# HEALTH OF THE ELDERLY IN INDIA

## Some Aspects of Vulnerability

Indrani Gupta

Purnamita Dasgupta

Maneeta Sawhney

**Institute of Economic Growth**

**University Enclave**

**Delhi-110007**

**India.**

## 1. INTRODUCTION

Broadly speaking, the ageing of a population has been defined as an increase in the proportion of the aged vis-à-vis a decrease in the proportion of the young. There have been major occurrences in Asia that have impacted on the situation of the elderly: the decline in fertility that will gather further momentum in the twenty first century coupled with the continuing and steady decline in mortality which has resulted in significant changes in the size and structure of Asian populations. In India, the population of the elderly is growing rapidly and is emerging as a serious area of concern for the government and the policy planners.

Among the population aged 55 and above in Asia, there are about 90 men for every 100 women; for those aged 75 and above, there are only about 70 men for every 100 women (Lee and Mason, 2000). On account of high marriage rates in Asia as compared to other developed countries, a large majority of the elderly in the Asian countries have been married. With increases in life expectancy, the proportion of elderly who are widowed will go down further, and there will be more surviving elderly couples in the future. At the same time, since women tend to live longer than men, there will continue to be more elderly widows than elderly widowers.

While the number of workers in the elderly population in Asia continues to increase, there are differences across countries; in Japan due to economic security, labour force participation rates are projected to fall from 41 percent in 2000 to 29 percent in 2050, in India however, it is projected to fall from 46 percent in 2000 to only about 41 percent in 2050 (Lee and Mason, 2000). Thus the coming years will see an increasing number of elderly couples and widows, many of whom will continue to feel the pressure to earn a livelihood due to lack of social security and insurance. At the same time, the process of aging will be accompanied by increased vulnerability to illness and death. All these features of aging imply that the problems of the elderly will need a special focus and approach.

Old age can be broadly characterised by time-altered changes in an individual's biological,

psychological and health related capabilities and its implications for the consequent changes in the individual's role in the economy and the society (Irudaya Rajan and Misra, 1995). This immediately implies that there are a vast number of issues that call for an attentive focus on the elderly. As will be discussed later, there has been some pioneering work on the elderly in India, but a lot more remains to be done. One recurring issue in the literature on the health of a population is the special vulnerability of the females. Considerable literature exists on the gender disparities in health and health-seeking behaviour in India, especially of adults. This paper takes a fresh look at these issues in the context of the elderly, using more recent rural data from a national survey; in particular, the study examines the gender differentials in health and health-seeking behaviour of the elderly males and females in India. A more rigorous analysis is done to elicit the issues of vulnerablity, to investigate whether the gender effects, if any, are due to factors other than those that constitute vulnerability. Whether or not there should be a fixed age group to define the elderly is often the subject of debate but it has been a common practice to define old age in terms of the beginning of the sixties in the life span, characterised by retirement from work and certain other social responsibilities. This paper follows the convention of using sixty as the cut off age for the analysis.

Section 2 presents the demographic and health profile of the elderly in India. Section 3 describes the data and some preliminary results based on the data, while Section 4 presents a more rigorous econometric exercise to analyse the factors that determine who seeks care. In Section 5, the qualitative aspects of women's health seeking behaviour has been discussed. Finally, Section 6 summarises the main findings and conclusions from the study.

## 2. DEMOGRAPHIC AND HEALTH PROFILE OF THE ELDERLY

Before turning to rigorous data analysis, a look at the evidence from existing literature on the elderly in India and elsewhere might be useful in order to place the rest of the discussion in perspective.

The population aged 60 plus in India as per the 1991 census was 56.7 million, up from 26 million in 1961, which clearly indicates a doubling of the elderly population in the last thirty years. The proportion of the elderly has been going up steadily in each census, though at varying rates. The 1991 Census indicated that 6.58 percent of the total population belonged to the 60 plus age group. This proportion is expected to go up to 7.08 percent by 2001 and 9.87 by 2021.

The age pyramid of India is typical of a population just entering demographic transition from high to low fertility, with a large number of children and relatively small numbers of the elderly. Expectation of life at birth for India has increased from 48.9 for males and 49.3 for females in 1971, to 61.6 for males and 62.2 for females, respectively in 1996. For those above the age of 60, it has increased from 13.80 for males and 14.75 for females in 1971, to 15.01 for males and 16.23 for females in 1991 (Irudaya Rajan; U S Misra and P. Sankara Sarma, 1999). As for gender, the Census indicated that the 60 + category favored the males, but in the 70+ age group, the ratio of females was higher than males, which is explained by the higher life expectancy at age 60+ for females in comparison to males.

According to the 1991 Census, a majority of the elderly of the country, i.e. 78 percent, live in rural areas. Proportionately, more elderly males than females reside in the rural areas, in contrast to adult males. The latter phenomenon is due to migration of young adults to the urban areas and the return migration of the older males back to their native areas in the rural settings (Dandekar, 1996). Further, the proportion of the elderly men who live in rural areas tends to increase with age. The opposite is the case with respect to the elderly females who are more concentrated in the urban areas.

With regard to the work status of the elderly, in 1991, in rural areas, 65.36 percent of the elderly males and 18.96 percent of the elderly females were working, whereas in the urban areas, 42.93 percent of the elderly males and 6.30 percent of the elderly females were working (Irudaya Rajan et al. 1999). Two points should be noted about these statistics. Firstly, work force participation of elderly males is quite high in India, unlike in countries like Japan; secondly, compared to men, a very small percentage of women seem to be

working. The economic compulsion to work combined with the small size of the organized sector implies that most of the elderly work in the unorganized sector. This in turn means a lack of social security or post retirement benefits, making the economic vulnerability of the elderly even greater.

The task of looking after the welfare of these citizens, who are in need of physical, financial and emotional care, is a daunting one for a country where the majority of the population is barely able to live above the poverty line. One aspect of this welfare consists in providing affordable and adequate health care for the elderly, by taking into account the pathologies of old age. A second issue is the socio-economic vulnerability of the elderly (in addition to the physical problems of old age). Disease profiles are generally linked to the socio-economic status of the individual in an economy like India. A study based on a household survey in Bangladesh (Kabir 1992) studied the relationship between incidence of disease and the socio-economic characteristics of the elderly respondents. Both education and occupation were found to be inversely related to the incidence of disease among the elderly. Further, it was found that more than half the respondents did not avail of government facilities because of a lack of proper and /or sympathetic care from the doctors. About one-sixth of the respondents mentioned the distance to be traveled or the long waiting time as deterrents to the use of government hospitals. The study also indicated that the primary health care system had no special provision for providing health care for the elderly, and even the overall health policy showed no special concern for the elderly. These facts hold equally true for the Indian scenario (Bagchi 1998). The National Policy on Older Persons was designed to address the issues relating to the elderly, however it does not give specific policy recommendations on the health of the elderly.

As for the role of marital status, studies from other parts of the world have found that while marital status is positively associated with health and survival outcomes, it was more important in explaining the health of the widowers than widows (Goldman et al. 1995). This is corroborated from other sources; a survey of the sociological literature suggests that the elderly married males enjoy better health than the elderly females (Bose and Gangrade ed. 1988). The study states that this is largely due to the traditional role that

women play as the primary care givers, coupled with the lower status they enjoy, which leaves them with access to limited financial resources for themselves. Consequently, the health of the elderly woman gets ignored, which is further aggravated by the stigma of widowhood.

One of the approaches towards studying the well-being of the elderly has been to study their "competence" in daily living. Such "functional competence" based approaches assess the ability to manage the tasks of daily living by the elderly, without dependence on others. Statistics from India (Dandekar 1996) have found that there are male-female and rural-urban differentials in the incidence of disability relating to such functional competence. In fact, the conclusion reached is that the health-related quality of life of the elderly, especially women, from rural areas, is considerably lower in India when compared to other countries. Poor nutrition, inadequate health care, socio-economic conditions and gender have been the major factors explaining the ability of the elderly to maintain competence.

A study in Bangalore (Jai Prakash 1998) found that the fear of physical dependency, (including being sick, or disabled) rather than economic dependency was a major cause of worry for the elderly. Nearly 60 percent of the respondents suffered from some long-term illness that required at least one monthly visit to the doctor. Rural elderly rarely visited the medical units while urban elderly were more regular in their check-ups and followed medical regimens systematically. Even among the urban sample, the males accessed health facilities more than females. It is of interest to note that even in a state like Kerala, a survey (Irudaya Rajan et al. 1999) on the health of the elderly found that women are poorer and suffer more morbidity than men in old age, although their death rates are lower.

A few attempts have been made at etching the profile of the illness patterns among the elderly. Among these, cough, poor eyesight, anaemia and dental problems were found to dominate. The NSS 42nd round (July 1986 - June 1987) reported that 45 percent prevalence of chronic illness is reported from the elderly in India. In mapping disease patterns, Dandekar (1996) found no significant differences in male/female or rural/urban

proportions of those ill among the elderly. However, the pattern of diseases between males and females differed and problems related to blood pressure, heart disease, urinary problems and diabetes were dominant in the urban areas. For urban females, the chronically ill percentages were higher than for males. She found that poverty and health status were closely linked in her study.

This paper takes a fresh look at these issues using all-India level rural data. In particular, it investigates whether the gender differences found in other studies are due to pure gender effects or a set of vulnerability factors.

## 3. HEALTH OF THE ELDERLY: A PRELIMINARY ANALYSIS

The National Council of Applied Economic Research, under the Human Development Indicator Survey (HDIS), collected extensive data on an all-India basis on a variety of indicators that indicated vulnerability. This endeavour was supported by UNDP, UNICEF, UNFPA and IDRC and was carried out in 1994-95. There are two components to the data set, one is the household data set which is supplemented with a village-level data set.

In this paper, we use the HDIS household level data on the elderly, defined here as those who are 60 and above, to investigate their health status and health-seeking behaviour, with special emphasis on gender differentials, if any. In addition, we use qualitative data gathered from a survey carried out (April-June1999) among eighty elderly women in the Kusumpur Pahari slum in New Delhi to further explore some of the findings from the HDIS data. These elderly women who were of age 60 and above, were interviewed regarding their perceptions and response to their health status. It is important to bear in mind that the HDIS data is from rural India, whereas the qualitative data is from the urban slums of Delhi; however, since the urban slum dwellers in Delhi are almost entirely migrants from neighbouring villages, the qualitative data would provide crucial insights for the analysis.

The HDIS provides information on the health and well being of the elderly under two categories. Under the section on socio-economic and educational profile of the households

there is a separate sub section on the welfare of the elderly, which enquires into the main source of livelihood, physical well-being, nature of long-term health problems and the kind of medical attention an elderly person receives. In addition, the health profile of the households has been mapped in a separate section. A detailed questionnaire was administered to all the household members to document mainly the short and long duration morbidity, in addition to reproductive and child health concerns. We use information from these two parts of the HDIS to document some preliminary findings and to do a quantitative analysis on the well-being and health of the elderly. This is followed by some qualitative investigations to help explain the results for the quantative analysis.

There were in all 13,682 elderly in the HDIS sample, of which 54 percent were males. Ninety percent of the females had never been to school in contrast to 66 percent of the males. The educational attainment of the women in each education category was always lower than that of men. As for the work status of the elderly, the data revealed that 75 percent of the elderly males were employed and earning wages, while only 25 percent of the elderly females were thus gainfully employed. This is consistent with findings from the census and other studies reported earlier in the paper. With regard to marital status, we find that 80 percent of the males are currently married as opposed to only 40 percent of the elderly females, yielding a large number of widows, which is again corroborated by earlier studies. Table 1 gives information on the main sources of livelihood of the elderly.

**Table 1: Source of livelihood, by gender (%)**

| Main source of livelihood | Male | Female |
|---|---|---|
| Living on own income | 54.3 | 19.8 |
| Receiving support from NGOs/Govt | 1.0 | 1.3 |
| Supported by family | 42.3 | 76.8 |
| Destitute | 0.5 | 0.8 |

| | | |
|---|---|---|
| Other | 1.8 | 1.1 |

The two main sources of livelihood are own income; including pensions and support from family. Table 1 indicates that relative to men, women have a greater dependence on family, which could of course include their husbands. Only about 20 percent of all the elderly women in the sample had any source of income of their own, in contrast to 54 percent of the elderly men. Thus the educational attainment, work status, marital status and source of livelihood of the elderly together indicate that elderly women are more likely to have a lower level of economic well-being than males.

What is the health status of the elderly in the sample? Table 2 gives the responses by gender. Interestingly, a majority of the elderly about 65 percent in each gender, reported no major health problem. A little over 20 percent of all the respondents in each gender reported being ill, though not bed-ridden. Eight to ten percent of the respondents reported chronic problems or were bed-ridden. The data also revealed (not reported in Table 2) that in each category of these well being indicators, except the first two, there were more men than women; in other words, among all those who reported restricted activity with chronic illness, 54 percent were men. In the category of ill but not bed-ridden, there were 53 percent men, and in the last category of bed-ridden individuals, there were 60 percent men.

**Table 2: Physical well being, by gender (%)**

| *Indicator of physical well being* | *Male* | *Female* |
|---|---|---|
| Fit, no major health problem | 65.1 | 64.1 |
| No chronic problems, but assistance needed | 4.6 | 5.5 |
| Restricted activity with one or more chronic problems | 6.5 | 6.6 |

| | | |
|---|---|---|
| Ill, but not bed-ridden | 20.5 | 21.2 |
| Bed-ridden | 3.3 | 2.6 |

Our findings indicate a lower level of morbidity than what has been reported from other studies mentioned above, especially for females; in fact, more men than women self-reported illness/disability. Many gerontological studies have argued that the elderly women are more likely than the men to have chronic illnesses, and urban residence provides the elderly women the support of their children and the accessibility to specialised health care services of the urban areas (Bose and Gangrade ed 1988). This could explain the result on the similar morbidity rates of men and women in the data, but also raises the issue of accuracy of illness information for large-scale surveys such as this, and will be discussed further below.

What kind of illnesses do individuals report? The questionnaire enquired about the following six categories of ailments: cough, joint pains, blood pressure, heart disease, diabetes and cataract/loss of vision. It is interesting to note that when probed about these conditions, about 600 more individuals among those who said they had no major problems reported at least one condition, indicating that probing as a method of investigation, while time-consuming, always elicits better responses. About 40 percent of the males and 39.5 percent of the females reported an ailment. Table 3 indicates the percentage in each of these categories for men and women, in terms of the first and the second reported condition. Only 10 percent of all individuals (for both men and women) reported a second illness.

**Table 3: Nature of ailments, by gender**

| | *First condition* | | *Second condition* | |
|---|---|---|---|---|
| *Nature of ailments*[1] | *Men* | *Women* | *Men* | *Women* |

[1] The totals for each column is slightly less than 100 due to some non-response.

| | | | | |
|---|---|---|---|---|
| Cough | 22.7 | 18.0 | 6.6 | 4.9 |
| Joint pains | 25.0 | 32.1 | 23.9 | 21.7 |
| Blood pressure | 6.5 | 7.8 | 4.2 | 7.1 |
| Heart disease | 2.6 | 3.3 | 6.1 | 5.1 |
| Diabetes | 4.8 | 1.5 | 5.6 | 3.0 |
| Cataract/loss if vision | 9.8 | 14.4 | 22.4 | 32.2 |
| Others | 27.2 | 21.6 | 26.0 | 21.9 |

A sizeable number of individuals reported ailments outside the six mentioned in the questionnaire as indicated by the category 'others'. The bulk of the ailments were in the categories 'joint pains' and 'cough', followed by eye problems. In the second ailment reported, joint pains and eye problems were again the two most important ones. A higher percentage of women reported cataract/loss of vision than men. This was also true of joint pains, for the first stated condition. The data reveals that heart disease and diabetes do not seem to afflict the majority of the elderly population in rural India. On the whole, from the table it seems that the kind of conditions reported for males and females are similar, except for eye problems, and joint pains to a lesser extent.

Do all individuals seek treatment for their ailments? Table 4 indicates the percentage of ill individuals who did not seek care, as well as those who sought care from different sources. Contrary to the evidence from the previous studies, of those who reported some illness, only about 20 percent did not seek care, which is a fairly high rate of care-seeking behaviour. For those who did, allopathic doctors and medicines were the most important sources of treatment, followed by indigenous doctors. As in the previous tables, there does not seem to be a gender difference in either not seeking care, or the kind of medical care sought.

**Table 4: Kind of medical care, by gender**

| *Kind of care* | *Male* | *Female* |
|---|---|---|
| No care | 19.7 | 20.0 |
| Allopathy | 54.3 | 52.9 |
| Indigenous doctors | 13.3 | 14.0 |
| Paramedical care | 2.3 | 1.2 |
| Home remedies | 9.2 | 8.9 |

The data in the above four tables were based on the social welfare section of the HDIS data. In the following analysis, we look more closely at the data obtained from those who reported at least one long-duration morbidity from the same data set.

This part of the questionnaire asked about eight major long-duration health problems. These are: epilepsy, hypertension, diabetes, heart disease, mental illness, tuberculosis, leprosy and cancer. Thus in addition to hypertension, diabetes and heart disease mentioned in Table 4, there were five more illnesses in this section.

Unlike the data in the previous section, this section indicated a lower rate of morbidity among the elderly – about 30 percent for both males and females (it was around 35 percent in the previous calculations). To explore the prevalence of illness among the eight categories mentioned above, the information in Table 5 is useful.

**Table 5: Occurrence of long duration illnesses**

| *Type of Illness* | *Percentage of ill, by illness type* |
|---|---|

| | *Total* | *Male* | *Female* |
|---|---|---|---|
| Epilepsy | 0.7 | 0.7 | 0.6 |
| Hypertension | 3.4 | 3.2 | 3.8 |
| Diabetes | 1.6 | 2.0 | 1.1 |
| Heart disease | | | |
| Mental illness | 0.6 | 0.7 | 0.6 |
| Tuberculosis | 1.9 | 2.3 | 1.5 |
| Leprosy | 0.7 | 0.6 | 0.7 |
| Cancer | 0.6 | 0.6 | 0.4 |

The first point to note is that the three most important diseases are hypertension, tuberculosis and diabetes. These categories are clearly not adequate to cover all kinds of illnesses - about 16 percent reported 'other' illnesses which unfortunately could not be classified for the purpose of analysis. However, the overall incidence of illness, at least in the categories mentioned in the table, is not very high.

As for gender differentials, except for tuberculosis and to a lesser extent hypertension, both males and females seem to have a similar incidence of illnesses of these types. The percentage of males reporting TB is substantially higher than for females. On the other hand, fewer males suffer from hypertension than females.

Each individual was asked about the number of days the person was ill, and if bed-ridden, the number of days he/she was bed-ridden. The mean number of days of illness was almost the same – around 245 in a year – for both males and females. While the morbidity rates and incidence of illness was quite low, the mean number of ill days was quite high, and has implications for the well-being of the person and his/her relatives. As for the number of bed-ridden days, it was 31 for males and 26 for females. The mean number of days hospitalised was also quite similar across the two genders – 24 and 20 for males and

females respectively.

Finally, to analyse the mean expenditure on illness by gender, we look at Table 6, which summarises the responses to the question whether any treatment or therapy was sought, for all the three classes of response options (treatment sought, home remedy and no action).

**Table 6: Mean expenditure (in Rupees)**

| *Type of action* | *Male* | *Female* |
|---|---|---|
| Treatment sought | 1,428 | 1,262 |
| Home remedy | 72 | 74 |
| No action | 56 | 11 |

Females spent slightly less than males for formal treatment and much less when they reported 'no action'. It is not clear what this third category is, but since expenditure was reported for even this third category, it has been reported here. The expenditures are almost identical for home remedy across both genders.

Finally, in Table 7 we look at the kind of medical attention given, by gender. The table omits a few other categories that were reported, but were insignificant.

**Table 7: Type of medical care sought, by gender**

| *Type of medical care* | *Males* | *Females* |
|---|---|---|
| Indigenous practitioner/faith healer/religious person | 11.5 | 11.4 |

| | | |
|---|---|---|
| PHC/CHC/Sub-centre | 4.7 | 5.2 |
| Government hospital | 32.4 | 31.2 |
| Private consultations – govt doctor | 3.5 | 3.0 |
| Private hospital/nursing home | 10.0 | 10.4 |
| Private doctor – qualified | 30.1 | 31.2 |
| Private doctor – unqualified | 4.8 | 4.0 |

Most of the treatment seekers went to government facilities, followed by qualified private doctors. Although the analysis is for rural India, it does not indicate that an overwhelming majority went to traditional healers. Surprisingly, only around 11 percent of both males and females visited a traditional healer. It does seem as though rural Indians seek organised and formal care, unlike the popular belief to the contrary. Further, the data does not reveal that females seek non-formal care more often than males.

The picture obtained from the above analysis does not indicate significant gender differentials in health status or the health seeking behaviour. This is in contrast to evidence from various literature cited earlier. It is by now accepted that women's self-reported morbidity rates are lower than men's, and that women also seek less care than men. For both children and adults in South Asia, there is a strong evidence of gender differentials in both health status as well as the use of health services (World Bank 1994). The 1993 World Development Report indicated that between ages 15 and 44, and after age 60, men generally have higher rates of premature death, while women have higher rates of disability; this is especially true in Asia, Sub-Saharan Africa and the Middle East. Much of this is attributable to maternal causes, STDs and gender-based discrimination (World Bank 1993). Thus, our results need some explanations in view of the earlier findings. One likely explanation could be that the gender differentials are the least among the elderly in contrast to children and adults. Thus the gender differences in both health status and health seeking behaviour of earlier years more or less disappears in the later years. This is an important finding and implies that policies on the elderly need careful thought. The other part of the explanation has to do with a genuine under reporting by women as mentioned

earlier. This was investigated further using qualitative analysis and is presented in Section 5.

## 4. DETERMINANTS OF HEALTH SEEKING BEHAVIOUR

If the previous results are correct, it does indicate that there are no striking differences between men and women in terms of health status as well as health seeking behaviour. However, to truly accept this, one needs to control for other variables like education, work status and marital status, and carry out a multivariate analysis. This was done by modelling the determinants of health seeking behaviour of the elderly in terms of an econometric estimation exercise.

For this purpose, a probit model was estimated using various socio-economic variables that could influence the health seeking behaviour of the elderly. Table 8 presents the summary statistics on the explanatory variables that were used in the estimations. The results are summarised in Table 9.

**Table 8: Summary Statistics on Independent Variables**

| *Variable Name* | *Mean Value* |
|---|---|
| Gender (1 if female) | 0.44 |
| Household income (Rupees/year) | 35474.52 |
| Education | 1.06 (completed primary) |
| Number of working adults | 4.57 |
| Proportion of elderly | 0.30 |
| Marital status (1 if currently married) | 0.62 |
| Work status (1 if currently working) | 0.52 |

Two alternative estimations were carried out. The first estimate was done excluding work status and marital status, whereas the second estimate was done including these two

variables. The reason for excluding these two variables while retaining the gender variable was due to the high correlation of gender with both marital status and work status; in other words, a bulk of the women were not working and were not currently married. Both the estimations were carried out using the sub-sample of the individuals who had reported a long-term illness. The dependent variable in the model takes a value of 1 in all those instances where care outside the home has been sought while for all those cases where care has not been sought (including home care), the dependent variable takes the value 0.

As can be seem from Table 9, household income has a significant positive effect on seeking care, in both the models; the higher the income, the greater is the probability of seeking care. Similarly, lower education has a significant negative effect on seeking care, indicating that those with less education are also less willing or able to seek care. The number of working adults in the household has a significant positive effect on seeking care. This variable was included in addition to the household income variable, since much of the income in rural India is from non-salary sources, or from income that is not from formal work, i.e. farm income. Thus, in a household with a larger number of working members, there will be a positive and independent effect on seeking care, than in a household with fewer working members. In other words, household income alone (which could be only from a single source) may not be sufficient to ensure a greater probability of seeking care. Also, the first model indicates a negative and significant gender effect, implying that education or income are not sufficient to eliminate a gender effect, and that even after controlling for these variables, women are less likely to seek care. However, if we add marital status and work status, this effect vanishes, and work status and marital status also remain insignificant. Excluding gender but keeping these two variables improves their significance considerably (not reported in the table). The results indicate that income, education and the proportion of working adults are the only variables that determine who seeks care.

**Table 9: Results from Probit Estimation**

**Dependent variable: Whether or not sought care**

| *Explanatory Variable* | *Coefficient Values:* | |
|---|---|---|
| | *Alternative 1* | *Alternative 2* |
| Gender | -0.08 (-1.87) | -0.05(-0.88) |
| (log) Household income | .072 (4.03) | 0.07(3.96) |
| Education_1 | -0.649 (-1.816) | -0.65(-1.81) |
| Education_2 | -0.19(-0.53) | -0.20(-0.54) |
| Number of working adults | 0.02(2.01) | 0.02(2.00) |
| Proportion of elderly | 0.04(0.60) | 0.04(0.55) |
| Marital status | - | 0.04(0.92) |
| Work status | - | 0.03(0.69) |
| Constant | 0.58(1.41) | 0.53(1.28) |

*Note: The total number of observations used in the estimation is 4252. Figures in parenthesis denote the corresponding T-statistic. The education variable has been graded on a scale of three: 1 - below and upto primary; 2 – up to matriculation; 3 - higher secondary and above.*

These results indicate that the gender effect is not a pure effect, but comes from other reasons that impinge on the status of women. The vulnerability for the elderly comes mainly from low income and low education. Dependent individuals have a higher probability of being looked after, higher is the number of family members working in the household. Low income in turn is determined by many factors including lack of work as well as other social variables like widowhood. Even if the reporting of illness is lower than the actual morbidity rate for women, it is unlikely that this result (of the lack of pure gender effect) will change significantly, if one accepts that vulnerability of women arises from a whole host of factors, two of the most important being income and education. Below, we look at qualitative data to understand more about women's perceptions about their health.

## 5. WOMEN'S HEALTH SEEKING BEHAVIOUR: QUALITATIVE RESULTS

Do women generally report lower morbidity? What are the perceptions of the elderly women regarding their illnesses? To understand this, in-depth interviews were conducted among 80 elderly women (Sawhney 1998), sixty two of whom were suffering from various types of illnesses ranging from heart problems, joint pains, diabetes, loss of vision and hearing. The women interviewed were above the age of 60 and lived in slums of a South Delhi locality.

It may be recalled that the morbidity rates were very similar among men and women in the HDIS data. In the qualitative data, a majority of the women (58 out of 80) highlighted the fact that they do not complain of any medical problem until it starts interfering with their activities of daily living. The reasons were economic constraints as well as the fact that there is nobody to care for them in any case. One of them said:

" I have only told you that I have severe joint pains (the pain is so much that I at times find it difficult to go to the bathroom), but I have not told my husband, as he cannot take me to the doctor; we cannot afford the local private doctor. Besides, these aches and pains are part of old age."

In the interviews many women reported illnesses that they were unable to cope with themselves and for which they needed external help, which was not forthcoming from their families. The elderly women's health problems were ignored due to the fact that their families had no time to take them to the doctor or provide a regular treatment which at times was unaffordable for many.

"I had a heart problem since the last 10 years for which I was taking treatment and medicines. But ever since I stopped working I have been forced to stop the medicines. What am I supposed to do? I cannot help it as I am dependent on my husband who spends the little pension money he gets in gambling, so how can I ask my son for money knowing

that he can barely make ends meet in the house".

Clearly the economic compulsions force many to remain silent or ignorant of their condition. Old age for most of them implies a lot of health related problems and this they feel is part of the normal process of ageing. When asked why they did not take treatment for something which was treatable and curable, the responses were along the following lines:

"When you are old you are bound to see less and other things like joint pains are gifts of old age. It is God's wish that we have this problem He has destined it for us and we have no control on it. All I can say is that God should take me while I am well and not bedridden as you have no one to care for you and you die in agony. But it is not in my hands, you see."

The medical problems of the elderly women belonging to the lower class was clearly related to their low economic and social status. Gender is one of the important factors which results in the poor health status of the women in general and the elderly women in particular, as the social norms compel them to believe that they are no longer productive to the society and therefore should also not be a burden to their families. This attitude is inculcated from the very beginning at the time of the socialization of the child which results in the children also giving more attention to the elderly males than their female counterparts. As one woman who had a heart problem said:

"Just because I am a woman nobody cares for me, and my husband is used to me looking after him and caring for him. He has severe diabetes and our son always gets his medicine on time and takes him for regular check-ups, but he does not care for me. We women are nobody in the family so you are never ever given a priority right from birth in your natal house to after your marriage in your husbands home."

For most women suffering from some type of illness, it was their perception that they are alone in it as sufferers. This can be largely attributed to the role of poverty and economic status which forces the family to make choices in favour of the younger generation as well as the male members as they are they are economically and socially more productive.

The qualitative interviews only corroborate what others have found earlier regarding reporting of illness among women: women tend not to complain and therefore report their illnesses much less frequently than men. For this reason, it is very possible that the morbidity rates self-reported by them is much lower than the actual rates. The resignation to tolerance of pain, the recognition that there is not much that will change if they do report pain, and the inability to support themselves economically for treatment all go into a lower reporting of illnesses in quantitative surveys. Qualitative interviews are therefore needed to elicit proper responses.

Both the quantitative as well as qualitative data however do indicate that lower economic status and low levels of educational attainment go into determining who seeks care. These variables are in turn determined by work status and widowhood status, making women especially vulnerable to lower well-being than men.

## 6. SUMMARY AND CONCLUSIONS

In India, the government concern for the elderly began with India's participation in the World Assembly Conference in Vienna in 1982, where India adopted the United Nations International Plan of Action on Ageing. This plan focused on the government's role in adopting programmes for the care and protection of the elderly, synchronising these with the changing socio-economic conditions of the society. The government has begun to recognise the aged as a social category, in need of specialised attention. One of the early interventions was the introduction of pension schemes that were applicable to a minority of the elderly along with other welfare measures. The government has promised to set up an inter-ministerial committee to implement the National Policy on Older Persons which was released by the Government of India in January 1999, in the International Year of Older Persons.

These policy changes comprise a positive step in the right direction. However, the problems of the elderly need to be tackled from both the supply and the demand side.

From the supply side, there is a greater need to provide facilities, infrastructure and sensitive handling, to cater to the health of the elderly. But to ensure that treatment reaches those who need it, there is also a need to focus on the demand side of the problem by generating the demand: this would entail focusing on vulnerability factors, and giving special attention to the most vulnerable group. The present study did not find pure gender effects in health-care seeking behavior in rural India; in other words, there is no evidence to indicate that everything else remaining the same, women would seek less care than men. However, the quantitative as well as the qualitative analysis reveal that women may be more vulnerable than men due to reasons such as lack of productive employment and income, their widowhood status and low education, all of which make them dependent on others and also less empowered so that they are unable to voice their needs and problems.

Since resources are scarce, any programme must be based on prioritising and targeting. Targeting however should be done carefully, by looking at vulnerability factors first, so that those in need of help the most are not left out. At the same time, planners need to explore the reasons that make a particular group more vulnerable than others, so that these can be tackled in the programme design. At the national level, a mixture of pension schemes, social security systems or insurance need to be funded and implemented, which would go a long way in helping elderly men and women. In addition, attention must be paid to those factors that impede individuals or groups from taking advantage of these new or even existing programmes like current supply of health services. Education is a key variable that determines who would be better able to express his/her demand. Adult education programmes that already exist in many forms, need to be more aggressively targeted, because the benefits spill over from adults to the elderly. Finally, widows, those who are unemployed, as well as those who are below the poverty line need specific intervention and programmes than others. It is precisely these nuances in policymaking that are called for if an impact has to be made on the welfare of the elderly in India; rather than focussing on health care interventions based on differentials alone. Vulnerability of the elderly has to be viewed in terms of going much beyond the straight jacket of gender bias.

**REFERENCES**


Bagchi, K. 1998. *Some Important Areas of Gerontological Research in India*. Research & Development Journal. Vol. 4: 2 & 3.

Bose, AB and K.D.Gangrade, (ed) 1988. *Aging in India: Problems and Potentialities*. New Delhi Abhinov Publication: Citizenship Development Society Publication.

Dandekar. 1996. *Elderly in India*. Sage Publications: New Delhi.

Goldman, N. , S. Korenman and R.Weinstein 1995. *Marital Status and Health Among the Elderly*. Social Science and Medicine. Vol. 40: 12.

Government of India 1999. *National Policy on Older Persons*. Ministry of Social Justice and Empowerment.

Irudaya, Rajan S. and U.S.Misra 1995. *Defining Old Age: An Indian Assessment*. Bold. Vol. 5: 4.

Irudaya, Rajan S., U.S. Misra and P.S.Sharma 1999. *India's Elderly: Burden or Challenge?* Sage Publications: New Delhi

Jai Prakash, I. 1998. *Maintenance of Competence in Daily Living and Well-being of Elderly*. Research & Development Journal. Vol. 4: 2 & 3.

James, K.S. 1994. Indian Elderly: *Asset or Liability*. Economic and Political Weekly. September .

Kabir, M. 1992. *Effects of Social Change on the Health of the Elderly: Evidence from a Micro Study*. Journal of Family Welfare. Vol. XXXVIII: 1.

Lee, S. and Mason, A. 2000. *Population Aging Raises Questions for Policymakers. Asia-Pacific* Population and Policy. Number 53, April.

Sawhney, Maneeta. 1998 *"The Social Construction of Senility."* Unpublished Mphil. Dissertation submitted at the Department of Sociology, Delhi School of Economics.

World Bank 1993. *World Development Report 1993: Investing in Health*. New York: Oxford University Press.

World Bank 1994. *A New Agenda for Women's Health and Nutrition*. World Bank, Washington DC.

**Acknowledgements**

The authors gratefully acknowledge the National Council of Applied Economic Research (NCAER) for providing the data on which a large part of the analysis in this paper is based. The National Council of Applied Economic Research, under the Human Development Indicator Survey (HDIS), collected extensive data on an all-India basis on a variety of indicators that indicated vulnerability. This endeavour was supported by UNDP, UNICEF, UNFPA and IDRC and was carried out in 1994-95.