



A COMPARATIVE STUDY OF ELDERLIES OF MAHARASHTRA AND RAJASTHAN THROUGH ACTIVE AGEING INDEX

Namrata Kumari

Ph.D Research Scholar at Centre for Study of Regional Development,
Jawaharlal Nehru University, New Delhi.

ABSTRACT:

Background: Elderly population is on rise in India because of increasing life expectancy and decreasing mortality rates along with declining fertility rates. Quality of life lead by elderly after attaining age sixty is a matter of concern. To extend healthy life expectancy and improved independent life is the approach of active ageing concept as proposed by World Health Organisation. The spirit of active ageing model is that as people grow, their age climbs up, they continue living a life as they were living before from every aspect including their engagement in work, their social cohesion, their independent life-style, their self- care ability, healthy and depression free life, health care utilisation etc. The concept talks about providing conducive atmosphere to elderly by improving opportunities for health, increasing their community or social participation and making them feel secure both physically and mentally in and out of the house.

Aims & Objective: To compare the level of active ageing among elderlies in Maharashtra and Rajasthan.

Material & Methods: The data used is of WHO Study on Global Ageing and Adult Health (SAGE) Wave 1 survey, 2007-2010. Level of active ageing is calculated by Active Ageing Index which is framed by European Nations as per the WHO model of active ageing. Results: Maharashtra scored similar to some of the European countries of Bulgaria, Latvia and Greece. Overall score of Maharashtra is 37.84 and Rajasthan scored 33.16. Employment rate is high in Maharashtra. Participation in community and societal affairs are almost equal in both the states. Income security and physical security of elderly is more in Rajasthan.

Conclusion: Conducive environment is required to be provided to elderly to utilise their full potential and worth. The differences is rooted in the socio-cultural differences along with the differences in the kind of support government provides in the specific states. To face many upcoming challenges, the WHO model needs to be given wider attention.

KEYWORD: Elderly Population; WHO Active Ageing model; Active Ageing Index; Healthy life; Community Participation.

INTRODUCTION



The percentage of the elderly in India has been increasing at an increasing rate in recent years and the data speaks that this tendency is likely to continue in the coming times. The life expectancy has steadily gone up from 32 years at the time of independence to over 66.8 years in 2011(11). The credit for this development goes to better medical facilities which have led to decreasing mortality rates along with declining fertility rates. To get the best of the demographic dividend, the emphasis is largely on the children and youth as they constitute the major share of country's population and are considered as nation's future(7). However, the decadal growth rate of elderly population has always been more than

other age- group's population henceforth, indicating the growing share of elderly in the total population of India(3). In addition to this, elderly sex ratio is more favourable for women, which again signal towards need of the society to care for elderly women and the problem faced by widow women at large(7). The concept or model of active ageing is the aggregation of many aspects of human life. The spirit of active ageing model aims to circulate the fact that as people grow, their age climbs up, they continue to live their life as they were living before from every aspect including their economic engagement, their social cohesion, their independent life-style, their self- care ability, healthy and depression free life, health care utilisation etc. (12). Changing of traditional values and the family structure have impacted elderly (6). With increasing proportion of women employed in labour force a 'crisis in caring' for the elderly could be seen more with the passage of time (Prakash, 2004). WHO model of Active Ageing is based on

Model is based on

- Three pillars – participation, health and security
- Six determinants- economic, social, physical, personal, behavioural, health and social services
- Four key aspects- autonomy, independence, quality of life and health life expectancy

Active Ageing Index was developed with the objective to spread the new phenomena of population ageing and the affirmative actions to deal with the challenges attached with it. For making active ageing index the following definition of active ageing was given due attention. "Active ageing refers to the situation where people continue to participate in the formal labour market, as well as engage in other unpaid productive activities (such as care provision to family members and volunteering), and live healthy, independent and secure lives as they age." (Siderenko and Zaidi,2012).

Aims &Objective: To understand the level of active ageing in Maharashtra and Rajasthan through active ageing index.

MATERIAL & METHODS:

Data Source: SAGE data has been collected three times named as SAGE Wave 0 (2002-2004), SAGE Wave 1 (2007-2010), SAGE Wave 2 (2014/2015) by WHO. In India, survey were based on the criteria that states with a population of five million or more were grouped into six geographical regions: north, central, northeast, east, west and south. These states of population five million or more were again categorized into six groups based on four important indicators; they are infant mortality rate, female literacy rate, percentage of safe deliveries (births) and per capita income. Then one state from each geographical region was surveyed. The states surveyed were namely Assam (1259 samples), Karnataka (1744), Maharashtra (2215), Rajasthan (2319) and West Bengal (2215). Total sample size is 12198. The data chosen for this work is of SAGE Wave 1 (2007-2010). For this study states are being chosen on the basis of highest and lowest work participation rate calculated from SAGE data. Among all the six SAGE surveyed states, WPR is highest in Maharashtra and lowest in Rajasthan.

CALCULATION OF INDEX

Total sample for calculating active ageing index is 681 (44.6%) from Maharashtra and 845(55.4%) from Rajasthan, thus making 1526 samples (100%) together for both the states. Active Ageing Index is considered as a means to measure the unexploited possibility of the older population designed and developed by European policy makers. The AAI was developed in 2012 by the European Centre. The purpose of active ageing index is only to find out the region wise differentiation in the potential of elderly .Score close to 100 means that the model of active ageing is very well applicable and successful in any country or any region. Each indicator comes within one domain out of total four domains. Domain specific index is made to make comparison between the impacts of the contribution of each domain in both the states (Table 1). Total weight of domain and indicator is 100. 18 indicators are used to make Domain index. Indicators are given weight and from the summation of indicators, domain value is made (10). Weight of the domain and indicators carrying within each domain is given as per the importance it owes in contributing to the active

ageing of an individual and to the society. The indicator’s value is multiplied with the weight assigned to each indicator. The indicator value is added and again multiplied to the domain weight, then divide the result by 100. Thus, domain index is obtained.

Table 1 Domains and indicators weights for active ageing index

Domains and Indicators	Weight for an indicator (proportion within domain)	Domain weight (within overall index)
Employment	100	35
Employment rate of 60- 69 years	33.3	
Employment rate of 70-79years	33.3	
Employment rate of 80+ years	33.3	
Participation in society	100	35
Voluntary activity	10	
Care given to grandchildren	25	
Care given to older adults	10	
Political participation	25	
Community participation	30	
Independent, healthy, secure living	100	15
Physical exercise	20	
Access to health care	20	
Independent living	20	
Income security	20	
Physical security / safety	10	
Capacity enabling environment for Active Ageing	100	15
Mental well being	20	
Social connectedness	30	
Educational attainment	20	
Good quality of life	20	
Sense of happiness	10	

Source- computed as per AAI(Zaidi, 2012

Following formula is used to calculate index (10). Where, I is the indicator , D is domain, W is weight assigned to indicators and domain for calculating active ageing index,.

Index _Domain =

$$\frac{1 * W_1 D_1 + 2 * W_2 D_1 + 3 * W_3 D_1 + 4 * W_4 D_1}{W_1 D_1 + W_2 D_1 + W_3 D_1 + W_4 D_1} * 100$$

Index _AAI =

$$\frac{\sum D_1 * WD_1 + D_2 * WD_2 + D_3 * WD_3 + D_4 * WD_4}{WD_1 + WD_2 + WD_3 + WD_4} * 100$$

Active Ageing Index is the summation or outcome of the all four domain indices

- Engagement of older section in gainful employment
- Societal engagement and participation of elderly
- Independent and healthy and secure life of older proportion of population,
- Capable environment provided by government for promoting active ageing among elderly.

Each realm/domain indicates towards different aspect of active ageing and has regional variations. It can vary over space and time, culture and gender (11). The country which is marked with good domain value or with higher outcome it means that execution of policies is properly reaching the needy without any differentiation and discrimination.

RESULTS:

Employment rate varies between groups, as it is general fact that it decreases with increasing age, but the noticing fact is that it decreases more in Rajasthan than in Maharashtra. For Employment domain, index value for Maharashtra is 30.13 out of total domain value of 100, whereas, Rajasthan scores less than Maharashtra i.e. 22.47. In Maharashtra more elderly support their next generation. Care given to children and grandchildren and older adults by elderly member captures the point that elderly are not irrelevant at least in those households where they are contributing to the family by giving care to children. Political participation of elderly is little more in Maharashtra than Rajasthan. Among all indicators, access to health care indicator is the strongest and almost equal to universal. Physical security among elderly is more than income security. About 25 percent of elderly are capable of doing vigorous exercise and hard work. About 78 percent of elderly have income security as they have enough money to meet their need. Elderly living independently are very low only 14 percent live life with full authority and autonomy. In terms of physical safety and security, like no life threat from family, neighbour or society, Rajasthan scored more than Maharashtra. Rajasthan is better place for elderly to live in than Maharashtra as about 89 percent of older section feels them totally secure and safe. Environment supporting the capacity for active ageing domain is more favourable in Maharashtra. Maharashtra scored 43. 44.3 percent of elderly have no difficulty in connecting to society (Table 3). Rajasthan lags behind Maharashtra in the indicator concerning social connectivity, good quality of life and in educational attainment (Table 2).

Table 2 Active Ageing Index for Rajasthan showing all domains and indicators

Indicators- Rajasthan	Domain weight (within overall index)	weight of index (within domain)	employment rate	sum of indicators	index domain value	active ageing index	
Employment rate	35						
60-69		40.7	33.3	1355			
70-79		21.2	33.3	705.96			
80+		5.6	33.3=total 100	186.48	2247.44	22.4744	786.604
Participation in society	35						
Voluntary activity		0.2	10	2			
care to children and grandchildren		17.4	25	435			
care to older adults		15.2	10	152			
political participation		21	25	525			
participation in community affairs		76	30=total 100	Total=2280	3394	33.94	1187.9
Independent living	15						
Physical activity		24.8	20	496			
Access to health care		97.7	20	1954			
Independent living		14	20	280			
Income security		78.1	20	1562			
Physical security		88.8	10=total 100	Total=888	5180	51.8	777
Enabling environment	15						
Mental well-being		71.5	20	1430			
Social connectedness		37.6	30	1128			
Educational attainment		15.1	20	302			
Good quality of life		24.9	20	498			
Sense of happiness	Total=100	41	10=total 100	Total=410	3768	37.68	565.2 33.16

Table 3 active ageing index for Maharashtra showing all domains and indicators

Indicators- Maharashtra	Domain weight(within overall index)		weight of index		index domain		active ageing index	
			(within domain)	employment rate	sum of indicators		value	
Employment rate	35							
60-69		46.1	33.3	1535				
70-79		25.9	33.3	862.47				
80+		18.5	33.3 Total=100	616.05	3013.5	30.13	1054.7	
Participation in society	35							
Voluntary activity		3	10	105				
care to grandchildren		18.2	25	546				
care to older adults		22.8	10	228				
political participation		24.9	25	622.5				
Community participation		77	30 Total=100	Total =2310	3811.5	38.115	1334.0	
Independent living	15							
Physical activity		26.7	20	534				
Access to health care		99.6	20	1992				
Independent living		16	20	320				
Income security		67.2	20	1344				
Physical security/safety		81.3	10 Total=100	Total=813	5003	50.03	750.45	
Enabling environment	15							
Mental well-being		60.6	20	1212				
Social connectedness		44.3	30	1329				
Educational attainment		21.7	20	434				
Good quality of life		38	20	760				
Sense of happiness	Total=100	56.5	10 Total=100	Total=565	4300	43	645	37.84

DISCUSSION:

As per Suchandrima Chakraborty in her work on Active ageing Index in India, Maharashtra ranked the top in workforce participation rate index both for male and female among seven states of India taken for calculation, the states are namely H.P, Maharashtra, Kerala, Punjab, Orissa, Tamil Nadu and West Bengal where elderly population is high in India. Elderly engagement in paid activities declines as they grow grey. This happens may be because they become less productive for the society. May be sometimes, younger generation replaces them, as younger generations are more capable in handling new technologies. These are some of the reasons that elderly could not get new job, or find difficulty in sustaining with the continuing one (10). Political participation shows that they talk about politics, discuss political news with their peer groups. Maharashtra ranked second in social participation index calculated in the work of Chakraborty(1). Good accessibility to health care in Maharashtra suggests that elderly have easy accessibility of health care, in terms of hospitals, either government or private along with good connectivity and better transportation facilities. Able to do hard work, or fast work needs lots of energy which older people do not have courage to do, sometimes they accept that they should not do vigorous work (5). They made up their mind set that this kind of work is for younger generation. Happiness in old age up to a great extent relies upon a busy life, good health, having enough money to spend on self and easy accessibility of services and most importantly having spouse and social so that social life do not decay with ageing(3). Rajasthan performs better in the participation in society domain than Maharashtra. The probable reason may be less urbanised society of Rajasthan than Maharashtra. In the rural areas joint family set up is still the norm, the chances of elderly giving care to grand –children is more and their participation in society is also higher than urban set up. However, independent, healthy and secure living domain is equal for both the state. But in security indicator index Rajasthan performs better, reason may be elderly of Rajasthan feel themselves more secure in society from any kind of violence and crimes in home as well as outside out even when they are alone compared to elderly of Maharashtra. Maharashtra scored similar to Bulgaria, Latvia and Greece (1). The differences in the scores among various states of India is rooted in the socio-cultural differences. A difference in the kind of support government gives in specific states. The nature of variables used for calculation for Indian states differs from the actual index computed for European Nations (11).

CONCLUSION:

The growth of the elderly population in the coming decades will bring with it extraordinary burdens of morbidity and mortality across the country. Since youth are traditionally being linked with the future and progress of country, the strength of elderly as a potential population of India could be turned into widely accepted reality if direction could be determined.

RECOMMENDATION:

The Active Ageing Index provides indication on the contribution of older people across society to their social and economic lives. It covers their paid and unpaid contributions, and their independent, healthy, and secure living. In addition to all this it also captures how the one state differs with respect to capacity and enabling environments for active and healthy ageing with another state. In India, there are enough policies for elderly but awareness rate regarding rights of elderly is very poor. Therefore, it is required that society should be cooperative enough not to look at elderlies as useless section of society and should respect their potentials.

LIMITATION OF THE STUDY:

Firstly, Rajasthan is one of the eight “Empowered Action Groups” states in India. Scheduled Tribe population hold strong position in the cultural set up of the state. Whereas some districts of Maharashtra is hub for migrated residents which shows multicultural character. Many more aspects could be included in the work, but the entire work revolves around the secondary data. Secondly, there is not any cut- off value for determining the label of active ageing. Thirdly, due to lack of data on some indicators like use of information and communication technology by elderly, life expectancy of elderly, learning process, access to dental check-up etc., the index is made by either putting absent indicator’s weight on the other indicator or by replacing it with next best indicator chosen as per their importance in society. Fourthly, because of lack of work on Active Ageing Index in India, the result cannot be compared with other states having same demographic and socio-economic backgrounds.

RELEVANCE OF THE STUDY:

Life expectancy has increased but there is need to improve the quality of life after sixty so that elderlies utilise their full potentiality and they may no longer be seen as a burden by any section of the society. There is an urgent and very basic need to cover the needy elderly women in the policies of government so that active ageing model of WHO could become a success in India.

REFERENCES:

1. Guntupalli, Aravinda and Chakraborty, Suchandrima (2015). Active ageing index in India: Is the UNECE approach applicable to developing countries? In: UNECE, Active Ageing Conference, 16-17 Apr, Brussels.
2. Government of India. Situation analysis of the elderly in India. Central Statistics Office, Ministry of Statistics & Programme Implementation, Government of India, June 2011.
3. Khan A. M. (2004). Decay in family dynamics of interaction, relation and communication as determinants of growing vulnerability among the elderly. *Indian Journal of Gerontology*, 18, 34 – 36.
4. Prakashl. J. (2004). Mental health of older people in India . In Ramamurti P V.Jamuna D. (Eds.), *Handbook on Indian gerontology* (pp. 176 – 208). Delhi, India : Serials Publications.
5. Singh, Archana and Mishra, Nidhi (2009). Loneliness, depression and sociability in old age, *Indian Psychiatry Journal*, 18(1), 51-55.
6. Swarnalatha, N. (2008). A study on health problems of aged women in rural areas of Chittor district. *Help Age India- Research and Development Journal* 14(1),16-23.
7. S. Siva Raju. 2011. “Studies on Ageing in India: A Review”, BKPPI Working Paper No. 2, United Nations Population Fund (UNFPA), New Delhi.

8. United Nations. World population ageing: 1950–2050. New York: Department of Economic and Social Affairs, Population Division, United Nations; 2002.
9. Zaidi A, Zolyomi E (2011) 'Active ageing' research note 7/2011. Produced by the social situation observatory, for the European commission, directorate-general for employment, social affairs and inclusion, Brussels
10. Zaidi A, Gasior A, Hofmarcher M, Lelkes O, Marin B, Rodrigues R, et al. "Active Ageing Index 2012: Concept, Methodology and Final Results" (2013), Methodology Report Submitted to European Commission's DGEmployment, Social Affairs and Inclusion, and to Population Unit, UNECE, for the project: "Active Ageing Index (AAI)," UNECE Grant No: ECE/GC/2012/003, Geneva, the European Centre for Social Welfare Policy and Research, Vienna, March. 2013.
11. Zelenev, Sergei (2006). Towards a "society for all ages": Meeting the challenge or missing the boat page 601 -616(58) International Social Science Journal.
12. World Health Organization (2002). Reducing Stigma and Discrimination against Older People with Mental Disorders. Geneva: World Health Organization and World Psychiatric Association.