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GENDER VARIATIONS IN LATER-LIFE HEALTH AND WELLBEING

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Abstract:

One of the primary issues that ageing societies face all around the globe is keeping their health, as well as their quality of life, while also reducing the number of years spent living with impairments in old age. This study intends to show existing gender-related health disparities throughout life, particularly in late age, as well as gender differences in social and personal resources that impact health, functioning, and well-being all over the globe. This article also examines the subject of whether or not the gender differences that exist at earlier ages tend to decrease later in life, as a result of the various biological and social changes that take place in old age. Conclusions regarding future changes in gender gaps are presented, along with practical implications for future improvements in women's health and well-being. These conclusions are based on international data pertaining to these gender gaps, as well as trends of change in personal resources and health-related lifestyles in more and less developed nations.

Keywords: *gender differences, health, well-being, old age, international differences*

Introduction:

The enormous extension of human life expectancy in the past century is one of the most significant advances made by modern civilisation. However, social advancements often give rise to new requirements and difficulties. The rise in the absolute size and share of people aged 60 and older, and especially of those aged 80 and older, is accompanied by an increasing number of people living with chronic diseases and disabilities for longer years [e.g., (1)]. This places a significant burden on families as well as on society as a whole. Although the number of years of healthy life expectancy has increased, the absolute size and share of people aged 60 and older has increased. As a consequence of these advancements, the problems faced by ageing societies all over the globe include preserving a high level of health and quality of life, as well as reducing the number of years spent in old age with some kind of disability (1). The need to address these challenges stems from humanitarian values that are ingrained in the cultures of democratic countries, as is eloquently stated in the Declaration of

Independence of the United States of America: "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are life, liberty, and the pursuit of happiness" (US Declaration of Independence, 1776). Another pressing need to address this challenge derives from the anticipated threat to the economies of countries that are experiencing rapid growth in a large, mostly unproductive sector of the population, as well as rising costs for people who require medical and social services [for example, (2)]. These countries face an urgent need to find a solution to this problem. As a result, it is of the highest significance to get a knowledge of the reasons why some demographic subsets of the ageing population are more likely than others to experience infirmity, a worse quality of life, and dependency on their family and on society. In this context, it is well-established throughout the world that even though women make up more than half of the world's population and generally live longer than men, they also live more years of their lives with functional limitations (1, 3–6). This is the case despite the fact that women generally live longer than men. In addition, when older women are compared to males, they score considerably worse on the majority of indices of subjective well-being and mental health (7–12).

Differences between the sexes are inherent to the human species and may be seen in both the structure and the functioning of biological systems. On the other hand, it would appear that beyond the differences in biology, a culture's social structure, which includes the division of gender-related roles, societal functions, and social status, has been a more influential factor in determining the differences in quality of life experienced by men and women according to their respective genders. In the Old Testament, we read that God told women that they would have to endure agony in order to give birth to children (Genesis 3:16), whereas God told males that they would have to eat "by the sweat of thy brow" in order to have food (Genesis 3:19). A strong paternalistic approach has dominated human ideas and conduct around the globe for thousands of years. This paternalistic approach has included the division of social roles, social authority, and social status. Cultural ideas and the social laws that derive from them have been of use in maintaining the patriarchal system of domination that males have historically held. In the majority of nations, women are prevented from achieving positions of social authority within the family and society as a

whole by sociocultural obstacles that have been set up through time. As a result, women in many civilizations are prohibited from acquiring personal resources like education and economic means, both of which contribute to the growth of social status, economic independence, and societal impact. Despite the fact that many of these restrictions have been eliminated over the last several decades (mostly in Western nations), the present generations of elderly people have spent the majority of their life in paternalistic society [for example, (13)].

Health and Well-Being:

"Health is a condition of total physical, mental, and social well-being and not only the absence of sickness or infirmity," as stated in the statement that was signed by 61 countries and presented to the World Health Organization in 1946 [(14), page 100]. In other words, health is seen as a multidimensional phenomenon, which in addition to the absence of physical and mental illness, also includes dimensions of quality of life as perceived and facilitated by society. Health is viewed as a multidimensional phenomenon that includes dimensions of quality of life as perceived and facilitated by society. Because of this, a person's state of health is dependent not just on their genetic make-up but also on the circumstances of their physical, cultural, and social environments. Since the second half of the 20th century, unprecedented advancements in medicine, medical technology, sanitation, nutrition, and quality of living have resulted to considerable improvements in human health as well as an increase in the average lifespan. Alterations in lifestyles that have resulted from changes in cultural knowledge and beliefs on the factors that determine sickness and health have also played an essential part in the prevention of disease and the promotion of health.

According to the definition of health provided by the World Health Organization, a full assessment of health has to be based on a range of different indicators. In general, one's life expectancy, the absence of sickness, and the absence of disability are used to gauge their level of physical health. In most cases, a person's mental health is assessed based on the absence of mental illnesses and dementia, in addition to psychological qualities and coping skills. These characteristics and resources include things like self-esteem, self-efficacy, toughness, and sense of coherence. The financial situation, familial status, level of social activity, and availability of social support are all factors that are considered when evaluating a person's social well-being.

Objective measurements of these spheres are often used to determine a person's quality of life. However, individuals who are rated similarly on objective measures of quality of life may have quite different opinions of the quality of their lives based on their own subjective experiences. Furthermore, research conducted in a variety of nations has shown that subjective assessments of health and wellbeing are more accurate predictors of senior individuals' likelihood of living longer than objective measurements of health, such as evaluations conducted by medical professionals (15–17). Because of these results, there has been a great deal of study conducted that focuses on subjective assessments of health and well-being, particularly among people of advanced age [for example, (18)].

Gender Differences in Personal Resources and Social Roles Related To Health and Well-Being:

Education and money are two of the most crucial human resources for social mobility in contemporary and open societies. Additionally, both education and income are key predictors of outcomes in health and well-being. Around the globe, women have a lower average degree of education than males have had for many centuries. Despite the fact that there is evidence to suggest that this disparity has shrunk over the course of the years, it is still present in a great number of nations. Literacy rates for women aged 15 and older over the globe went from 76.4 percent in the year 2000 to 82.6 percent in the year 2016, but literacy rates for males increased from 86.6 percent in the year 2000 to 89.8 percent in the year 2016. (24, 25).

The gender disparity in education levels varies greatly from nation to country. Countries are categorised by the United Nations (UN) into one of three different groups based on their socio-economic status. This status is determined by factors such as their gross domestic product (GDP), per capita income, level of industrialization, standard of living, life expectancy, and literacy level. The countries that make up the "most developed" or "most developed" nations are primarily located in Western Europe and North America, with the exception of Japan, Australia, and New Zealand. Countries such as Namibia, South Africa, China, Malaysia, India, Brazil, and Bolivia are examples of "less developed" or "developing" states. Other examples include countries in Southeast Asia. Countries such as Afghanistan, Sudan, Ethiopia, and Yemen are examples of "least developed" countries. These are the nations that are the poorest in Africa, Asia,

and the Middle East (26). By definition, the levels of education that are available to people of both sexes in more developed countries are much greater than those that are available in less developed ones. In many countries, the gender-related education differences in the younger age groups (those between the ages of 35 and 44) either become smaller with time or totally vanish altogether. Nevertheless, in the majority of nations that are members of the OECD at the moment, older males have completed more years of formal schooling than older women (27).

Gender Differences in the Role of Informal Caregiving:

In addition to the disadvantages that women face in terms of education and income, both of which have a negative impact on health and well-being, one of the most significant factors that affects women's socioeconomic status, health, and well-being is the social role that women are expected to play in raising children and providing care for ailing members of their families. This traditional position has been one of the impediments that has prevented women from being able to expand their contribution beyond the family unit to society as a whole for hundreds of years, which has had a detrimental impact on the status that women enjoy in society. These last several decades have brought about some shifts in this traditionally held profession. On the one hand, the number of children in many communities is decreasing, while on the other hand, the burden of caregiving has greatly grown owing to the lengthened years of life with disability of elderly family members. This phenomenon is occurring in many different civilizations. Women are more likely to take on the position of primary caregivers within their families. This responsibility often involves taking care of several family members (children, grandkids, parents, and spouses) simultaneously or one after another over the course of a lengthy period of time. In addition, in today's contemporary households, women continue to fulfil these caregiving responsibilities throughout their whole lives, in addition to their many other jobs both within and outside the home, including the added responsibility of working outside the home.

In point of fact, women make up the vast majority of unpaid caregivers across the board, and this is especially true for those afflicted with dementia (1). In the United States, when male and female carers were compared, it was shown that women make up 70 percent of main caregivers. In addition, compared to males, women are more likely to devote a higher number of hours per week to providing care and to take on a bigger proportion of

the more challenging personal caring responsibilities. Women also continue to play the job of caregiver far into their later years, which means that they are more likely than males to be subjected to the heavy, multidimensional load and pressures associated with these activities, despite the fact that they are themselves physically and mentally exhausted (44). As a result, the role of nurturing and caregiving prevents women from fully participating in the labour force while they are young and raising children; it has a negative impact on women's social status and income; and it subjects women to ongoing physical and emotional burdens throughout the course of their lives. The public's knowledge of the risks associated with providing care has risen as a result of the rising number of elderly individuals in need of assistance in societies that are becoming older. Studies have shown that primary caregivers of elderly people have a lower quality of life (45, 46), and they are a group that is at a high risk for nutritional deficiencies (47), stress and depression (48–52), and general morbidity and mortality (52, 53), especially if they themselves are elderly persons. This is especially true if the primary caregivers themselves are elderly.

Conclusions:

These concerns were discussed by concentrating on gender disparities in quality of life outcomes such as life expectancy, health, functioning, and subjective well-being, as well as their tendencies to change over the process of ageing. The report also contained explanations of social changes that have occurred in the acquisition of personal resources and lifestyle-related activities that have an influence on these outcomes at all stages of life, but particularly in old age. Comparisons made at the national and worldwide levels show that women have an edge over males in terms of life expectancy; yet, they are at a disadvantage in practically every facet of quality of life relating to health, functioning, and subjective well-being. Despite this, there is evidence to suggest that gender roles within the context of the individual, the family, and the country all have an impact on gender equality in health. For instance, Palencia et al. (128) report that gender inequality in self-perceived general health is highest in traditional Southern European countries, while it is not significant in the majority of dual-earner and market-oriented countries. This finding is based on the findings of a multinational European study. Therefore, societal structural and cultural barriers to women's equality in social status and personal resources

continue to exist worldwide, particularly in developing nations, where the process of change toward increased gender equality has only just begun or has not yet begun. These barriers exist despite the fact that gender equality has made some progress, particularly in Western nations. Disability, loneliness, and depression are three conditions that affect older persons, but women are more likely than males to experience them. In general, women have a lower will-to-live and rate lower on markers of subjective well-being than males do. This is also the case. So the question is, does the gender disparity in health indicators widen or narrow as people become older? Some worldwide statistics suggest that there is a tendency toward gender convergence with respect to life expectancy and in some elements of health and well-being, however this is only the case for persons who are very elderly and/or those who have a high level of education and lead an active lifestyle. Nevertheless, the gender discrepancy in the number of years of life spent with a handicap persists until late adulthood, which is to the detriment of women. As a result of ongoing observations of trends that have opposing implications on gender disparities in health and well-being, it is not yet possible to provide a definitive solution to the issue of whether divergence or convergence will be the more likely outcome for future cohorts of older individuals. However, we are able to speculate that the magnitude of influence exerted by these two distinct social processes on health and well-being may in fact vary over time as a result of differences in the rate at which they change and in the manner in which they have an effect on health and well-being in later life. There is a slow but steady movement toward gender equality in education, involvement in the workforce, and income, and the glass ceilings that women face are beginning to show signs of breaking. These processes have somewhat gradual and indirect beneficial impacts on health and well-being, but they do have these benefits. At the same time, the increase of ratios of women involved in risky health behaviours (such as smoking, drug and alcohol consumption, and unhealthy diets resulting in obesity) seems to be more rapid with direct effects on women's physical and mental health. These behaviours include smoking; drinking alcohol and drugs; and eating unhealthy diets that lead to obesity. This analysis leads to the conclusion that if other factors remain the same in the near future, the advantage that women currently have over men in terms of life expectancy in the more developed nations is likely to decrease, while the number of years that older women live with physical or mental

limitations is likely to increase. This inference is reached as a result of the fact that this analysis leads to the conclusion that this analysis.

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