International Journal of Biomedical and Healthcare Science.
Volume 6, Number 2 (2016), pp. 211-218

http://www.ripublication.com

Social and Health Status of Elderly People in the Selected Areas of Hardwar District in Uttarakhand

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1. INTRODUCTION

In India, the proportion of the population aged 60 years and above was 7 per cent in 2009 and was projected to increase to 20 per cent by the year 2050. In absolute numbers, the elderly population in 2009 was approximately 88 million and is expected to sharply increase to more than 315 million by 2050. The more developed states in the southern region and a few others like Punjab, Himachal Pradesh and Maharashtra have experienced demographic transition ahead of others and therefore are growing older faster than other states. Certain regions, primarily in the central and eastern parts of the country, still have high fertility and mortality levels, and therefore, younger population age structures. While improvement in health, decline in fertility, and increase in longevity are desirable, the projected increase of elderly population over the next few decades is a development concern that warrants priority attention for economic and social policies to become senior citizen-friendly (Alam, Moneer, 2006).

Old age means reduced physical ability, declining mental ability, the gradual giving up of role playing in socio-economic activities, and a shift in economic status moving from economic independence to economic dependence upon other's for support. The expectancy of life in India is much less than 72 years. Psychologically too, most state population in Uttarakhand appear to consider themselves old earlier than the chronological age of 60 years and the mountain women regard themselves to be old even much earlier (Bose, A.B and K.D. Gangrade, (ed.),1988). According to Goldman, N., S. Korenman and R. Weinstein ,1995), "Some people use their chronological age as a criterion for their own aging whereas others use such physical symptoms as failing eye-sight or hearing, tendency to increase fatigue, decline in sexual potency etc. Still others assess their aging in terms of their capacity for work, their output in relation to standards set in earlier years, their lack of interest in competing with others, lack of motivation to do things or a tendency to reminisce and

turn their thoughts to the past rather than dwell on the present or the future." The acceptance of the fact that they are old develops in the aged an "old age complex" (Bose, A.B and K.D. Gangrade, (ed.),1988). In India as elsewhere, life expectancy has improved with better medical care and improved nutrition (Siva Murthy, AR Wadakannavar, 2001).

Uttarakhand like many other states in the India is witnessing the rapid aging of its population. Urbanization, modernization and globalization have led to change in the economic structure, the erosion of societal values, weakening of social values, and social institutions such as the joint family. In this changing economic and social milieu, the younger generation is searching for new identities encompassing economic independence and redefined social roles within, as well as outside, the family. The changing economic structure has reduced the dependence of rural families on land which has provided strength to bonds between generations. The traditional sense of duty and obligation of the younger generation towards their older generation is being eroded. The older generation is caught between the declines in traditional values on one hand and the absence of adequate social security system on the other (Gormal 2003). Illness increases with age. All else being equal, an older population has greater needs for health care.

Aging is considered as natural and universal process. It is regarded as an inevitable biological phenomenon. Elderly people are suffering from various physical, mental, social and economic problems. Elderly are vulnerable to long term diseases of insidious onset such as cardiovascular illness, CVA, cancers, diabetes, musculoskeletal and mental illnesses. They have multiple symptoms due to decline in the functioning of various body functions. The Indian value system prescribes respect, reverence and physical care for elderly from their children. With emerging changes in our social and cultural values, the elderly who are economically unproductive are sadly neglected. It is recognized that the elderly are prone to psychic disorders through vicissitudes such as social isolation, malnutrition, economic and emotional depression and so on. Information on morbidity profile of elderly is the basis of any meaningful plan of action to improve the quality of life of this section of the population. Hence the study will be conducted to assess the health status and morbidity pattern among the rural elderly persons and it implications.

2. KEY OBJECTIVES OF STUDY

- To assess the key health status of elderly people in selected area of Uttarakhand (>60 years)
- To understand the socioeconomic status of elderly people
- To assess the level of access to various welfare schemes and health insurance
- To assess the support system available within the family and community for the elderly people

3. STUDY METHODOLOGY AND STATISTICAL ANALYSIS

A cross sectional study was conducted among elderly persons above 60 years in Haridwar district of Uttarakhand in India. Study area comprise of 8 villages in 2 ANMs center of Bahadarabad block of Haridwar district which also is field project area of Rural Development Institute – Himalayan Institute Hospital Trust. The study sample included two ANMs centers which were selected by random sampling method (lottery method) among 8 villages. Enlisting of all elderly persons from all the villages in selected ANM were done using Anganwadi workers survey records & Village Panchayat record. A 20% elderly people were selected from this record using systematic random sampling which formed the study sample (total 250). The survey was conducted on prescribed formats and necessary modifications were done in the format before conducting the final study. Each study subject will be interviewed with pre-structured & pre-tested questionnaire.

3.1 Tools of data collection

The recruitments of investigators were done based on their qualification and pervious experiences in research and data collections. All the selected investigators were conducted in a three days orientation programme, which include one-day of fieldwork. The entire fieldwork was carried out in two phases. In the first phase, investigators were collect primary information at the household level by the help of ANMs and ASHAs. This primary phase survey was conducted by investigators. For the qualitative data, individual interviews and focus group discussions (FGDs) were conducted through a pre designed and pre tested semi-structured checklist. Three FGD-meeting were planned to be organized in the selected states.

For ensuring the quality, a process including ethical approval, informed consent and confidentiality were followed at all the levels of research. The selection process of the geographical areas, districts and development blocks are fixed in number. The time duration of this study was very short, especially considering the type of fieldwork required for the study. The research team is supposed to face many problems in the field because of summer season and difficult geographical terrain, which always hinders the quality assurance of programme.

3.2 Statistical Analysis

For quantitative statistical analysis, the questionnaires were submitted by investigators teams were coded with the Identification numbers and data was directly entered in statistical packages i.e. in SPSS or STATA for Window, version 19. The missing values were allowed for the analysis and frequencies were calculated from the univariate analysis. Bivariate analysis was used to describe the relationship between different variables and the dependent variables.

The qualitative analysis was done based on the conceptual framework and as identified by the researchers as the priori themes of the qualitative data analysis, i.e. the factors affecting the enrolment rates adversely and the factors affecting the

utilizations of inpatient healthcare adversely. Then the researcher used these a priori themes to code the transcripts.

4. RESULT

4.1 Socio-Economic and Demographic Profile

In Uttarakhand, almost 60 per cent of the elderly are heads of the households that they live in. The headship rate, as expected, is found to be substantially higher among elderly men as compared to elderly women. About 78 per cent of sampled elderly households are Hindu, nine per cent each are Muslim and Sikh, 21 per cent belong to Scheduled Castes, six per cent to Scheduled Tribes, and 35 per cent to other backward classes.

About two third of households were lived in their houses and rest of them rented houses. More than half of the surveyed households use LPG as cooking fuel and rest were depends on wood and other sources of cocking fuel. About two-fifth of the households have a below poverty line (BPL) card. More than one-third of elderly households have a monthly per capita expenditure (MPCE) below Rs. 1,000 and only 17 per cent have an MPCE more than Rs. 2,500. The wealth quintiles calculated on the basis of asset holdings and amenities within the household show that the variation in wealth in Uttarakhand 40 per cent of the households belongs to the lowest wealth quintile. About 27 per cent of the surveyed elderly households had an outstanding loan at the time of survey and 13 per cent reported that the loan is taken for meeting the medical expenditure of the elderly. The survey also collected information on material and financial transfers to and from the households. The findings suggest that around 16 per cent of the households are receiving financial transfers from their children, relatives or other members.

The profile of the individual elderly indicates a low level of educational attainment, particularly among women. Overall, half of the elderly report not having any formal education, with a higher proportion, almost two-thirds, among women. With regard to marital status, around 60 per cent of the elderly are currently married while 38 per cent are widowed. Widowhood is as high as 59 per cent among elderly women.

4.2 Work and Income Status

The survey found that the work participation rate among elderly males in Uttarakhand is as high as 39 per cent as against 11 per cent among women. The majority of workers are in the 60 to 69 age group but the workforce participation among the oldest old is also relatively high in male. More than 80 per cent of the elderly workers are main workers. Although work participation is low among women, they would certainly be contributing to the family chores, enabling the other adult members to go to work. A majority of the elderly (71%) work due to economic necessity and not by choice. This is particularly true among women.

Women living alone have a higher incidence of work participation compared to those living with spouse or others. In addition, the data highlights the unskilled and low paid nature of the jobs that the elderly are engaged in. The elderly are working primarily in the unorganized sector, where both productivity and pay are low. The significant level of workforce participation by senior citizens is an indication of economic compulsion. Though the number of years spent in the labor force is considerable, pension or retirement benefits are not available to a large majority. In fact, due to the informal nature of the work they are engaged in, less than 10 per cent of all elderly get employer's pension.

As a result of being part of the labor force, nearly three quarters of elderly men and a little less than half of elderly women report having some type of personal income. Only about 7% of all elderly men receive income from employer's pension however majority of them receiving social pension. However, having income does not necessarily reflect the economic well-being of the elderly, especially when the income is linked to current labor force participation. Further, almost three quarters of all elderly say that they are fully or partially dependent on others to meet their economic needs. Even though the income earned by the elderly is not high, over half of all elderly who report receiving personal income say that they contribute towards the household budget with the majority of it going for daily expenditure. This implies that households still depend on the income of the elderly to meet their day-to-day needs. As such, the wages as well as the social pension, although meager, appear to be important for their family's survival. The findings from the survey also reveal that although significant proportions of the elderly own some form of asset (land, housing, jewellery or savings), the magnitude of ownership is marginal. A wide gender gap in assets is also observed. While inheritance is a significant way of acquiring wealth in rural areas, in urban areas wealth is usually self acquired. Thus, the implications of transfers of wealth between generations are likely to be more important in rural areas compared to urban areas.

4.3 Living Arrangement and Familial Relations

Family has traditionally been the primary source of support for the elderly in Uttarakhand. It is a matter of concern that even with a strong preference to live with children or relatives, not to mention high levels of economic dependency, about one in ten elderly women live alone. Our data also show that a large majority of them are from illiterate and poor classes and hence their vulnerabilities multiply. The elderly depend primarily on their families for economic and material support. In fact, the elderly report that sons are the major source of economic support, even more than spouses. The findings indicate that about 80 per cent of the elderly co-reside with their spouse and children and in some cases with other relatives. In addition, about a quarter of all elderly receive money transfers from their non-resident children and about eight per cent elderly transfers money to their children. While a majority of the elderly prefers to live with their sons, a small proportion prefers to live alone or with their spouse. In effect, the family home is the preferred place to live in old age with only 0.3 per cent preferring to live in old age homes or alone.

The vulnerability the elderly is reflected in the fact that one in 10 reports being subjected to some form of abuse – verbal, physical, emotional or other – after turning 60 years of age. Higher levels of abuse are reported by the elderly living in rural areas. About six per cent report that some form of abuse took place in the month prior to the survey, with verbal abuse being the primary form of violence. The main perpetrators of abuse were from outside the family for elderly men and within the family for elderly women.

4.5 Subjective Well-being, Functionality and Health Care Utilization

The various indicators of physical and mental well-being show a significant level of poor health among the elderly, with a high proportion of oldest old, poor, illiterate and widows in this category. The analysis on self-rated health shows about 55 per cent of the elderly rating their health as poor or fair on a five point scale. Self-rated health also has a close connection with mental and physical health of the elderly. Prevalence of risky health behaviors is quite high among the elderly. Around 30 per cent of the elderly are currently smoking, chewing tobacco or drinking alcohol and the incidence is particularly high among males. The study shows that a significant percentage of the elderly have high levels of acute and chronic morbidities. More than 90 per cent of the elderly sought treatment for their acute ailments with about 40 percent each from public and private health facilities. Wide variations are also observed. Financial insecurity remains the most commonly reported reason for not seeking treatment.

Nearly two-thirds of the elderly report suffering from at least one chronic ailment with arthritis, hypertension, diabetes, asthma and heart disease as the most commonly reported ailments. Women have higher prevalence rates of chronic conditions than men on average, and are much more likely to suffer from arthritis, hypertension and osteoporosis specifically, while men are more likely to suffer from heart disease, and skin and renal diseases. The majority of the elderly sought treatment for chronic ailments. Private hospitals are the predominant source of treatment for chronic conditions. Government hospitals are found to account for only about a quarter of the treated cases of hypertension, diabetes, and asthma. Both awareness of and access to health insurance schemes are limited among elderly people. Awareness and utilization of government assisted health insurance through the Rashtriya Swasthya Bima Yojana (RSBY) is also limited.

4.6 Awareness and Utilization of Social Security Schemes

A significant proportion of the elderly are aware of social security schemes such as the Old Age Pension Scheme and the Widow Pension Scheme, while awareness of the *Annapurna* Scheme is rather limited (40%). More than 70 per cent of the elderly are aware of the old age and t widow pension schemes. Although the elderly belonging to BPL households are the main target for these social security schemes, slightly more elderly in non-BPL households than elderly in BPL households are aware of all three schemes. The utilization of all three schemes is abysmally low among the target group of those belonging to BPL households. Around 90 per cent of elderly belonging to BPL households are beneficiaries of old age pension, while only 3.5 per cent utilize

the *Annapurna* scheme and a two third of elderly widowed women utilize the widow pension. It should be noted that substantial wrong targeting of the scheme is apparent with up to 9 per cent of non-BPL cardholders benefiting from the IGNOAPS and 15 per cent from the IGNWPS.

Awareness of concessions and benefits is also found to be poor. Around 40 per cent of the elderly are aware of concessions in train tickets or bus reservations, 20 per cent each know about the preferences given for phone connections and higher interest rates on small savings in banks and post office, 13 per cent are aware of income tax benefits and about 30 per cent are aware of the Mahatma Gandhi National Rural Employment Guarantee Scheme. Utilizations of these benefits is very low, with about 9 per cent of elderly availing of concessions in train or bus reservations and negligible proportions utilizing the other programmes. Only 14 per cent of the elderly are aware of RSBY and a mere seventeen per cent of BPL households have registered under the scheme.

5. RECOMMENDATIONS

The findings of the study clearly highlight that income insecurity, illiteracy, age related morbidity, and physical and economic dependency are factors that tend to make the Indian elderly, and particularly elderly women, vulnerable. The information emanating from the study has important policy and programmatic implications for improving the well-being and quality of life of the elderly. The approach needs to be holistic and multidimensional; at the individual, family, community, governmental and non-governmental levels. First and foremost, opportunities need to be provided for improving socio-economic status and access to health care. Also important is extending social pension and health insurance, especially to women. At the family level, stronger intergenerational bonding needs to be encouraged and at community level, greater participation of elderly has to be ensured by active involvement in decentralized bodies. Effective implementation of national policy and programmes for older persons in line with the international instruments is imperative and government should ensure availability of physical, financial and human resources to do so. Further, government needs to enable civil society groups and engage the private sector in creating an elder friendly environment. Data and research gaps in understanding issues of the elderly within the cultural context need to be undertaken on a regular basis and appropriate monitoring systems have to be put in place.

ACKNOWLEDGEMENT

I gratefully acknowledge the financial support rendered by Rural Development Institute, Himalayan Institute hospital Trust for conducting the study. I also acknowledge the technical support for developing online questionnaire and tabulation for analysis provided by Mr. Vikesh Semwal, Rural Development Institute, Himalayan Institute Hospital Trust. I also appreciate sincere efforts of field investigator Ms. Leela and Ms. Pawaneep and other team members from RDI.

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