Chapter VII

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VII.1. Summary

The aim of the present study was to study the interplay of various indicators affecting quality of life of the elderly and computing a quality of life index for the elderly population of Patna District. The study has been completed in seven chapters. Chapter one dealt with the Introduction part. The literature review has been presented in chapter two. Chapter III deals with the demographic, social and economic profile of the elderly population in Bihar which is based on the secondary data. The analysis of the primary data has been done in chapter four, five and six. Chapter four deals with the economic and health determinants of the quality of life of the elderly; whereas chapter five deals with the housing, family and social environment of the elderly population. The quality of life index has been computed and analysed in chapter six. This chapter, which is the last chapter of the thesis, provides summary and conclusion of the study. The chapterwise summary has been presented below.

Chapter I deal with the introduction of the study, its objectives, research questions, data sources, methodology, introduction of the study area etc. This chapter begins with a brief background of the concept of the quality of life, concept of the elderly population, general research problems and specific research problems. It also provides a brief introduction of the study area i.e., Bihar and Patna district. Besides, it highlights the objectives of the study, the research questions, data sources and the methods to achieve the answer of the research questions. The detail list of indicators that have been used in this study is also presented in the chapter. Lastly, the chapter presents brief background characteristics of the respondents collected from the primary survey. Elderly population composition as per their age, sex, marital status, caste, religion, head of the household etc has been discussed in this chapter. In economic profile of the respondents, the economic status, their work profile, source of income etc. have been discussed.
In Chapter II, major studies on the quality of life and the elderly population have been outlined. The survey of the literature confirms the fact that there is a need for the study of quality of life aspect in the field of elderly population. This study is an attempt to fill this gap and bring the concept of the quality of life in the study of elderly population. The literature confirms that there are various opinions among scholars in defining the terms quality of life and identifying its indicators. The term and indicators of QOL is dynamic and keeps on changing as per the need of the study. The concept of ageing process and definition of the elderly population is however static\(^1\). Elderly in India is defined as persons over and above age sixty. There are demographic, social, health, and economic aspects of the elderly on which number of study has been undertaken both at the international and the national level. Role of NGOs in reaching to the elderly population to extend a helping hand has been a focus in number of studies. Besides, an attempt has been made to review the United Nations effort in planning and proposing a quality of life of the elderly through its various summits. International Plan of Action on Ageing, 1982, United Nations Principles for the Older Persons- 1991, and the recent Madrid International Plan of Action – 2002 has been a major milestone in advancing the ageing agenda globally. It has helped many countries in formulating their own policies and programmes. National policies, plans and programmes on ageing have also been reviewed in order to know the national government approach towards the well-being of the elderly population. National Policies on Older Persons (NPOP) – 1999 has been a welcome step in which government has shown its commitment for the elderly population. Besides, state government policies have also been reviewed to know the initiatives taken by the government.

Chapter III presents a profile of the elderly population of Bihar which in turn provides a background for analyzing the quality of the elderly in the study area. It prepares a framework for the further study. In demographic profile, the size, growth, mortality rates (ASDR), life expectancy at birth and sex-ratio have been studied. Here, it is observed that the size of the elderly is growing steadily. The sex-ratio of the elderly is contrary to the hypothesis that the old age sex-ratio is higher than all age sex-ratio. The

\(^1\) Though it is not static in true sense because when the expectation of life at birth makes a major shift, the definition of the elderly also changes.
longevity at age sixty and above is increasing over the decades. In the socio-economic characteristics, the illiteracy is high in the old population as on an average four-fifth of the elderly are illiterate. In the rural areas, female elderly literacy is as low as less than five percent. Marital status analysis shows that widowhood is declining. Dependency ratio of the old age is increasing. Bihar elderly people are found to be more engaged in the work. Particularly in the rural areas, the work participation rate among the elderly is high. Of the total elderly workers, almost nine-tenth is engaged in agricultural works. Health status of the elderly of Bihar shows that in all the chronic diseases and in physical disabilities, people have lesser prevalence than the national average.

Chapter IV deals with the various indicators related to economic and health which has its effect on the quality of life of the elderly. Frequency distribution of the individual indicators, bivariate distribution of the various indicators and multivariate analysis has been the tools to discuss and analyze the data. Among the economic indicators, financial status of the respondents, source of income, working status, type of work respondent does, total income of the respondent, member to be supported by that income, satisfaction level from the economic condition, agricultural landholding, livestock ownership are some of the indicators that has been used for the analysis. For health analysis of the elderly, ill in the last one month, ill in the last one year, morbidity profile, number of days ill, number of days inactive, treatment, diagnosis, time taken to reach the nearest health centre, mode of transportation, total amount spent on the treatment, whether the public health centre is sufficient, whether public health centres needed, disability profile, treatment, any appliances for the disabilities taken etc. are some of the indicators that have been used.

The economic profile of the elderly shows that more than half of them are economically independent. Agriculture in the rural areas and pension in the urban area are the two most of important source of income for the elderly. Almost half of the elderly in the urban areas and two third in the rural areas are still active economically. In the urban areas, elderly are largely involved in small businesses where as in the rural areas, agriculture keeps them busy. It was found that 93 percent of the elderly have less than Rs. 10,000 of income per month. In the urban areas, almost 11% of the elderly have income more than Rs.10000. But, in the rural areas, elderly with more than Rs.10000 per month
are less than one percent. 76.9 percent of the elderly in the rural areas and 66 percent of them in the urban areas possess land. However, the size of the landholding is small as nearly three-fourth of the elderly owns less than 5 bighas of land and those owning landsize of more than 10 bighas are nearly one-tenth of the total respondents. Livestock possession shows that in the rural areas more than 80 percent of the respondents have one or more cattle. Even in the urban areas, there are some elderly who owns some milking cattles. It was found that even in their old age, the elderly in the urban areas have to support their family members as the family income is not sufficient and in few cases there are no other earning members in the family. As far as the satisfaction level of the elderly from their economic condition is concerned, the elderly in the rural areas are relatively more satisfied than urban areas. Bivariate relationship shows that income and land ownership have positive relationship with the satisfaction level of the elderly. Multivariate relation, however, does not give significant results.

Health profile of the elderly shows that nearly three-fourth of the elderly have fallen sick during the last one year from the reference period. The morbidity profile of the respondent shows that ophthalmic diseases like cataract, night blindness etc. has emerged as the highest occurring disease (43.18%) in the study area. Followed by it, are the orthopaedic diseases (24.34%) like joint pain, backache, kyphosis, rheumatism etc. The cardiac related diseases seem to be concentrated in the urban areas. Elderly in the rural areas, are sick for more duration of time in comparison to their urban counterpart. It was found that most of the elderly go for some kind of treatment, as far as the diagnosis is concerned rural elderly falls behind. The mode of transportation to reach the nearest health centre is by and large poorly available in the rural areas, as almost three-fourth of the elderly has to walk down to reach the nearest health centre. If the health condition of the elderly does not permit to walk, then villagers carry them on their shoulder to reach the nearest health centre. Bivariate analysis has shown that distance of upto an hour is also covered by walking. The perception on the availability of the public health centres shows that more than eighty percent of the respondents are of the view that there is scarcity of public health centres. In the villages, the greatest help is offered from paramedical staffs. Disability profile shows that the elderly in the urban areas are more affected by it than rural areas. The visual disability is the highest occurring, followed by
locomotor disability. Nutritional level shows that nearly 46 percent of the elderly have low nutritional intake, whereas 49.55 percent of the elderly have medium level of nutritional intake. In the rural area, however, almost seventy percent of the elderly have low nutritional intake. Bivariate analysis of satisfaction from treatment and health conditions shows that the elderly who are not ill in the last one year from the reference period is more satisfied in comparison to those who were ill. Residencewise rural areas and genderwise female are more morbid.

The satisfaction level of the elderly seems to be affected by several variables. Those who are less morbid, treated and diagnosed, who need to walk shorter distance and who can afford to travel a long distance for the treatment, who use either personal and public transportation in comparison to those who walk to reach a nearest public health centre, who can spend more money on treatment and have high nutritional intake, and those who have sufficient family income are found to be more satisfied. Similarly, among the background indicators, elderly in the urban areas, from the general category, living in the joint family system, having higher standard of living, higher educational status and high income are more satisfied from their health.

Chapter V presents the housing, family and social environment of the elderly. This chapter has dealt with the three aspects in detail with the help of the primary data collected through fieldwork. It has been observed that housing conditions for the elderly in the urban areas are far better than the rural areas. Be it the matters of type of house, source of water, source of drinking water, type of toilet, availability of kitchen in the house or type of fuel used in the household all have been found in relatively better state than rural areas. Even the availability of the durable goods is high with the elderly in the urban areas. The accessibility of the elderly in the rural areas in terms of access and availability of the durable goods is poor.

As far as the family environment is concerned, the data shows that in the study area almost two-third of the elderly live in the joint family system. Elderly living in the joint family system are larger in proportion in the urban areas than rural areas. One reason is economic. The family members of the elderly in the rural areas are poor, they can not afford to sustain their immediate family of wife and children, and therefore they
are unable to take care of the elderly of the family. Because of low income, family feuds too often take place and in such environment, elderly do not feel safe and comfortable. It has also been analyzed that the satisfaction level of the elderly from the family is significantly correlated with the family environment. The questions whether or not elderly are willing to leave the family, how do the family members treat the elderly, what role elderly play in the family, response of the family members when elderly fall sick and whether or not the elderly are satisfied by the financial contributions made by them, helped to diagnose the satisfaction level of the elderly.

Social environment is largely supportive. Neighbourhood in the rural areas, particularly is quite helpful and the community extend help all the time. Neighbourhood in the urban areas is found to be less responsive. Even the elderly do not depend on others in the urban areas for the help. Elderly were found to be showing interest in the affairs of the society and those who do not show are because they do not have interest in the society affairs, or their family members do not allow them to participate in such social affairs even when they themselves are willing to participate or the society does not consider them for the purpose of decision making or any other activities. Society does consider the views and opinion of the elderly for the purpose of decision-making in 55 percent of the cases. In rest of the cases, elderly are not involved in delicate affairs. In sum, rural areas show more cohesiveness in terms of social support than urban areas.

Chapter VI presents the quality of life index and its analysis. The indicators taken and the methods adopted have been presented in the beginning of the chapter. Three tables of indices have been prepared. First one is the computed total scores in each broad category and aggregated score. Second is the standardized QOL indices and the third one is the categorised QOL into low, medium and high category. It is followed by the results and discussion. Large proportion of the elderly has been found with the medium level of the quality of life index. However, urban areas have an edge in better quality of life in comparison to the rural areas. Our hypotheses that the urban areas have better quality of life than rural does not stands valid and true for all the broad categories of QOL, as economic related QOL has shown the rural areas with high QOL indices than rural areas. Even in the urban areas, ward number 2 experience relatively better quality of life in comparison to the ward number 31. In the villages, Shankarpur Khas has been found to
be enjoying relatively better quality of life in comparison to the other villages. Hypothesis that male elderly enjoying better quality of life in comparison to the female has been found true and valid for all the broad categories of QOL indices.

Hypothesis regarding the age that the young elderly have relatively better QOL than old-elderly, is not true for all the aspects of quality of life. The aggregated QOL indices indicate that elderly of 70-79 years age-group have relatively high value than the young elderly (60-69 years). In housing and household amenities also, elderly of 70-79 years age-group have been found to have relatively high QOL indices than the young elderly. The elderly in the old-old (80+) age group, however, have relatively the lowest QOL indices which indicate that the growing age has its adverse impact on the QOL.

As far as the marital status of the elderly is concerned, the QOL indices for the widow have been found to be relatively the lowest. It validates our hypothesis that the widow elderly have a poor QOL in comparison to the married elderly and widower. The QOL indices for the widower on the other hand are lower than the married elderly.

The pattern emerging from the educational profile indicates and validates our hypothesis partially that the educational attainment of the elderly has its positive impact on the QOL. Partially because the QOL indices for economic indicators have been found high in the illiterate elderly. Other than this, the QOL indices for the higher educated elderly have been found to be the highest in all the other broad categories. The QOL indices for the illiterate on the other hand are lowest for all the other broad categories of QOL. The primary and middle educated elderly have been found with the medium level of QOL indices.

Elderly living in the joint family system are found with relatively high QOL than elderly living in the nuclear family system. The result has been found true with all the broad categories of QOL and hence validates our hypothesis that the joint family system still provides a better QOL to the elderly than nuclear family system.

As far as the caste of the elderly is concerned, the elderly in the general category have been found with the highest QOL indices where as SC elderly have the lowest QOL indices. Hypothesis that the general category has better QOL than the OBC and SC category elderly stands valid. However, the economic indicators of the QOL show that
the OBC elderly too have high QOL indices, though it lags behind in the other QOL indices.

VII.2. Conclusions

Quality of life of the elderly as per their perceptions, beliefs and experiences has been the major focus of this study. This study has adopted a comparative approach in discussing and analyzing the results both among the elderly themselves with different background and among different QOL indicators. The study can be concluded as follows:

- The percentage of population in the old age group is growing steadily. The sex-ratio among elderly is contrary to the general trend of high females per thousand males. The Illiteracy is found to be prevalent among the elderly.

- Economically, more than half of the elderly are independent and active and have their own sources of income largely through pension (in the urban areas) or through agricultural pursuits (in the rural areas). Agricultural land and livestock possessions have been found to be a major support system for the elderly and hence the satisfaction level of the elderly from their economic condition is high in the rural areas than in the urban areas.

- Health profile of the elderly shows that nearly three-fourth of the elderly had fallen sick during the last one year prior to the reference period (2005). The morbidity profile of the respondents shows that ophthalmic diseases like cataract, night blindness etc. have emerged as the highest occurring diseases followed by orthopaedic and cardiac diseases respectively. The perception of the respondents on the health infrastructure indicates a poor health facilities. Three-fourth of the respondents walk down for almost half an hour to reach the nearest health centre. The ill-elders are to be carried on the shoulder to reach the nearest health centre by walking for an hour. Lack of roads and lack of public transportation are major stumbling blocks in order to access the health centres in the rural areas. Low income is another important factor for poor access to the health.

- There has been a wide gap between the urban and rural areas in the housing and household amenities related QOL.
• The joint family system emerges to be a natural support system for the elderly as three-fourth of them still live in the same. Joint family system has been found to be stronger in the urban areas than rural areas. The concept of family being considered to be the natural support system for the elderly, however, needs reconsideration as it has been found that several elderly people are not willing to be in the family as they do not get adequate support, respect and care and are willing to leave the family and settle somewhere else. If family is to be promoted as the natural caregiver for the elderly, then government must strengthen the capacity of the family per se so that they can easily sustain the elderly members of the family.

• Neighbourhood of the elderly has been found to be supportive. The urban areas are however, relatively less responsive in this regard.

• QOL indices indicate towards substantial differentials in the QOL of the elderly in the rural and urban areas. Other than the QOL pertaining to the economic indicators, quality of life has been found to be high in the urban areas in sectors of health, housing, family and social environment. The aggregated quality of life also indicates higher index in the urban areas than the rural.

• The young age of the elderly has not been found to be associated with high indices of QOL for all the five broad categories. Instead, the elderly in the age-group of 70-79 years have higher aggregated QOL index. The old-elderly on the other hand experience low QOL showing relatively a poor economic, health, housing, family and social status.

• Genderwise pattern of QOL indices show a better economic, health, housing, family and social status for the male elderly.

• Though the incidence of the widowhood among the elderly has been found to be lower, the quality of life of the widow elderly has been found to be low. The QOL of the widowers is also low in comparison to the married elderly.
VII.3. Policy Implications:

The policy implications of the study can also be presented in five major heads namely, economic, health, housing, family and social environment:

- As the study has shown that the economic condition of the elderly is poor. The elderly need two kinds of intervention for improving their economic QOL. Number one is direct intervention, where the elderly themselves are targeted and given some kind of economic opportunity (for young elderly) and pensions (for the old elderly who are unable to contribute). This will make them economically independent which in turn will not only improve their economic quality of life but also their housing and household amenities related quality of life. The other intervention is indirect, where their family members are to be strengthened in terms of economy and education. This will have its indirect impact on the family relationship and care of the elderly. It was found that where family members are economically weak, elderly are more prone to be separated and left alone than in the cases where their family members are economically well-off. Therefore, indirect intervention by strengthening the family members is also required.

- Health infrastructure and facilities needs a serious care particularly in the rural areas. Often the treatment remains incomplete due to lack of money, lack of health facilities, lack of transportation facilities, lack of awareness, negative attitude towards life etc. Availability of either a geriatrician or a doctor with training in geriatric medicine will help in improving the health standards of the elderly.

- Medical help in the form of free check-ups, distribution of medicine and cataract-removal surgery need to penetrate in the rural areas. By and large, they are restricted in the city confined to the city areas.

- Beside health, the general infrastructure like roads, elderly-friendly transport system and electricity which enables good access to the health and healthy quality of life should be strengthened. Mass awareness through counseling for a healthy and positive outlook towards the senior citizens should also be cultivated.
• Poor elderly in the urban areas are particularly in need of some housing arrangements. Old age homes with appropriate infrastructure will be blessings in disguise. Currently, the awareness about the existing old age homes and the facilities therein are not much known.

• Education of the elderly in general and their family members in particular is also very important. Higher educated elderly have been found to be enjoying better QOL. Their education gives them strength in terms of knowing their rights and thereby taking advantage of several policies of the government which otherwise is not possible.

• The intervention in terms of mass media mobilization will also prove to be beneficial for the elderly. Public should be made more aware of their growing number, psychology, health concerns, family concerns, social and economic concern etc. This would prepare them to approach the issues on the elderly population with care and compassion.