



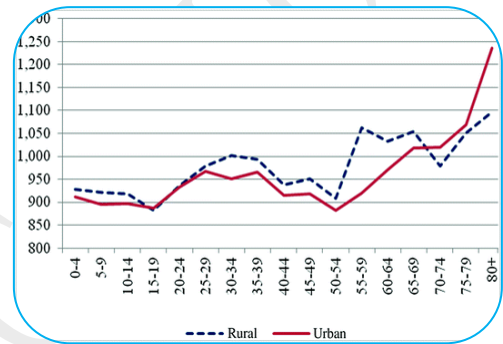
HEALTH STATUS AND ECONOMIC PARTICIPATION OF AGEING POPULATION: A COMPARITIVE STUDY OF MAHARASHTRA AND RAJASTHAN

Namrata Kumari

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

ABSTRACT:

Increasing proportions of the elderly in the general population is a matter of pride and an indicator of success of public health system along with advancement of medical technologies that has resulted in decline in death rate and increase in life expectancy. Economic, health and social security becomes vital when ageing is looked from the lens of 'active ageing' concept. Health of the elderly has continuously been a thoughtful matter of concern world-wide. The present study discusses the health condition and economic participation of elderly in Maharashtra and Rajasthan states of India.



Maharashtra and Rajasthan states are totally distinguished both economically and demographically. The level of economic status has enormous consequence on the health of the ageing population. Economic determinants play important role in understanding the enabling environment provided to elderly. Moreover, this determines the unmet needs for health care facilities for elderlies in both the states. Participation in labour market determines not only their physical activeness but also points towards their self-reliance nature. The objective of the paper is to compare the health status and economic participation of elderly in the two states. The data chosen for this work is of WHO conducted SAGE survey Study on Global Ageing and Adult Health SAGE (2007-2010).

KEYWORDS: Ageing Population, Health Status, Economic Participation, Active Aging, SAGE.

INTRODUCTION

Ageing is a common occurrence and every entity in the world has to pass through the course of ageing. Ageing is not a result, but a progression (Nair, 2014). Population ageing is a phenomenon which takes place when the proportion of aged in the total population increases to over seven percent due to reduction of fertility and mortality (Prakash 1999 cited

in Dhar, 2015). Population ageing is an acknowledged problem in developed regions of the world. It is estimated that by 2050 for every child there will be two elderly persons. However, in developing countries this problem of ageing is not much in the limelight (United Nations, 2004).

In India, proportion of elderly has shown an increase from 5.6 percent in 1961 to 9 percent of

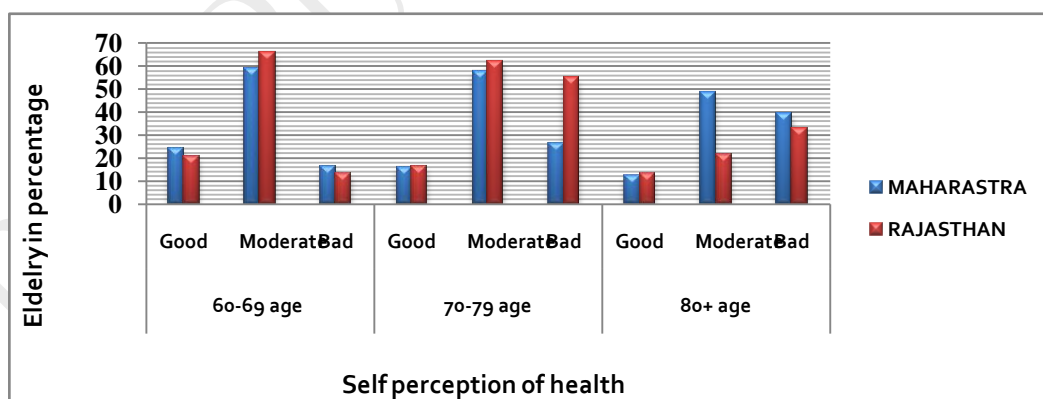
total population. India is having the second largest older population in the world. The population of India has increased from 361 million in 1951 to 1.21 billion in 2011. During this period, elderlies have increased from 19.6 million in 1951 to 103 million in 2011. Maharashtra has 9.9 percent of elderly population in 2011 while 7.5 percent is in Rajasthan (Census, 2011). However, rise is more

prominent among females than their counterparts. Therefore, we see feminization of ageing along with ruralisation of the elderly as we have more than two- third of rural population. In addition to this, migration has its impact on elderly. Since population above sixty is on rise in India, it becomes indispensable to look into their economic participation on one side and to understand their health and their social life on other side. Thus economic, health and social security becomes vital when ageing is looked from the lens of 'active ageing' concept. Population ageing indicates achievement for public health policies as well as social and economic development. (WHO, 1999). Active ageing concept deals with the problems faced by elderly section. World Health Organization (WHO) defines "active ageing" as "***the process of optimizing opportunities for health, participation, and security in order to enhance quality of life as people age***". For making the old age a successful practise it calls for providing an enabling environment to elderly with focus on independent, healthy and secure living for them along with increasing their community involvement and social participation so that they can live with dignity (WHO report, 2010). The objective of the paper is to compare the health status and economic participation of elderly in the Maharashtra and Rajasthan states of India. The data chosen for this work is of WHO conducted SAGE survey Study on Global Ageing and Adult Health SAGE (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 while lowest in Rajasthan.

HEALTH DETERMINANT AND ACTIVE AGEING

Health and economic determinants are important factors in understanding the enabling environment provided to elderly and this also determines the unmet needs for health care facilities in the study areas. Participation in labour market determines not only their physical activeness but also points towards their self-reliance nature. Due to the dramatic socio-demographic changes such as breakdown of the joint family system associated with increased urbanization, lifestyle changes and development, elderly needs to increasingly look after. Health determinants which affect elderly at large are chronic diseases, continuum of services, health promotion, age-friendly health care and long-term care etc.

Figure1: showing own perception of health among elderlies (in%)

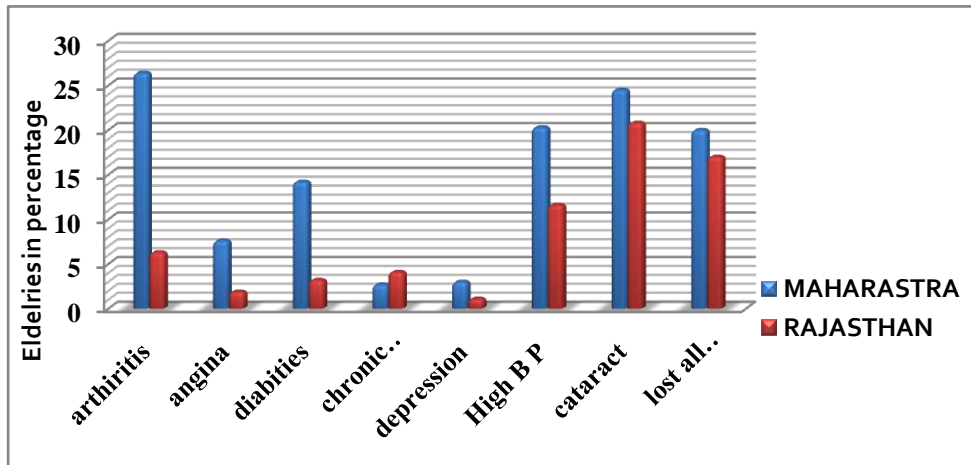


Source- SAGE, 2007

Figure one shows the health status among elderlies of three age groups. Most of the elderly in older adult age-group have replied for moderate health for both the states. While among age group of 70-79 it is clear that percentage of people replied for bad health increases as one touches age 70. In Rajasthan about 55 percent of people have stated for bad health whereas for Maharashtra percentage of people replied for bad health is approximately of half of the Rajasthan. Among age group of 80 plus age groups usually health began to decline because of nearness to death. Bad health is stated by more

elderly in Maharashtra than in Rajasthan. Maximum chunk of elderly have stated that they have moderate health. Elderly who have poor financial support or who gets poor income are also the one who face more problem in doing basic chores relating to bathing, dressing, climbing stairs, changing posture while sitting and standing up (Alam, 2005).

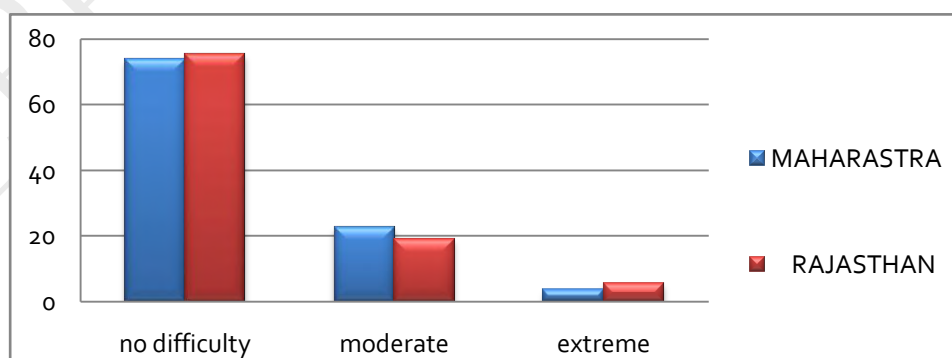
Figure2: Nature of ailments among elderlies



Source- SAGE, 2007

Figure two is showing chronic diseases among elderly. It is universal that people with their advancing age becomes more vulnerable to chronic diseases and faces more physical problems due to deteriorating capabilities with age. Health problems among elderly also differ as per the difference in socio-economic status. For instance, elderly poor reply their bad health on the basis of easily recognised symptoms while wealthier and elite elderly state those illnesses which could be known only after going through medical examinations and following regular diagnosis and check-ups. Disease like blood pressure, diabetes, heart attacks or angina could be known by diagnosis and doctors consultation only (S. Raju, 2011). Maharashtra has higher percentage of elderly suffering from ailments than in Rajasthan. Elderly suffering from arthritis and diabetes, depression are much more in Maharashtra. In Rajasthan elderly suffering from chronic lung disease is more. Rajasthan has the most mineral mines in the country. Many elderly work in those mines. Working in mines could be the nearest possible reason for respiratory related lung diseases among elderly.

Figure 3: Problems faced by elderly while caring themselves



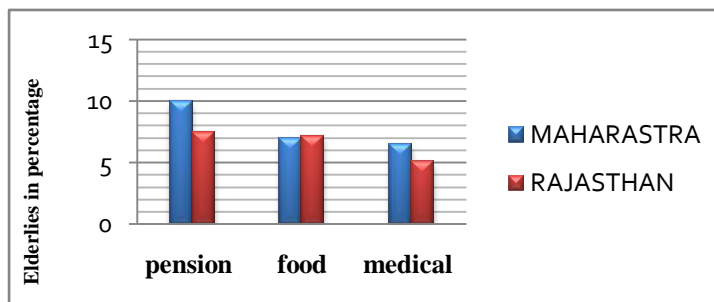
Source- SAGE, 2007

Figure three shows that about three- fourth of elderly do not faces any difficulty in taking care of them. They can easily manage their everyday work and are not burden on family members for their physical maintenance. Very meagre percentage of elderly faces extreme difficulty in caring themselves. This suggests that they may be cared by some other members of the family. Moreover more elderly from Rajasthan faces extreme problem in caring themselves than Maharashtra.

Economic determinants and active ageing

Economic determinants include their socio-economic status, employment and working conditions along with pensions and social transfers’ benefits.

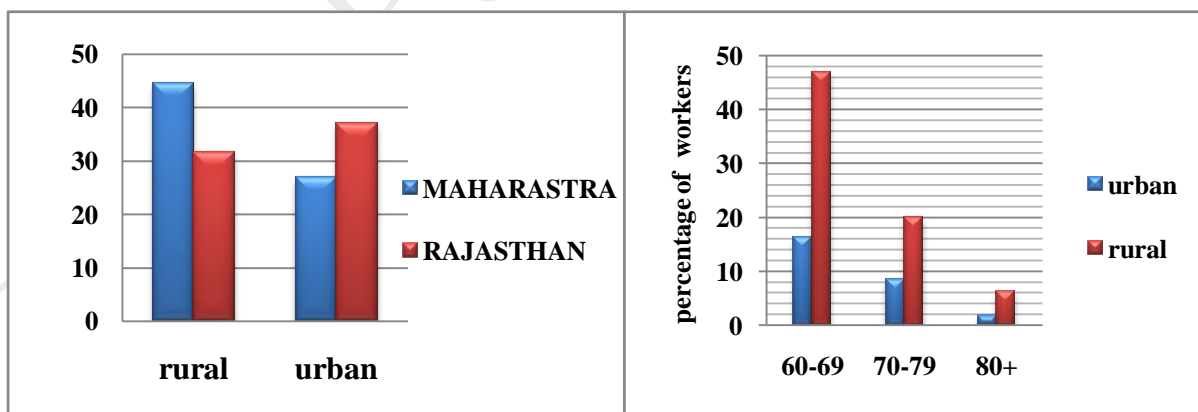
Figure 4: Benefits given to employed elderly in addition to payment



Source- SAGE, 2007

The figure four shows the benefits earned by those elderly who are engaged in any job either in government or private job where they are paid by their boss. In addition to payment in either cash or kind, pension are given to only those employee who are engaged in government jobs, while medical facility and food facility benefits are not limited to government employee only, but then also only about 6 to 7% of elderly are receiving food and medical provision from their job. Limited elderly receives pension are also which is received by more elderly from Maharashtra than from Rajasthan.

Figure 5: showing working elderly as per residence and age group

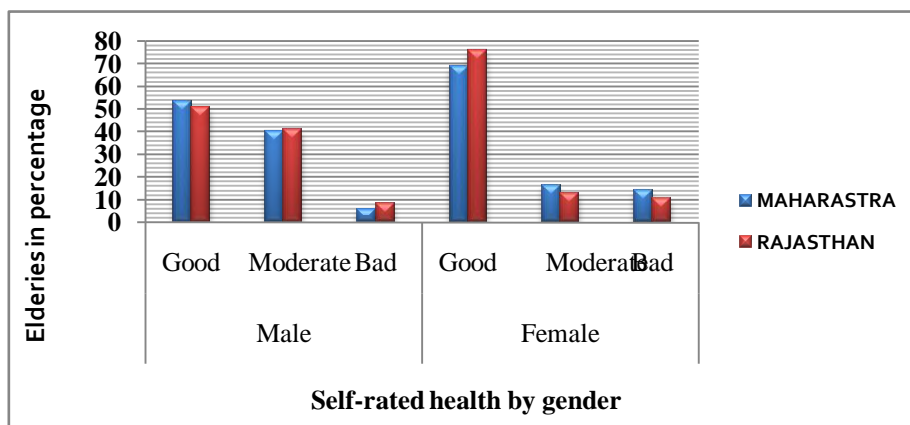


Source- SAGE, 2007

Figure fiveshows that more elderly are engaged in work in rural areas in Maharashtra than in Rajasthan whereas elderly engagement in work in urban areas of Maharashtra is less than in Rajasthan. When we look at the work force participation of elderly at India label, we could see that in rural WPR has been higher than urban WPR. In rural areas since most of the elderly population are engaged in

primary activities there is no formal age for retirement, elderly work till they want, but the case is not same for urban areas. There is huge difference in the way of living of rural areas and urban areas. Rural areas lacks infrastructural in terms roads, hospital lacks well equipped with high technological instruments, urban elderly are more aware about sanitation and hygiene due to more open to mass media. Enhanced health facilities and accessibility of medical care services in urban areas greater than before, access to health knowledge for maintaining health, coupled with economic growth, have augmented life expectancy. Therefore, world's population is growing older, the older are also living longer, especially in urban areas.

Figure 6: Self-rated health by Gender in Maharashtra and Rajasthan



Source- SAGE, 2007

The figure six depicts the male- female health status as stated by them. Female are in better position than males in terms of good health. More females possess good health in Rajasthan compared to Maharashtra. Males replied majorly for good and moderate health compared to elderly females. Women take care of their husbands in the old age when other members of the family do not care the elderly male. Mostly women marry men older than them by several years and the increasing life expectancy of women with little or no assets of their own at old age makes their condition more pathetic and vulnerable which altogether affects their health and creates gender wise health inequality (Shetter, 2013). It is important to discuss gender when we are discussing the health of aged because of the fact that not only do women live longer but most of them are widows. Widowhood becomes a matter of grave concern especially when dependence is on other members of the family for requirements of everyday needs. Unlike men most of the time they face severe discrimination with respect to their rights and in addition to all these they are overburdened with family household tasks. This adversely affects their health, nutrition and mental well-being. Irrespective of economic, marital or educational status, elderly women face an emotional vacuum in their life. This is also a true fact that gender disparity is faced by women irrespective of her age, but the distressing fact is that for elderly women this disparity makes them more vulnerable as this has direct implication on health because of less expenditure on food and on medicine.

CONCLUSION

Old age is generally seen as the age of decline with the assumption that it is natural to face health problems and other related socio-economic problems with advancing age. Although various socio-economic and demographic indicators affects ageing but health is generally considered as the prime concern in old age. Active Ageing approach of WHO covers much wider aspect of ageing, it mainly emphasises to provide conducive environment to elderly so that the general perception attached to ageing as age of isolation and retirement from all responsibilities and worthlessness of elderly could be changed from the mind set of both individual and society. Each individual and society should work

towards making old age as the age free from physical ailments and from economic and social repression. Change in the mind-set of society towards the worth of elderly is the prime concern of this concept. Cooperation from society is inevitable for making active ageing approach a success. In India, with rising elderly population it becomes imperative for nations to care for their increasing needs relating to health, economy, and security. Plans and policies should be made as per the current requirement of elderly and properly implemented. Making effective plans and policies as per the need of the hour and bringing desirable changes Coverage of more elderly in the pension schemes and other types of financial assistance could save them from abuse, isolation. Old-age homes should be made available at village level for elderly so that they have substitute in life in the condition of lack of family and social support. The government and society should work towards improving the unmet needs for healthcare facilities and work towards providing secure environment to elderly.

REFERENCES

- Alam, Moneer and Mukerjee, M (2005) Ageing, activities of daily living disabilities and the need for public health initiatives: some evidence from a household survey in Delhi, *Asia-Pacific Population Journal*, volume-20, no-2: 47-55
- Chakrabarti, Suvalaxmi and Ashis Sarkar (2011). Patterns and trends of ageing in India, *The Indian Journal of Spatial Science* volume 2, no.2: 1-11
- Dhar, Antara (2014). Workforce participation among elderly in India: Struggling for economic security, *Indian Journal of Labour Economics*, Vol. 57, No. 3
- Jamuna, D., (2001). An investigation of Psychological factors including quality of life of very senior citizens from the rural urban areas of Andhra Pradesh, *Indian Journal of Gerontology*, New Delhi, ICSSR, volume-18, no.2: 151-158.
- Liam, Foster and Alan Walker (2013) Gender and active ageing in Europe *European Journal of Ageing* 10:3-10
- Kalache, Alexandre (1999). Active ageing makes the difference, *World Health Organization Current Opinion in Psychiatry*: July 1999 - Volume 12 - Issue 4 - p 449-450
- Nair, L.V. (2014): Ageing in India – A conceptual clarification in the background of globalization. *European scientific Journal*, 10 (2)): 1857 – 7881.
- Siva Raju, S. (2002). Meeting the Needs of the Poor and Excluded in India, *Situation and Voices. The Older Poor and Excluded in South Africa and India, UNFPA, Population and Development Strategies*, 2, 93-110.
- Siva Raju, S. (2011). Studies on ageing in India: A Review, BKPPI Working Paper No. 2, United Nations Population Citation Advice: Fund (UNFPA), New Delhi.
- Shettar, Shakuntala.C (2013). "Problems of Aged in Changing Indian Scenario" *Yojana*, August, 38-46.
- World Health Organization (WHO) (2002) Active ageing: a policy framework. World Health Organization, Geneva
- World Health Organization (WHO) (2007) Women, ageing and health: a framework for action. World Health Organization, Geneva.



Namrata Kumari

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