996), more worried (McCann, Stewin & Short, 1991), anxious (Bernstein & Carmel, 1991; Stewart, Taylor & Baker, 1997), stressed and depressed (Rosenfield, 1980, 1989; Gove, 1984; Kessler, Price & Wortman, 1985; Verbrugge, 1989; Lennon, 1995; Mirowsky, 1996; Kark, et al., 1996). Furthermore, many studies have found that women score lower than men on psychological indicators of wellbeing such as self-esteem (Rosenfield, 1980; Fleming & Countey, 1984; Feingold, 1994; Raymore, Godbey & Crawford, 1994; Orr & Dinur, 1995; Carmel & Bernstein, 2003), satisfaction with life (Verbrugge, 1989; Wood, Rhode & Whelan, 1989; Kark et al., 1996; Carmel & Bernstein, 2003), and the will-to-live (Carmel, 2001).

Some studies pointed out, that men suffer more from potentially fatal diseases than women, who, in turn, have higher rates of milder illness conditions (Marcus and Seeman, 1981; Haavio-Manila, 1986; Verbrugge, 1984, 1986, 1989). This can partly explain why despite living longer, women complain more than men about health problems, perceive their health status as worse than that of men, are more depressed, and less satisfied with their lives (Carmel, 2001).

The question that arises is whether gender differences in physical and psychosocial wellbeing diminish in old age as a result of a natural biological selection that occurs during late adulthood, the changes in men's and women's social roles, and equal governmental pensions provided to old people in many countries. Two opposing hypotheses regarding the persistence of gender differences in physical and psychosocial well-being in old age are found in the literature - the convergence and divergence hypotheses.

Some researchers in developed nations have addressed this question. Verbrugge (1985, 1986) reported in a number of studies that the gender gap narrows in old age with regard to frequency of illnesses, drug consumption, and use of health services. Support for diminishing gender differences with aging in protective health behavior and in the utilization of health services in old age are also reported in Israeli studies (Anson, Carmel & Levin, 1991; Carmel, Shani & Rosenberg, 1994). Some national studies that distinguished among various age groups of elderly persons indicate that gender differences

are maintained in old age with a tendency to diminish only from the age of 80 (Macintyre, Hunt & Sweeting, 1996, Carmel & Bernstein, 2003). Regarding functional disabilities and depression, findings indicate that the gaps between men and women increase with aging (Arber & Ginn, 1995; Beckett et al, 1996; Mirowsky, 1996).

The purpose of this paper is to address the question of gender differences in health and wellbeing in old age, as well as trends of change by analyzing international data sets.

RESULTS AND DISCUSSION

Gender comparisons will focus on life-expectancy, health and functioning, socio-economic status, and indicators of wellbeing.

Life expectancy

Regarding life expectancy, women outlive men in all the continents and in almost all the countries of the world (Tables 1 and 2). However, the difference in years between genders decreases with age in all countries. Furthermore, in some of the less developed nation, life expectancy for both genders becomes similar or even higher for men, as for example in the ages of 85-89, and 100+ in Egypt, India, Turkey and China (Table 1). In most of the less developed nations the gender discrepancy in life expectancy is smaller than in the developed nations, and it has increased relatively more in favor of women in the last 35 years than in the developed nations (OECD, 2007). This phenomenon is also expressed in the sex ratios (number of men per one hundred women), which increase from the more developed to the less developed, and are lowest in the least developed nations (Table 2), and in the countries of the former Soviet Union.

Accordingly, the percentage of women in the aged population increases with age in most countries, especially in the developed countries, but in some countries such as India, an opposite trend is noticed, where the percentage of women decreases in the older age groups (U.S. Census Bureau, 2000a).

Health and functioning

Some international comparisons indicate that while women outlive men, their health is worse and they live more years with disability. Jacobzone (1999) who calculated the portion of old age (from the age of 65) lived without needing significant help with at least one ADL, showed that in many of the developed nations a significant discrepancy exists between the genders in favor of men. For example, in Canada the percent of a person's life lived without disabilities was 85 for men and 78 for women, in Japan 92 versus 87, and in France 94 versus 90. These analyses were conducted on data of the early nineties. Smaller gender discrepancies were presented for all European countries in the WHO Atlas of Health in Europe (WHO, 2008) for the early years of 2000. For example, in Italy, while men have an expectancy that 92.1% of their lives will be lived free of disability from the age of 65, women can expect only 90.6%, in France 91.3% versus 89.5% and in Israel 91.2% versus 88.8%, respectively. Similarly, U.S. data indicate that women in old age suffer more than men from limitations in physical functioning, ADL and IADL (Pleis & Lethbridge, 2006).

Subjective evaluations of health across countries are in accordance with the more objective data. In the developed nations a high percentage of old people between the ages of 60 and 70 respond that their health is very good or good (from 80% in Canada to 60% in Germany). These percents decrease significantly in the less developed countries (from 42% in Mexico to 22% in China). In most countries, however, these percents are systematically higher among men (Harper, 2004). Differences among countries can be noticed regarding trends of change with aging. While in some countries the gender discrepancy in the subjective evaluations of health decreases (in support of the convergence hypothesis) as for

example in North American and Latin American, in other regions, such as Asia, South Africa, and East and West European countries, the discrepancy increases with aging (in support of the divergence hypothesis) (Harper, 2004).

The differences in the diseases suffered by men and women can partly explain the objective reports regarding functioning as well as the subjective evaluations of health by men and women. Women suffer more from chronic diseases such as arthritis, osteoporosis and the fractures that follow (WHO, 2003), which cause suffering but are less life-threatening than heart diseases, which appear in men in younger age, and cancer diseases, which are more prevalent among men in recent years.

Socio-economic status

The socioeconomic status of men and women is an outcome of culture, dominant values and beliefs, and norms of behavior. Since paternalism has dominated almost all the societies in our world, women have been deprived from positions of social power in the family and society. Two most important indicators of socioeconomic status are education and income. Until today, the percentage of women participating in the labor force is lower than that of men in all the countries and much lower in the less and least developed nations (Table 3, and U.S. Census Bureau, 2000a; UN Population Division, 2006). This pattern of social order continues to be a significant barrier for women's independence and equality in the less and least developed nations, but is gradually changing in Western societies since the second half of the twentieth century. In developed nations increasing percents of women acquire high education, join the labor force, and increase their presence in high societal positions. However, according to a UN report for the years 1980 to 2010, although in general, the percentage of illiteracy decreases, the gender gap in favor of men of about 20% continues to exist in the 105 less developed nations (United Nations, 2005). In old age men have higher education than women in all countries, although the levels of education are significantly higher in developed nations for both genders than in the less developed nations. It is important to point out that in a number of countries the gender-related education gaps either narrow or completely disappear in the younger age-groups (ages 35 to 44) (Organization for Economic Co-Operation and Development, 2001).

In the Western world, despite the significant changes in education and orientations that have occurred in the last century, women are still facing a "glass ceiling" even in the most advanced societies (Cubillo & Brown, 2003). According to a national U.S. report, about 70% of the full time female labor force work in low-paying occupation categories. "The invisible barriers that limit women toward employment equity extend all the way from the 'glass ceiling' at the top of the nations largest corporations to the sticky floor of low paying, low mobility jobs at the bottom of the labor market." (Harlan & Berheide, 1994). Among employed persons, women are less likely than men to have job security, authority, autonomy, and opportunities for advancement (Jacobs & Steinberg, 1990; Karasek, Gardell & Lindell, 1987; Reitzes & Mutran, 1994). This situation derives from many still existing social barriers. Women are still disadvantaged in education, in dominant orientations towards gender roles, and in dominant beliefs regarding gender-related capabilities. For example, in a longitudinal (1979-2005) U.S. study, Timothy and Livingston report that although gender role attitudes (the beliefs that people hold about the proper roles for men and women at home and at work) are becoming less traditional for men and for women, traditional role orientations continue to exacerbate the gender wage gap" (2008). In summary, in comparison to men, lower percents of women participate in the labor force, often hold part time and low status positions, have fewer years of work and lower wages. All of these result in lower percents of elderly women than men receiving pensions from work

places. If women do receive them, their pensions are lower, resulting in an inferior economic status than that of men (Whitehouse, 2000).

Income and education are considered to be significant resources, which determine people's health and wellbeing. "High educational attainment improves health directly, and it improves health indirectly through work and economic conditions, social-psychological resources, and health lifestyle" (Ross & Wu, 1995, p.719). Lower levels of education among women and their nurturers' social roles are some of the reasons for women's disadvantage in employment and incomes. The causal relationship between low income and poor health has often been reported in sociological literature (Benzeval & Judge, 2001). The level of education was found to be a good predictor of life expectancy and active life expectancy among elderly Americans (Guralnik et al., 1993). A significant association between socioeconomic status and women's mortality has been also reported in an Israeli study (Manor et al., 2000). Thus, women's disadvantages in education and income may partly explain their poorer health, as well as their accumulated levels of stress.

Wellbeing

The gender differences in life expectancy create a situation where significantly more elderly men are married and more women are living alone. The ratios of elderly persons living alone are significantly lower in the less and least developed countries, probably due to traditional values and economic conditions (Table2). Loneliness is one of the most disturbing problems of old people worldwide because of its negative implications to individuals and society. Loneliness is related to cardiovascular diseases, rapid decrease in cognitive functions, depression and suicides among older people (Wright, 1985; Bazargan & Barbre, 1992; Creecy, Berg, & Cheng, 1992; Prince, Harwood, Blizard, Thomas, & Mann, 1997; Sorokin, Rook, & Lu, 2002; Waern et al., 2002; Hawkey, Burleson, Bernston, & Cacioppo, 2003). About 40% of older persons suffer from loneliness or social isolation, and it is more prevalent among women (Holmen, Ericsson & Winblad, 1999). For all ages, women are more vulnerable than men to the needs of members of their social networks, and more of them are involved in caregiving roles. Thus, in addition to all the disadvantages in their social roles, health and economic status, women nowadays, more than ever, carry a heavy burden of caregiving besides multiple roles at home and as workers outside home. Furthermore, in comparison to men main caregivers, women perform more caregiving tasks, and invest more weekly hours in caregiving, all of which expose women more than men to the heavy burden and stressors related to these tasks (AARP Caregiver Identification Study, 2001).

The data presented above pointing to disadvantages experienced by women throughout their lives result in significant gender differences on almost all indicators of wellbeing in old age. In two Israeli national samples of elderly people, women ranked themselves systematically lower than men on their self-esteem, satisfaction with life, will to live, social support and higher on experiencing loneliness (Carmel & Bernstein, 2003; Carmel, S., Iecovich, E., & Sherf, M. (2007). These recent findings support previous findings from other countries (Rosenfield, 1980; Fleming & Countey, 1984; Feingold, 1994; Raymore, Godbey & Crawford, 1994; Orr & Dinur, 1995; Verbrugge, 1989; Wood, Rhode & Whelan, 1989; Kark et al., 1996).

CONCLUSIONS

In conclusion, women have an advantage over men in life expectancy but in all countries are disadvantaged in almost all the dimensions of quality of life in young as well as in old age due to cultural orientations and norms of behavior which continue to exist in all countries. This situation is, however, much worse in the less and least developed nations, where the process of change towards increased gender equality has only started or not yet started. Some of the international data indicate some trends towards convergence between the genders in life expectancy and health but only in very old ages.

Longitudinal studies of elderly populations, which are designed to control for natural selection and cohort effects, are essential for validating the findings regarding changes in gender differences in physical and psycho-social wellbeing throughout old age.

An important aspect in women's lives is their caregiving role. Nowadays more than ever, in all societies, more women than men carry the heavy burden of caregiving to their families, friends and neighbors, in addition to multiple roles at home and as workers outside home. The demanding role of caregiving is more prevalent among women than men in old age, and affects negatively their health and wellbeing.

Health and wellbeing are related to socioeconomic characteristics. The data regarding the socioeconomic status of women indicate that it is improving in many countries, especially in the Western world. However, even in these countries as young women, they have to deal with the 'glass ceiling', which denies their having equal opportunities. The accumulated disadvantages experienced throughout life in education, income and health continue to exist in old age, and are expressed in subjective evaluations of indicators of wellbeing. However, international statistics indicate that in the younger age groups, in some countries, the percents of men and women who acquire high education are similar. This trend and increasing changes in gender role-related orientations might result in trends of convergence in health and wellbeing in the future in the young as well as in older ages.

In order to enhance these developments, efforts have to be invested in improving women's health and social status in all the countries, but especially in the less and least developed nations. Societies have to empower women in all ages (young and old), and in all areas of life, for the advantage of the women and the societies at large.

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Table 1: Life expectancy by sex and age groups in selected countries

	65-69		75-79		85-89		100+	
	Females	Males	Females	Males	Females	Males	Females	Males
France	22.4	18.1	14.2	11.2	7.6	6.1	2.4	2.1
UK	19.7	16.9	12.1	10.2	6.5	5.5	2.2	2.0
USA	20.0	17.3	12.7	10.8	7.1	6.0	2.3	2.1
Republic of Korea	19.8	15.8	11.7	9.4	5.9	5.0	2.0	1.9
Israel	20.2	18.2	12.4	11.3	6.5	6.4	2.1	2.2
China	16.2	14.2	9.3	8.4	4.8	4.5	1.8	1.8
Turkey	16.2	14.0	9.4	8.2	4.8	4.4	1.8	1.8
Egypt	13.6	12.2	7.9	7.4	3.6	4.1	1.5	1.7
Germany	20.4	17.1	12.4	10.4	6.4	5.6	2.1	2.0
India	13.1	12.3	8.2	8.1	5.1	5.2	2.0	2.1

WHO, World Health Statistics, 2006.

Table 2: Population aged 60 years or older: world, major areas and regions

	Percentage currently married M/W 2006	Percentage living alone M/W 2006	Percentage in labor force M/W 2006	Sex ratio (men per 100 women) 2007		Life expectancy at age 60 2005-2010 M/W
				65+	80+	
World	80 / 48	8 / 19	40 / 16	77.4	55.8	17 / 21
More developed regions	79 / 48	13 / 32	22 / 11	67.7	46.8	19 / 23
Less developed regions	81 / 47	5 / 9	50 / 19	84.0	66.3	17 / 19
Least developed countries	85 / 39	4 / 8	71 / 37	82.3	72.8	15 / 17
Africa	85 / 39	6 / 11	64 / 32	79.9	67.1	15 / 17
Asia	81 / 50	5 / 9	48 / 18	84.1	63.0	17 / 20
Europe	80 / 47	13 / 35	15 / 7	64.2	43.3	18 / 22
Latin America	75 / 42	7 / 10	46 / 16	78.6	65.5	19 / 22
Northern America	75 / 48	15 / 34	29 / 18	73.4	54.0	20 / 24
Oceania	76 / 50	16 / 34	26 / 12	82.1	59.6	20 / 24

Source: United Nations Population Division, Population Ageing, 2006.

Table 3: Population aged 60 years or older selected countries

	POPULATION AGED 60 YEARS OR OLDER						Sex ratio (men per 100 women)		Life expectancy at age 60 2005-2010 M/W
	Percentage of total population	Percentage 80 years or older	Percentage currently married M/W	Percentage living alone M/W	Percentage in labor force M/W				
						60+	80+		
Egypt	7	8	87 / 33	4 / 13	27 / 3	85	69	16 / 18	
China	11	10	78 / 56	- 8 -	39 / 13	92	57	17 / 20	
Republic of Korea	14	10	87 / 37	- 8 -	49 / 28	77	43	18 / 23	
India	8	10	81 / 44	2 / 5	59 / 18	91	81	16 / 18	