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The gender disability gap

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Life expectancy at birth increased by leaps and bounds in 20th century France, from 45 years in 1900 to 79 years in 2000. For the past thirty years, the gains have been mainly due to mortality improvements among the older population. But are these added years ones of well-being or ill-health? In the ten years from 1981 to 1991, while expectation of life at birth rose by 2.5 years for males and females alike, disability-free life expectancy—i.e., the period free of any limitation on performing activities of daily living—increased by 2.6 years for women and 3.0 years for men (table 1) [1]. So every year added has been a year free of disability. Women live with disabilities longer than men (in 1991, 12.6 years against 9.1 years). Their longer life expectancy means that they survive to the older ages at which disabling conditions are more common. Also, age for age, they are more often affected by disabilities. Most countries in which this kind of study has been done produce the same findings [2].

◆ Women report more disabilities

The proportion of people reporting a disability rises sharply with age, from 8% at age 20-24 to 88% at age 80-84 and 96% among the over-90s, with differences by type of disability (box 1, page 3, and fig. 1).

Gender inequalities between the under-65s are slight and vary by type of activity and degree of severity (fig. 2). This finding, like all others reported in this

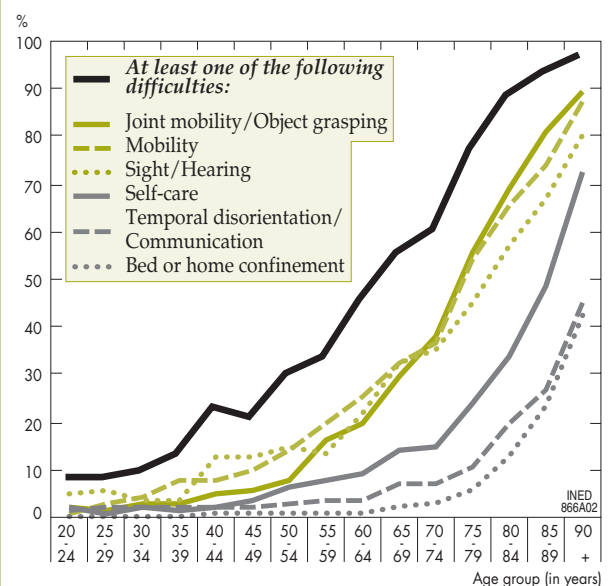
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Table 1 - Life expectancy at birth in France, 1981-1991 (years)

	1981		1991	
	Males	Females	Males	Females
Life expectancy	70.4	78.6	72.9	81.1
of which:				
disability-free	60.8	65.9	63.8	68.5
with disability	9.6	12.7	9.1	12.6

Source: Robine et Mormiche [1].

Figure 1 - Share of people with difficulties (severe or moderate) by age and type of disability



Scope: people aged 20 and above living in private households or community health institutions.
Source: INSEE, HID survey 1998-1999.

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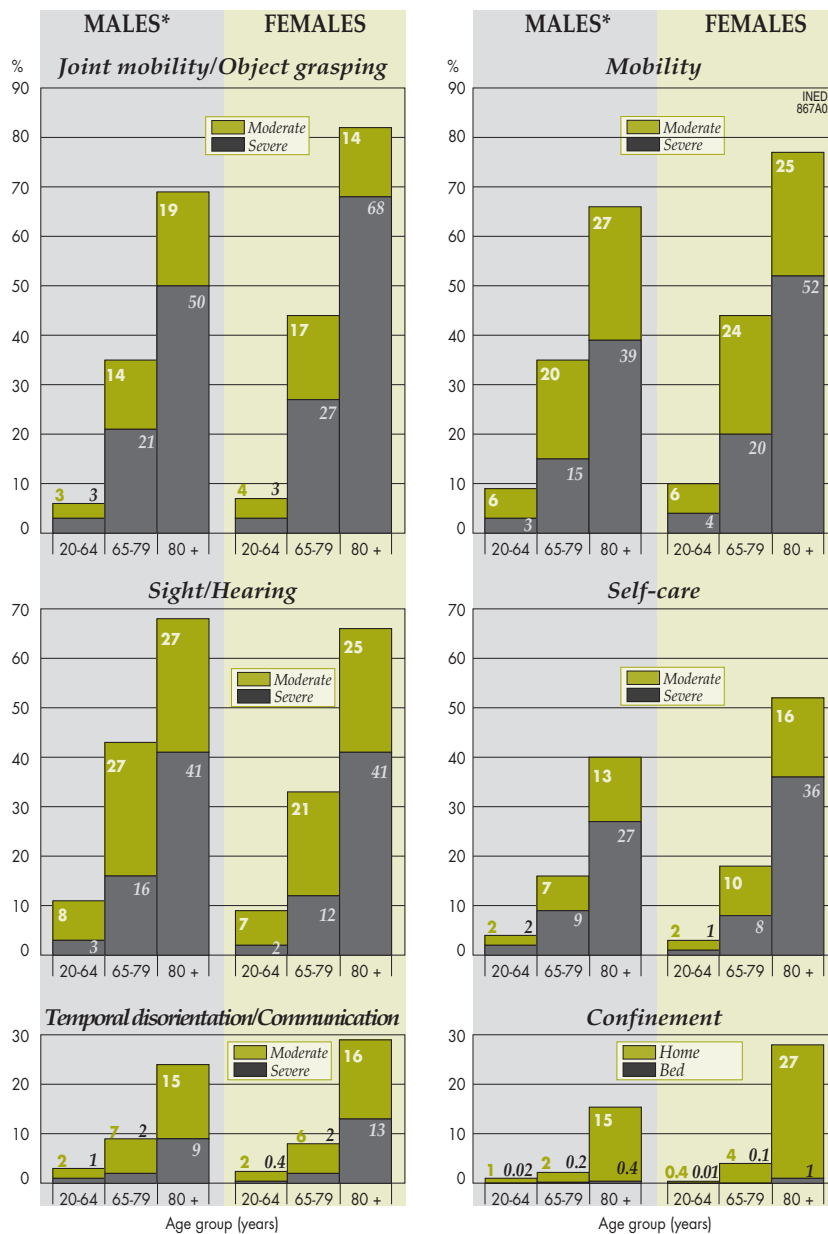
article, takes into account the male and female age structures (see box 2). Vision and hearing limitations (9% of women, 11% of men) and mobility difficulties (10% and 9%, respectively) are the most frequent. If only severe difficulties are considered, mobility remains the greatest problem: 4% of women and 3% of men under 65 are affected.

The disability rate after age 65 rises particularly sharply for severe difficulties, which tend to be more frequent than moderate difficulties among the over-80s. The order of severe disabilities is identical at ages 65-79 and 80 and over. Problems of joint mobility and object grasping are most common, affecting 68% of women and 50% of men aged 80 and over. Sight and hearing limitations come next for men, followed by mobility difficulties, whereas the prevalence of mobility restrictions is higher than visual and hearing limitations among women. In all, nearly one in two people aged 80 and over have severe mobility difficulties and two in five a vision or hearing limitation. Severe temporal disorientation or communication problems are comparatively less frequent (just over 1 in 10 people aged 80 and over).

Finally, these problems are often causative of severe difficulties with self-care, which affect over a third of females and over a quarter of males aged 80 and over, and of confining disabilities. While bed confinement remains very uncommon even among those aged 80 and over (less than one person in a hundred), the proportion who are homebound is much higher (just over 1 in 4 women and 1 in 7 men).

After age 65, women experience more difficulties than men across all types of activity and levels of severity, apart from hearing limitations which affect men more than women [4][5]. It could be argued that differential perceptions of disabilities produce a higher reporting frequency among women than men on a like-for-like basis. That may hold good for moderate

Figure 2 - Share of people with difficulties (severe or moderate) by sex, age group and type of disability



Scope: people aged 20 and above living in private households or community health institutions.

Interpretation: 16% of women age 80 and over have moderate temporal disorientation and/or communication problems.

* data standardized on the female age structure (see box 2).

Source: INSEE, HID survey 1998-1999.

difficulties, but not for severe difficulties, which are more objectively assessed.

◆ Frequent multiple disability

In many cases, a person may exhibit a combination of difficulties. Very poor health increases the risk of multiple disability. So, about 9 out of 10 bedridden men and women have problems or need assistance with self-

Box 1

The “Enquête handicaps-incapacités-dépendance (HID)”

The survey into disability and dependency situations (HID) carried out by INSEE in 1998 and 1999 [3] questioned over 30,000 people of all ages living in private households or in community health institutions about the difficulties they experienced with:

- **self-care:** washing/bathing, dressing/undressing, using toilets, feeding including cutting food;
- **mobility:** getting in and out of bed, going up/down a flight of stairs, bending over and picking up an object from the floor;
- **joint mobility and object grasping:** cutting toenails, using hands and fingers;
- **temporal disorientation and communication problems:** forgetting what time of day it is, difficulty communicating with other people for reasons other than hearing impairment;
- **sight and hearing:** seeing things close to, seeing things far away, hearing.

For each reported disability, a distinction was made between severe difficulties (“can manage only with great difficulty”, or “cannot manage without assistance”) and moderate difficulties (“can manage with some difficulty”). Bedridden respondents were considered as having severe mobility restrictions.

care, or have severe limitations in joint mobility or object grasping. Difficulties with activities of daily living are frequently due to physical, sensory or cognitive problems: so, severe difficulties with self-care are found together with limitations in joint mobility or object grasping in 93% of cases for women and 83% for men, and with mobility limitations in 80% and 70% of cases, respectively. While often causative, physical, cognitive and sensory difficulties do not inevitably restrict the ability to carry out core activities, since these limitations can be addressed by the use of assistive devices and adaptations to the home: so, 62% of women and 55% of men with severe physical limitations (mobility, joint mobility or object grasping) do not have severe problems with self-care. It is noteworthy that while men generally report fewer physical limitations than women, those that do report physical limitations more often encounter self-care problems. Finally, severe problems of temporal awareness or communication, although rare, more often result in home confinement or self-care restrictions than do sensory and physical limitations, and more so among women than men.

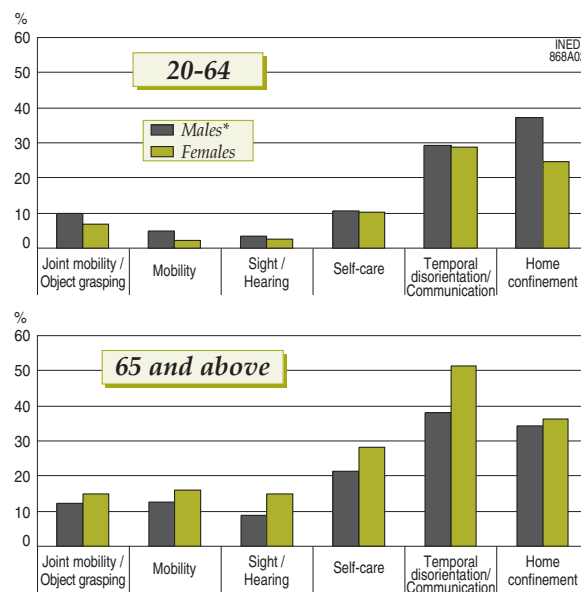
To what can these gender differentials be attributed? For one thing, women bear a greater burden of

Box 2

Age-for-age comparison of women and men

Any comparison of women and men’s situations must take account of the different age structures of the female and male populations. Women’s life expectancy advantage means they outnumber men at the older ages [6]. The data for men therefore have been calculated based on a standardized age-for-age distribution.

Figure 3 - Share of people in institutional care by sex and type of severe difficulty experienced



* data standardized on the female age structure (see box 2).
Source: INSEE, HID survey 1998-1999.

disabling conditions (psychiatric disorders, degenerative joint diseases, etc.) than men [5]. They also manage their restrictions differently: being more inclined to caregiver usage than men, with similar limitations, women may more often report needing assistance. For physical limitations, men use assistive devices and other adaptive aids more than women [6], so they may report difficulties only at more advanced stages: consequently, they report fewer physical limitations than women, but at stages where the risk of combination with other difficulties is higher.

◆ Differential institutional care service usage

When an individual’s limitations create substantial support needs, institutional care may be required. Men and women’s institutional care usage shows

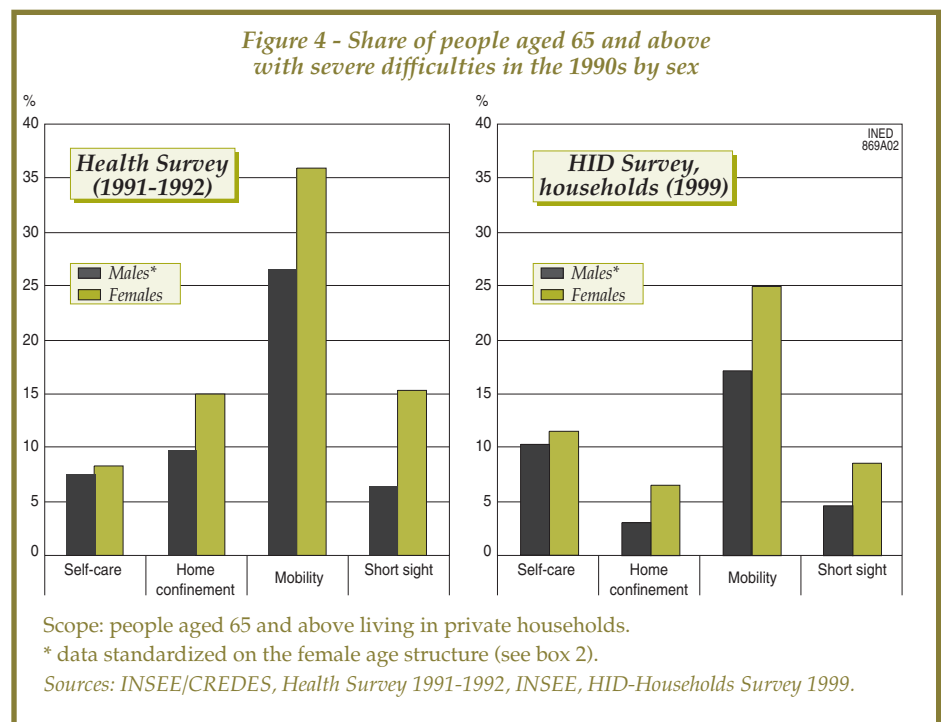
like-for-like age and difficulty differentials (fig. 3). Under age 65, men outnumber women in institutional care provision, whereas after 65, the situations are reversed for all types of difficulty. Because of their longer life expectancy and the spousal age gap, women are more often confronted with widowhood, and so must address their limitations alone, when men will still have their wife to assist them. Also, a greater propensity to use caregivers may make women more prone to elect for institutional care services. Finally, compared to men, women's disabilities are more often associated with psychological disorders or mental upset for which provision is generally limited to institutional care.

◆ Trends in gender gap

Focusing on the household-based population, these findings can be compared to those of the 1991-1992 Health Survey to identify the gender gap trends (1). The indications are that the decline in mobility and sight limitations evidenced in the 1980s [5] continued between 1991 and 1999 with a sharper decrease in sight limitations among women than men (fig. 4). Correlating with this progress, home confinement seems also to have decreased. By contrast, the proportions of both men and women reporting difficulties with self-care have risen. This trend may be due to the higher rate of people living at home with this kind of restrictions than ten years ago, and to more systematic use of home help services, increasing the number of persons reporting need for assistance. Figure 4 shows that the gender gap has remained broadly unchanged in the 1990s, with the possible exception of sight limitations.

There is therefore a manifest and persistent gender disability gap. One explanation may be differences in disabling conditions. But compensatory

(1) The scope of the Health and Medical Care Survey 1991-1992 (Insee/CreDES) is restricted to the population living in private households, and the questions on disability relate only to ages 65 and above. The survey method and wording of the questions differ slightly from those of the HID survey. The small Health Survey sample size gives wide confidence intervals around the reported levels of disability.



strategies for functional limitations also play a key role. If it is confirmed that the disability advantage possessed by older males is due to their use of assistive aids that enable them to continue core activities for longer, then this may offer a clue for action. The advanced stages of disability could be prevented and the need for carer services limited by early intervention. This progress could be achieved by better addressing the limitations and difficulties through a wider dissemination of technical aids, assistive devices, home adaptations, rehabilitation, occupational therapy, etc. Therefore, as well as research into accidents and disabling conditions, research into the disablement process and the management of functional limitations is essential to help forestall dependency and the social, medical and economic consequences it brings.

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