Journal of Economic Behavior & Organization xxx (2015) xxx–xxx

Contents lists available at ScienceDirect

Journal of Economic Behavior & Organization

journal homepage: www.elsevier.com/locate/jebo

Gender bias in public long-term care? A survey experiment among care managers☆

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ARTICLE INFO

Article history:
Received 29 September 2014
Received in revised form 16 June 2015
Accepted 4 September 2015
Available online xxx

JEL classification:
C90
H42
I13
I18

Keywords:
Care rationing
Gender bias
Public care
Survey experiment

ABSTRACT

Daughters of elderly women are more likely to provide informal care than sons. If care managers take this into account and view informal care as a substitute for formal care, they will statistically discriminate against the mothers of daughters. Using a survey experiment among professional needs assessors for long-term care services in Norway, we find that if a woman with a daughter had a son instead, she would receive 34 percent more formal care. On the other hand, daughters do not provide more care for fathers. Correspondingly, we find no effect of child gender for fathers in the experiment.

1. Introduction

In many OECD countries, long-term care (LTC) services are predominantly publicly financed and rationed according to health needs (Colombo et al., 2011). At the same time, daughters are more likely than sons to provide informal care for their elderly parents (Colombo et al., 2011; Haberkern and Szydlik, 2010; Schmid et al., 2012) and children are more likely to provide informal care for a parent of the same gender (Lee et al., 1993; Leopold et al., 2014). The gender gap is remarkably robust across European countries (Haberkern and Szydlik, 2010; Schmid et al., 2012), even though there are

☆ Thanks to an anonymous referee for useful comments andsuggestions. We would also like to thank seminar participants atLinneaus University, Norwegian Social Research, Norwegian School ofEconomics, the University of Oslo, and conference participants at the35th NHESG meeting in Reykjavik. In addition, we thank Thea Berge,Magnus Carlsson, Henning Finseraas, Tarjei Havnes, Tor Iversen,Martin Karlsson, Viggo Nordvik, Edda Torsdatter Solbakken, Mari B.Solheim, Mikael Svensson, and Gaute Torsvik. The research reported inthis article was supported by a grant from the Research Council ofNorway (project EqualCare 196425/V50). Andreas Kotsadam would alsolike to thank the Centre for the Study of Equality, SocialOrganization, and Performance (ESOP) at the Department of Economics,University of Oslo. ESOP is supported by the Research Council ofNorway.

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http://dx.doi.org/10.1016/j.jebo.2015.09.004
0167-2681/

large differences in eldercare policies and in gendered norms of family care (Kotsadam, 2011). If care managers who are responsible for matching public service provision to needs take into account the likely availability of informal care when rationing care, there will be a relationship between the sex of children and access to formal care. Supply side health care disparities arise if providers base treatment decisions on demographic characteristics that are not justified by the underlying individual health needs (Balsa and McGuire, 2003; McGuire et al., 2008). A potent explanation for such disparities is statistical discrimination, whereby decision-makers use easily observable characteristics to infer unobservable characteristics (Balsa and McGuire, 2001; Balsa et al., 2005; Fang and Moro, 2010; McGuire et al., 2008). We test this using a survey experiment among care managers in Norway, where the allocation of formal care should explicitly be independent of socioeconomic status and children have no legal obligation in caring for parents (Karlsson et al., 2012; Kotsadam, 2011).

Health inequality and discrimination in the provision of public services are important public policy issues (Lutfey et al., 2009), but identifying discrimination is difficult without clear predictions. We derive the result that health-maximizing care managers who view informal care as a substitute for formal care will condition the level of formal care provided on the likely availability of informal care. Analyzing recent Norwegian data, we find that daughters provide more informal care for mothers than for fathers, and more informal care than sons provide, while there is no statistically significant difference for the other caregiving pairs. Our prediction is therefore that statistical discrimination should lead to less formal care being allocated to needy elderly women with daughters.

It is difficult to identify discrimination using observational data. Instead, we constructed hypothetical (but realistic) case descriptions of persons in need of care, and randomly assigned the cases to care managers. The only characteristics varying across cases are the gender of the potential client and the gender of the client's child. After reading the case descriptions, the care managers were told to carry out a needs assessment and decide the number of minutes of home care services to provide per week. We find evidence of discrimination in Norwegian LTC in that there is tighter rationing of care for elderly women with daughters. In particular, we find that, if a woman with a daughter had a son instead, she would on average receive 167 min (34 percent) more formal care per week. These results are especially striking since Norwegian care managers are explicitly instructed not to consider the family situation of the persons needing care and since Norway is regarded as one of the most gender-equal countries in the world (Anxo and Fagan, 2005; Kotsadam, 2011).

Our results are relevant to several academic literatures. We add to the literature on health economics and discrimination by investigating the rationing of public services and by showing discrimination in long-term care; we contribute to the study of family economics by linking public services and unpaid work; and we shed light on the relationship between formal and informal care. To the best of our knowledge, it is the first study to investigate discrimination in long-term care by means of a credible design for causal inference. As with all statistical discrimination, the resulting allocation becomes unjust in the sense that it affects elderly women who happen to have a daughter as well as daughters with frail elderly parents, irrespective of their relationship quality, preferences for a different care mix and life situation, including employment. The results uncover a norm within public provision that may be self-reinforcing, since it puts pressure on daughters to care more for their elderly mothers, which, in turn, strengthens the signal to the care managers. On the other hand, it can be argued that the care managers are doing the right thing as they try to maximize the total amount of care (formal and informal) provided. As mothers with daughters get a higher expected amount of informal care, they can in one sense be deemed to have less need of formal care. Hence, the normative conclusion will rest on how these principles are weighted.

2. Detecting discrimination in health care

Previous empirical work on discrimination in access to health services is scarce and most existing studies are based on observational data. Several recent studies examine the relationship between waiting times and socioeconomic status (Carlsen and Kaarbøe, 2012; Kaarbøe and Carlsen, 2014; Johar et al., 2013; Siciliani and Verzulli, 2009). All of these studies find higher income and education to be associated with lower waiting times for public health services. Controlling for socioeconomic and health status, the residual variation is taken as evidence of discrimination. Although definitely compatible with statistical discrimination, the results may be confounded by, for instance, the ability to signal needs. With respect to discrimination in diagnoses and actual expenditure, observational studies suffer from similar problems.[1] Whether the results from these studies are evidence of discrimination is questionable, since the results could be due to other factors. For instance, people with higher education may be better able to communicate their needs, they may perceive their needs as greater, or they may have greater trust in the health system. In brief, there is an abundance of potential explanations other than discrimination.

The literature on discrimination in the marketplace is extensive (Pager, 2007; Riach and Rich, 2002; Yinger, 1998). Field experiments show that individuals who are identical except for a group characteristic (gender, race, etc.) are treated differently in the housing market (Andersson et al., 2012; Carlsson and Eriksson, 2014; Ewens et al., 2014) and in the labor market (Bertrand and Mullainathan, 2004; Carlsson and Rooth, 2007). A critique of field studies made by Heckman (1998) is that

[1] Balsa et al. (2005) use a cross-section of black and white patients, and find that the probability of being diagnosed with depression and mental health problems is reduced for black patients relative to white patients. After controlling for socioeconomic status and measures of patients' health status, the result is taken as evidence of statistical discrimination based on miscommunication between white doctors and black patients. Using panel data, McGuire et al. (2008) find that the increase in expenditure in response to an increase in the severity of depression is twice as large for white patients than for minority patients.

Please cite this article in press as: Jakobsson, N., et al., Gender bias in public long-term care? A survey experiment among care managers. J. Econ. Behav. Organ. (2015), http://dx.doi.org/10.1016/j.jebo.2015.09.004