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The gender health gap in China: A decomposition analysis

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ABSTRACT

Around the world, and in spite of their higher life expectancy, women tend to report worse health than men until old age. Explanations for this gender gap in self-perceived health may be different in China than in other countries due to the traditional phenomenon of son preference. We examine several possible reasons for the gap using the Chinese SAGE data. We first rule out differential reporting by gender as a possible explanation, exploiting information on anchoring vignettes in eight domains of health functioning. Decomposing the gap in general self-assessed health, we find that about 31% can be explained by socio-demographic factors, most of all by discrimination against women in education in the 20th century. A more complete specification including chronic conditions and health functioning fully explains the remainder of the gap (about 69%). Adding chronic conditions and health functioning also explains at least two thirds of the education contribution, suggesting how education may affect health. In particular, women's higher rates of arthritis, angina and eye diseases make the largest contributions to the gender health gap, by limiting mobility, increasing pain and discomfort, and causing sleep problems and a feeling of low energy.

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1. Introduction

Gender inequality has long been a topic of academic research and a target for policy interventions. Female disadvantage is still apparent in various aspects of life, such as educational attainment and labor market outcomes. Studies also consistently show that, compared to men, women report more illnesses, worse health, and higher health care utilization despite their higher life expectancy (see e.g., Nathanson, 1975). There have been many attempts to explain this phenomenon.

One strand of literature has looked at epidemiological reasons (Case and Paxson, 2005; Malmusi et al., 2012; Verbrugge, 1989). Case and Paxson (2005) provide the

most convincing evidence using 14 years of data from the US National Health Interview Survey (1986–2001). Using a decomposition method, they demonstrate that female disadvantage in self-assessed health in the US is entirely explained by differences in prevalence rates of chronic conditions between men and women: females have significantly higher rates of degenerative but non-fatal conditions like arthritis and other pains, most respiratory conditions (excluding cancer), hypertension, vision problems and depression.

Another possible explanation that is often put forward – but not examined in Case and Paxson (2005) – is that women are less stoical than men. Given objective health, women may be more likely to report health problems (Verbrugge, 1982), or to factor less serious ailments into their assessment of own health (Spiers et al., 2003). While not implausible, such claims were mostly supported by suggestive evidence. It also contrasts the findings by Macintyre et al. (1999), who ask women and men open-ended questions about health problems, followed by a series

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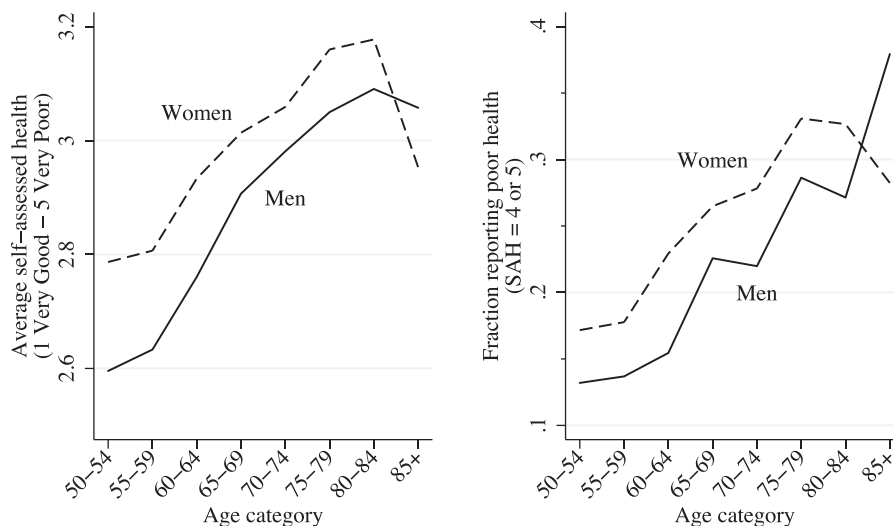


Fig. 1. Self assessed health (SAH) for men and women in China.
Data source: WHO SAGE Wave 1.

of probes for specific conditions. They find that men provide more information to the open-ended questions and women are not more likely to report trivial health conditions.

More recently, vignette methods have been used to formally test the claim of women's higher tendency to report health problems but have produced mixed results. Peracchi and Rossetti (2012) do find that European females are more likely to report difficulties in six health domains and that correcting for this reduces – but does not entirely eliminate – health differences by gender. By contrast, Grol-Prokopczyk et al. (2011) find American women to be more optimistic in their health assessment. For Chinese respondents, Bago d'Uva et al. (2008) find gender-specific reporting in only two out of six health domains – mobility and pain – but do not analyze the direction of the bias.

So far, most of the research has focused on western countries whereas relatively little is known for China. Fig. 1 shows gender differences in self-assessed health (SAH) using Chinese elderly (50+) from WHO SAGE¹ Wave 1 data (described in Section 2). In contrast to what is shown in western countries, where female disadvantage in SAH disappears at older ages, e.g., in the early sixties in the US (Case and Paxson, 2005, Fig. 1), the disadvantage persists into very old age (80+) in China. This is likely to be related to the son preference long embedded in Chinese traditions, of which a particularly worrisome aspect is the fact that female education was given little importance, if not even opposed.² As a result, previous generations of Chinese women have suffered from very unequal opportunities to

obtain an education while such gender gap in education has been eradicated – and sometimes even reversed – in western countries.

The current generation of elderly women in China is especially disadvantaged in education as they were born and raised during a time of poverty and social instability. Research has shown that, faced with the hardship of having more children than they can provide for, parents often invested more in sons at the expenses of daughters (Greenhalgh, 1985; Parish and Willis, 1993).³ Due to such institutional and financial barriers, Chinese women obtained much less education than men.

To put the Chinese gender gap in perspective, we compare it to that in the US. This is done by first comparing data on the abovementioned Chinese elderly to data on American elderly from the first wave of AHEAD cohort, of the Health and Retirement Study (HRS).⁴ We deliberately choose the oldest cohort in the HRS, born in 1923 or earlier (and aged 70+ at the time of the survey), while our Chinese dataset covers individuals born before 1961, because the rise in female education in the US long preceded a similar rise in China.

Gender differences (women-men) in the proportions of each education category are presented in Fig. 2.⁵ The female disadvantage in education is striking in China. The proportion of Chinese women with no formal education is more than 20 percentage points higher than that of men. In sharp contrast, the second bar in each education category shows little gender difference even though these Americans were born decades earlier than the majority of the Chinese sample. Fig. 2 also shows the distribution of education for the original HRS cohort (born between 1931 and 1941 and aged 50+ at the time of the survey). This

¹ World Health Organization Study on global AGEing and adult health (www.who.int/healthinfo/sage/en/).

² Under the influence of the traditional doctrine that having no education was a virtue for women (*nvzi wucai bian shi de*), it was not until 1907 that females were officially permitted to enter the national education system (Lei et al., 1993, p. 261). But even so, girls still had to go to separate schools, received fewer years of education, and had to focus more on etiquette and needlework rather than modern sciences (Du, 1995, p. 340).

³ The one-child policy was only introduced in 1980. Before that, parents were allowed to have multiple children.

⁴ Asset and Health Dynamics among the Oldest Old (AHEAD).

⁵ Sampling weights are applied.

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