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## Aging and Health: Influence of Social and Economic Conditions in Old age.

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### Abstract:

*Aging is a natural process growing old. It is an irreversible process. Whoever is born is destined to die. In between these two events everyone undergoes the process of aging. Growing from infancy to childhood, adolescence, adulthood and old age involves several implications on the life of an individual. This is particularly so in terms of health and well being of the individual. Although health and illness are the part and parcel of the life of an individual from birth to death, old age is correlated with several conditions of illness and illhealth. Several social and economic conditions determine the health conditions and state of illhealth during old age. In the present study the researcher attempts to identify the influence of certain social and economic conditions on health and wellness during old age. The study is based on the fieldwork conducted in Sullia Taluk of Dakshina Kannada District in Karnataka state. The study reveals that it is not simply the biological and physiological conditions that influence health and wellness and illhealth and diseases during oldage, but the social and economic conditions during that period determine the state of health during oldage.*

**Key words:** *Aging: the process of growing in terms of number of years lived by an individual*

*Health: state of physical and mental well being;*

*Ill health: loss of physical and mental wellness;*

*Marital status: status of being married or unmarried;*

*Living arrangement at retirement: Arrangements for life after retiring from service such as living with children, living independently, or living with relatives.*

### Introduction:

**Aging is a** natural phenomenon in the life of every living being. Ever since the birth of a child the process of getting old starts. But up to a particular age it is called growth. But after a point of time at which the growth in the sense of maturing to a state of saturation reaches its peak, the process is called aging. IT is then associated with all sorts of issues relating to deterioration of physical and mental health. Though it is a natural process and unavoidable, several social and economic factors play their role in determining the health conditions of the individual. Therefore aging as a process is not uniform with regard to all.

Some are experiencing a state of good health and wellness during the so called old age while many others are found with several health complications. Hence it is imperative to study the role of social and economic determinants of health during old age.

Decline in fertility and mortality rates, availability of different kinds of medicines for almost all the diseases, increasing awareness regarding health and sanitation, increase in the life expectancy have led to increase in the number of aged population not only in India but all over the world. India is the second country which is having greater number of aged population. In India the decadal increase of aged population is comparatively more than the increase of total population during each census period. The percentage of aged population has gone up from 6 to 8 percent during the period 1991-2011.

**Statement of the problem.** The Study on Aging and Health: Influence of social and economic conditions in old age is about the correlation between aging and health as influenced by social and economic conditions in old age. Majority of health problems of elderly are not only because of age but also due to socio-economic conditions & lifestyle. Health issues in old age are not simply determined by the process of aging, but influenced by the prevalent socio-economic conditions of the individual.

#### **Objectives of the study:**

The general objective of the present study is to assess the extent to which social and economic conditions influence the health of the aged persons.

#### **Specific objectives.**

- (1) To study the health condition, ill health and diseases of the aged population.
- (2) To assess the impact of education and income on the health conditions of the aged.
- (3) To assess the influence of marital status on the health of elderly. (4) To investigate the extent of social security benefits and medical care services available to elderly persons.

**Significance of the study :** It is due to rapid industrialization and urbanization lot of changes have been taken place in the patterns of families, social support systems, social values, living arrangements, occupations and income. Such alterations greatly influence the health conditions of elders. The significance lies in understanding the extent of influence of Marital status, living arrangements, type of family, participation in social and cultural activities, caste and religion, education, poverty, occupation, lifestyle on the health of elders.

**Area of the study:** The study covers both the urban and rural parts of Sullia taluk of D. K. district of Karnataka state.

#### **The concept of aged:**

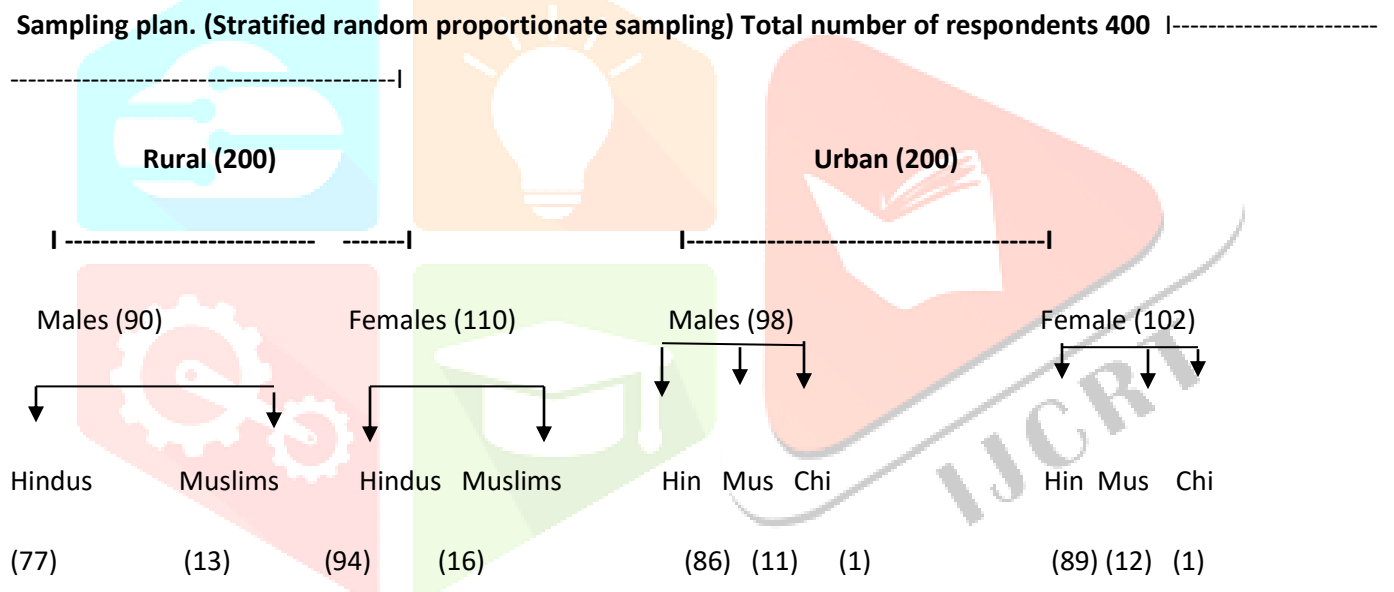
In 2\3 countries of the world the people above the age of 60 are considered as aged. For the presents study all the persons who have attained the age of 60 and above are considered as aged.

**Ageing:** - Ageing usually refers to biological, social, economic and psychological alterations in an individual which occur along with the passing of age. Ageing is a process of becoming older and older.

**Health:** Health is a condition of remaining free from diseases and disabilities. Health refers to physical, social, emotional and spiritual well-being.

**Socio-economic Conditions:** Social conditions refer to participation in community activities, the ability to develop interrelations with other people. Sex, religion, caste, type of family and social support, living arrangement and marital status are the few major social conditions. The economic conditions like economic status, education, occupation, nutrition, social security measures like pension, insurance have greater impact on the health of elderly persons. **Research design:** It is a descriptive study. The intention of the present research is to investigate the facts with adequate interpretation. The study involves detailed numerical descriptions like distribution, divisions of the elderly population of rural and urban communities by age, sex, religion, caste, income, education, marital status, living arrangement and life style etc. Interview schedule is the main tool.

**Sampling plan:** Stratified random proportionate sampling. Total number of respondents 400. The strata sample sizes is proportionate to strata's shares in the total population. From rural & urban male & female elders; among them Hindus & Muslims samples were selected proportionately.



#### Sources of data:

Both Primary and secondary sources of data are used. The data on aging and health and their social and economic determinants are gathered from the elderly people in Sullia Taluk, Dakshina Kannada district, who are responsive to our requests. The data includes both primary data collected from the people and the secondary data collected from available literature.

**Review of literature:** Sarasakumari (2001) in Kerala, John Mao (2003) in H.P., Sindhu (2004) in Kerala, Baharu & Mohanthy (2005) in Odisha, Ittrat et al. (2007) in Pakistan, Bansod (2009) in Maharashtra, Lena et al. (2009) in Karnataka, Audinarayana (2012) in T.N. made research on the social, economic and health problems of rural elderly. Lalitha & Jamuna (2003), Swarnalatha (2008), Geetha Gowri et al (2003) made studies on the problems of women elderly. Most of the studies on ageing in India in general & Karnataka in particular were centered on socio-economic & general problems of elderly. There are few studies on the health of elderly but they are cross sectional, done by medical staff from the medical point of view. But studies on the impact of socio-economic conditions on the health of aged from

Sociological point of view in Karnataka have not been undertaken till date. The present study is an attempt in this regard. The central points of the study are to assess the influence of age, sex, marital status, living arrangements, caste, religion, family, income and education on the health of elderly. The present study is undertaken with a view of providing information to fill the existing research gap.

**Analysis:** The collected data was systematically classified, tabulated and presented. In fact, the purpose of analysis was to arrange, tabulate and summarize the data in such manner that they yield answers to research questions. While assessing functional level of elderly of different age groups, perceived health status, medical treatment availed in government hospitals, pensions, senior citizen cards etc simple statistical techniques like averages and percentages are used. In order to test hypotheses some advanced techniques like Spearman's Rank Order Correlation, Chi-square Test( $\chi^2$ ), Cross tabulation (multivariate analysis), and Karl Pearson's coefficient of correlation are utilized.

**Main findings:** Perceived health status of rural elderly is concerned, slightly more than one third (34%) of elderly stated they are healthy, slightly more than two fifth (41.5%) perceived their health status as moderate and average. Slightly less than (24.5%) one fourth of elderly self rated their health status as poor and unhealthy. These findings are compatible with the findings of (Audinarayana 2012). So far as urban elderly perceived Health status is concerned, slight less than one fifth (19.5%) of elderly stated their health status as good (healthy), slight more than  $\frac{1}{2}$  (51.5%) of elderly perceived their health status as moderate and slight more than one fourth (29%) elderly stated their health status as unhealthy and poor. Self rated health status analysis proves that rural elders are healthier than urban elders. Slightly higher than  $\frac{1}{4}$  of elderly (26.75%) perceived their health status as good, nearly to  $\frac{1}{2}$  (46.50%) self rated their health status as moderate, and slightly more than  $\frac{1}{4}$  of elderly (26.75%) perceived their health status as poor. This finding is similar to the NSSO data of 2006.

Hardly  $\frac{1}{10}$  of elders are free from diseases and disabilities. 90.75% of elderly was suffering from one or the other diseases and disabilities. The finding is similar to what was observed in a study of (Deepak Sharma et al 2013). Nearly to one fourth (23.25%) of elders are suffering from poor vision and one fourth from hearing impairment. These findings are consistent with the 1995-96 NSSO data. There is a high degree of positive co-relations at 0.91, between men and women elders with respect to the scores of age related diseases in sample population.

One fourth of married elders, two fifths of widows and one third of divorced elders perceived their health status as bad. More percentage of widows and divorced elders are unhealthy as compared to married elders. There is a moderate degree of relationship between the health status among married and widowed and divorcee elders. Health Status Index of diseases of widowed/ divorcees is to a greater extent higher than H.S.I. rate of married.

$\frac{1}{10}$  of elders living with spouse and children suffer from emotional problems. Nearly  $\frac{1}{3}$  of elders living with spouse only and  $\frac{1}{3}$  of elderly widows/widowers living with children or relatives suffer from emotional disturbances. A vast majority of elders living alone were troubled by emotional problems.

Health Status Index of BPL is completely different from Health Status Index of APL. 3.57% of the BPL and 10.76% of the APL elders are quite healthy without suffering from any diseases. 42.86% and 50.32% of BPL and APL elders are suffering from 1 to 2 chronic diseases respectively. The percentages of APL elderly patients suffering from three, 4, 5, and 6 diseases are lesser than the percentages of BPL elderly.

There is a high degree of positive correlation at 0.8667 between the level of ill health among the elderly persons with illiteracy and matriculate education. Whereas the level of ill health between illiterates and graduates (0.4129) is moderately correlates. The correlation of level of ill health between matriculates and graduates is very low (0.2170). Illiterates, less educated and poverty stricken elders suffer from more diseases and disabilities than highly educated and higher economically placed elders. Majority of the

elderly with poor health status are economically backward, uneducated or less educated, widows and too older. The studies by (Mullis.1992; Ryff 1995) have brought out similar findings.

65.9% of over nutritive and 0.5 of under nutritive elders are facing the problem of obesity. B.P., diabetes, arthritis, obesity are the chief diseases from which more percentage of over nutritive elders are suffering. On the other hand, respiratory diseases and insomnia found to be more among under nutritive elders than over nutritive. Compared to teetotalers, alcoholic elderly persons suffer more from B.P., diabetes, arthritis. Teetotalers are healthier than alcoholic drinkers are. Even the same case is true in connection with smokers and non-smokers.

Compared to active elders, inactive elders perceived health status as poor. Slight lesser than 1/10 of inactive elders and slight more than 1/3 of active elders perceived their health status as very good. Only 1/10 of active and majority (64%) of inactive elders perceived their health status as very bad. In both rural and urban active elders are healthier than inactive elders. A simple majority of rural active elders and a good majority of urban elders are suffering from two or more chronic diseases. A vast majority (85%) of inactive rural and 93% of inactive urban elders are suffering from two or more diseases.

In spite of various welfare schemes, hardly 3.5% of Below Poverty Line rural elders are getting old age pension. 56% are unaware and ignorant about such welfare pension schemes. Compared to the large size of older persons the beneficiaries among them for different welfare schemes and programs introduced by the state and central governments are very insignificant.

**Conclusion:** Rural elders are healthier than urban. However, there is no significant difference. Aged living with spouse and children face lesser emotional problems. The calculated value of  $\chi^2(46.63)$  is greater than the tabulated value 7.82. Therefore, the null hypothesis is rejected, signifying the association between the living arrangement and emotional problems. As per chi-square test the research hypothesis is proved. The elderly living with spouse and children depict better health than the elderly living only with spouse or either only with children or living alone.

The comparative rates of HSI of BPL & APL elders show that the rate of BPL Health Status Index is (373.8) greater than APL. (318.9) **Chi-square test=  $\chi^2$ :** Calculated value (21.07) is much larger than the tabulated value (12.59).  $\chi^2$  test proves that there is significant relationship between income and health status. As per Spearman's correlation method there is a positive association or correlation at 0.78 between the scores in respect of various age related diseases between BPL and APL elderly samples.

The comparative rates of Health Status Index of Active & Inactive population show that inactive rate of HSI is higher than Active HSI. Calculated value (58.86) is very much higher than the tabulated value (12.59) and the research hypothesis is supported. The elders who lead sedentary life face more health problems. There is significant association between education and health. HSI rate of Uneducated is (414.85) moderately larger as compared to the HSI rate of educated. (302.00). I Set XY (between Illiterates and matriculates)  $R=0.8667$  Highest positive correlation. II set XZ (Illiterates and graduates)  $R=0.4129$  Moderate correlation. III Set YZ (Matriculates and graduates)  $R=0.2170$  Low correlation.

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