

CHAPTER XI

SUMMARY AND CONCLUSIONS

Introduction

‘Ageing’ of a population is a process whereby the share of older persons in a population grows relative to that of younger persons (United Nations, 2005). Population ageing or demographic ageing is the process whereby the proportion of older persons increases and that of children decreases. This is caused by decline in fertility and mortality rates prevailing in the population. According to United Nations (2009), the ageing of the population is characterized by seven factors: (a) Population ageing is unprecedented, a process without parallel in the history of humanity; (b) Population ageing is pervasive since it is affecting nearly all the countries of the world; (c) Population ageing is profound, having major consequences and implications for all facets of human life; (d) Population ageing is enduring; (e) Feminization of ageing - the numerical excesses of females in the elderly group takes place; (f) Marked differences exist between DCs and LDCs in the number and proportion of elderly; and (g) The pace of population ageing is faster in LDCs than in DCs.

As ageing is a silent process, the consequences of ageing were felt after some time lag. The focus of research pertaining to gerontology is still in its infancy in India (Raju, 2011). The understanding of the actual living conditions of the older population remains poor, especially in the LDCs (Palloni, 2001). Even if India is one of the signatories of MIPAA, and the national policy mentions about ‘living arrangements’ as one of the working area, few scholars have undertaken studies specially focusing on the living arrangements at the national and the state levels. Only recently, researchers and policy-makers have liked the idea of the familial system of care and they started looking at living arrangements as one of the consequences of ageing. Available literature shows that there is no clear definition of the ‘living arrangements’. Living arrangements seems to be a simple but multi-dimensional term to understand. The concept of living arrangements refers to the familial system of support and care of the elderly (Palloni, 2001). There are a number of reasons to be concerned about patterns of elderly living arrangements. First, individual decisions about joint or separate living arrangements affect social and

contextual characteristics, i.e., living arrangements have spill over effects. Thus, they have an impact on aggregate demand for housing and housing services as well as on the size and type of demand for social services and care giving for elderly persons. Secondly, it is widely believed that living arrangements are one factor, among many others, that influence older persons' well-being.

Health problems increase with age, especially at advanced age. With advancing age, ill-health becomes a major hindrance for the well-being of the elderly. In fact, the MIPAA prioritises 'Advancing Health' and 'Well-being' into old age as a central theme (MIPAA, 2002). Living arrangements are an important component of the overall well-being of the elderly. Available data suggests that living arrangements of the elderly are strongly associated with adverse health outcomes such as asthma, tuberculosis, malaria and jaundice (Agrawal, 2012). Some micro level ageing studies in India have found living arrangements, and care and support for older adults to be important determinants of their health status (Gupta and Sankar, 2002; Chaudhuri and Roy, 2007; Sheela and Jayamala, 2008; Lena et al., 2009). A number of studies have found that self-rated general health among the elderly is a valid measure of their health status (Krause and Jay, 1994). One of the benefits of co-residential living in India includes those to elderly health, particularly in terms of the relationship between co-residence and self-rated health, chronic and short-term morbidity (Sudha et al., 2006; Jadhav, 2011).

There appears to be a complex dynamic relationship between living arrangements and health status which differ by gender, socio-economic status, morbidity patterns, types of living arrangements etc. However, more detailed studies focusing only on living arrangements and how they affect health status measures have yet to be made. The present study collected data of the elderly about the status of their current health and compared it with that in the previous year and also with the people of the same age.

More developed states in the southern region and a few others like Punjab, Himachal Pradesh and Maharashtra have experienced demographic transition ahead of others and, therefore, are growing older faster than other states (UNFPA, 2011). Pune city of Maharashtra is the second most populous district after Thane (Census, 2011). The city has the literacy rate of 91.6 per cent which is higher when compared with the literacy rate in the district, state and urban India. The city is known as the *Oxford of the East* among

the locals. Because of extensive educational facilities and industrial activities, many pensioners have settled in Pune after retirement and is called as Pensioner's Paradise. It ranks sixth in the top ten wealthiest cities in India (CDP, 2012). The elderly account for 9.5 per cent of the total population (IIPS, 2012) and the large absolute size of the elderly population is a matter of concern. The study has been conducted in this city with 950 elderly respondents from 100 Primary Sampling Units (PSUs) with a focus on living arrangements and health of the elderly.

Objectives

This study is aimed at investigating the factors that are associated with the living arrangements of the elderly persons in Pune. The specific objectives of the present study are:

- To examine the pattern and trends of the elderly population of Pune in comparison with that of Maharashtra and India.
- To explore and highlight the pattern of living arrangements of the elderly.
- To assess the perception of the elderly about their preferred living arrangements, financial sources and support, and the state of current economic dependence.
- To identify the factors affecting living arrangements, morbidity and health of the elderly.
- To assess the awareness about the government schemes and facilities among the elderly and understand perception of the future elderly about their preferred expectations for living arrangements and financial support.

Data and methodology

The data used in the study have been collected using a quantitative research method. The sample size required to produce city level estimates of the ageing indicators has been worked out using scientifically designed procedure. We assumed the design effect as 1.25 and response rate of 90 per cent. Thus, based on the literature, reported proportion of key indicator- living alone or with spouse- is 20 per cent with 5 per cent error in estimate, generates as estimate of approximately 2200 households (HHs) from the city. An updated Urban Frame Survey (UFS) of NSSO is used as the basic sampling frame. A two-stage systematic random sample design was adopted to draw a sample from the sampling frame. NSSO blocks were selected using random systematic manner. On

average, 22 HHs in each of the selected PSUs were sampled systematically for the study. Thus the study of 950 elderly (445 male and 505 female) aged 60 years and above was conducted during year 2013-14 from one hundred PSUs of Pune city. The study collected information on various dimensions of elderly people: socio-economic and demographic profile; living arrangements; health status and household characteristics. Views of future elderly or non-elderly i.e., younger adult member aged 25 years and above who are staying with the elderly are also collected.

Summary of findings

Background characteristics of the elderly population

About 9-10 per cent of the total population of Maharashtra account for the elderly population aged 60 years and above. The absolute size of the elderly population is 11.2 million. In Pune, the elderly account for 9.5 per cent of the total population.

The review reveals that a majority of the ageing studies conducted so far in India mostly pertain to a particular locality and are based on sample surveys of specific segments of the elderly with a specific disciplinary focus. Using decennial population censuses, NFHS and health-morbidity-disability data from earlier rounds of the NSSO (52nd round, 58th round and 60th round), this analysis shows that ageing is an important emerging challenge in India.

The socio-demographic profile of the 950 elderly (age 60 years and above) interviewed for the study in Pune city shows that more than one-fourth of them were aged 60-64 years and another 29 per cent were aged 65-69 years. Thus, taken together, a majority of the elderly (56%) were below 70 years of age. Less than two per cent of the elderly were above 90 years of age. The average age of these elderly was 70 years (± 7 SD). The study also indicates that there is numerical excess of females among elderly persons. When distributed by five years age categories, except 70-74 years age group, all groups show the numerical excess of females. These findings indicate that “feminization” of ageing is occurring because of which we have more females in advanced age groups than males. About three-fourths of the elderly live in non-slum areas, whereas one-fourth of them live in slum areas. A majority of the respondents are Hindus (83%) and around 8 per cent are Muslims and Sikhs, while Christians are less than 3 per cent. More than half

(53.5%) of the elderly women are widowed and among the elderly men 9.2 per cent are widowers. The proportion of widows rises with increasing age. Further, one third (33.8%) of the elderly women are widows at age 60-64 years, reaching up to 87 per cent for elderly women of 80 years and above. However, for men, the picture is slightly different. Even at the age of 80 years and above, only one fourth (25%) of the men are widowers. Almost 15 per cent of the elderly males and two in five elderly females are illiterate. Another 8 per cent each of males and females have education upto primary level and 17 per cent and 13 per cent males and females completed higher secondary education respectively. Around 25 per cent males and 10 per cent females are graduates and above. Around 73 per cent of the elderly live with at least one of their children.

Living arrangements

A majority of the elderly co-reside (76.3%). About 47 per cent live with spouse, children and grandchildren; and little more than a fourth (25.8%) live with children and grandchildren without spouse. There are a few (3.1%) who live with married daughters (or with son-in-law). The elderly who live on their own also form a small group, i.e., 4.5 per cent. A higher proportion of elderly women (6.3%) than elderly men (2.5%) live alone. This is followed by the elderly who live with spouse only. Further, 4.7 per cent elderly individuals live with other relatives. In this study, none of the elderly persons lives with non-relatives. The proportion of the elderly respondents living with other relatives is also much higher among females (6.5%) than among males (2.7%). Almost one-fourth of the elderly of Pune city come under the low standard of living index (SLI) group, whereas 32 per cent belong to the middle SLI and 42 per cent elderly to the upper SLI group. Gender-wise there is not much difference in them.

The study found that the work participation rate among the elderly is 18 per cent in Pune. Although it declines with age, it is substantial even among the oldest-old male elderly of 80 years and above. This rate ranges from 24 per cent for men to 12 per cent for women elderly. Sharp gender differentials in work participation exist. Around 9 per cent of the elderly receive only retirement benefits and another 9 per cent receive only pension benefit. The elderly receiving both retirement and pension benefits were 18 per cent. The remaining 46 per cent elderly get employment benefit neither as pension nor from retirement source. The pension benefits significantly vary between men and women.

Around 9 per cent elderly receive pension but significantly more women (12%) receive pension compared with men (5%). This is because 10 per cent women get pension through government schemes like pension for the widowed.

Socio-demographic characteristics and living arrangements

The study also attempted to highlight the socio-demographic characteristics of the elderly associated with their living arrangements. About 2-3 per cent elderly males in the age groups 60-69, 70-79 and 80+ years live alone, whereas for elderly females this percentage is 4.9, 10.3 and 3.2 respectively. About 41 per cent of the oldest old (80+) elderly males and only 6.5 per cent of elderly females live with spouse, children and grandchildren. Also, 9.4 per cent elderly males live with children and grandchildren without spouse whereas this percentage is higher (45.9) in the case of elderly females. It is observed that 10 per cent widowed elderly persons are living alone. Of them, 17 per cent are widowers and 9 per cent are widows. Among the widowed elderly persons, 81 per cent live with children and grandchildren and 9 per cent with other relatives. There is no clear trend but the illiterate elderly and more educated elderly live alone. About 4 per cent of the elderly with no education live alone compared with nearly 8 per cent college educated elderly. However, 3.1 per cent illiterate elderly males and 4.9 per cent illiterate elderly females live alone. The proportion of living alone is high among the college educated females (10.5%) compared with college educated males (4.8%). Interestingly, about 12 per cent of the elderly having one or more surviving children still live alone and 8 per cent live with other relatives. Besides, among the elderly having one or more children, 45 per cent stay only with spouse.

Further, gender-wise distribution shows that 68 per cent elderly males and 4 per cent elderly females who live with spouse, children and grandchildren are head of the households. The trend is reverse in the case of widows. The living arrangements do not vary with religion or caste. About half of elderly men (45 per cent) and women (48 per cent) said that sons would be the best to live with when one is older, reflecting the continuation of the traditional practice in India. The predominantly preferred living arrangements across all elderly are living with sons (47%). Around 8 per cent preferred living alone but close to children and living with children in rotation. About 5 per cent of the elderly reported living alone as the preferred living arrangements. Preference of living

with daughters was very low (6%). Further, 82 per cent men and 70 per cent women think that they are important to their family, 12 per cent men and 20 per cent women think that they are somewhat important, and 6 per cent men and 11 per cent of women think that they are not at all important to the family.

Economic characteristics and living arrangements

About 6 per cent of the elderly (3% males and 12% females) living alone is still currently working. Nearly 16 per cent elderly who are living with their spouse are contributing in work participation and almost more than three-fourths of elderly who co-reside are currently working. Also, more elderly women (22%) than men (7.5%) who live with children and grandchildren contribute in work participation. As expected, about 42 per cent elderly women living with other relatives are work currently. Also, more elderly women (8%) than elderly men (1.6%) living alone have accounts in banks. This is because elderly women who are widows get benefit of the social security pension schemes under which money is deposited directly in their bank accounts. This is reflected in the case of women living with children and grandchildren without spouse. About 44 per cent women and only 8 per cent men living with children and grandchildren without spouse have bank accounts. More than 7 per cent elderly get income from work stay alone and 16 per cent are with spouse. More than half of the elderly getting income from work stay in family with spouse, children and grandchildren, as oppose to only 22 per cent elderly staying with children and grandchildren. This might be because they get help from the children as most of them are elderly widows staying with children without spouse. Among the elderly getting pension, about 5 per cent stay alone and about 20 per cent with spouse.

About 70 per cent elderly are either fully or partially dependent for meeting their financial needs. Eight per cent elderly live alone and 24 per cent live with spouse reported financial independence. Around 59 per cent elderly live with spouse, children and grandchildren reported partial dependence. About 39 per cent, who reported complete dependency, stay with children and grandchildren. In short, most of the elderly live alone or with spouse is not dependent while partial dependence is more among the elderly staying with spouse, children and grandchildren. Complete financial dependence is reported by 39 per cent elderly living with children and grandchildren. About 18 per cent

elderly females and 4 per cent elderly males are financially not dependent and live alone, whereas 13 per cent elderly females and about 28 per cent elderly males are financially not dependent and live only with spouse.

Determinants of living arrangements

The regression analysis shows that the elderly from age group 70-79 years are more likely to live alone compared with the oldest old elderly (80+ years). There is a strong marital status dimension to ageing which shows that the widowed have high odds of living alone compared with those that are married- which means that the widowed are more vulnerable. But as mentioned earlier, there are more widows than widowers. This implies that more widowed elderly women are vulnerable. Also, the elderly with general caste are almost two times more likely to live alone compare with the elderly of OBCs or other castes elderly. As expected, those with more education like collage and above are more likely to live alone compared with those with less education or illiterate. Those elderly who get pension or retirement benefit are more likely to live alone than those who get financial support from children. This is reflected in economic dependency. Those elderly who are economically not dependent are three times more likely to live alone. Religion, gradient in the standard of living and whether the elderly saved money for their old age are not significant determinants of living arrangements. Surprisingly, gender also does not play a role in living arrangements. Presumably, because there are more widows and the dependent variable included living alone together with living only with spouse.

Current and relative general health status and living arrangements

The data reveals that only 62 per cent of the elderly reported their current health condition as good. Thus, nearly two out of every five elderly people consider themselves to be health-deficient or not enjoying good health. It further shows that a higher proportion of the elderly women consider themselves as in 'fair or poor' health conditions (26.2%) than their male counterparts (16.2%).

About 19 per cent elderly living alone and 17 per cent elderly living with spouse reported poor health as compared with those living with children/grandchildren. Also, 34 per cent elderly living without spouse but with children or with other relatives reported poor health. A similar pattern is observed with respect to relative health, i.e., health

compared with the last year and compared with that of their peers. Hence, there seems to be an association between the elderly self-rated health and living arrangements.

At the time of the survey, two elderly were bedridden and one was handicapped from birth and two elderly had only one eye. Within the three age groups of elderly persons of 60 years and above, the disability increases with age. The highest disability rate (7.7%) is observed for persons aged 80 years and above. Within the three age groups of elderly persons, the disability increases with age. Among the age group 60-69 years, 3.7 per cent elderly males and 3 per cent elderly females reported disability. Both groups have shown similar disability rates. There is no difference with respect to the extent of disability among male and female elderly.

Visual disability is the most common. More than one third of the disabled persons reported it. Elderly are more prone to eye impairment. About 35 per cent elderly females reported poor vision, cataract or eye impairment as against 34 per cent of elderly males. The next most prevalent disability is in movement. As many as 43 per cent elderly suffer from joint pain, 24 per cent from back pain/slip disc and 12 per cent from Osteoporosis. More females report disability in movement than men. Loss of hearing is reported by 24 per cent elderly. Besides, life style-related diseases like blood pressure (44%) and diabetes (24%) are reported by the elderly. Blood pressure is reported more among the elderly females and diabetes more by elderly males. Dental loss is found more in elderly females (40.8%) than in elderly males (38%). About 9 per cent elderly reported cardiac problems. Of them, 12 per cent are elderly males and 6 per cent are elderly females. Neurological problems like dementia, alzheimer, loss of memory, etc., are reported by 20 per cent of the elderly. Neurological problems are more in elderly females (24%) than elderly males (16%).

The distribution of ailments amongst elderly females shows differences from elderly males. About 66 per cent elderly women and 63 per cent elderly males have more than three illnesses/diseases. Ailing elderly females are more likely to suffer from eye problems, joints-related diseases and infections. They are also more susceptible to lifestyle and age-related disorders like blood pressure. However elderly males are more susceptible to diabetes mellitus and heart diseases.

Determinants of poor health status

The logistic regression analysis reveals that (Table 8.5), self-rated poor health status increases as people became older. Elderly without any formal education were significantly more likely to self-rate their health status as poor compared with their more educated contemporaries. The elderly living without spouse but with children and other relatives are more likely to report poor health status compared with those living with spouse, children and grandchildren. The next variant confirms that the elderly with no employment benefit (without pension or retirement benefit, i.e., indirectly no source of self income) have a higher probability of rating poor health which also reflects their economic dependency and failure to get money as and when required. There is an association between habits (tobacco chewing, smoking and alcohol drinking) and health status. In another Model, compared with currently married elderly, more widowed elderly reported poor health. Gender, location of residence and standard of living index did not appear to influence self-rated health. Even if we add caste or religion in both the Models, the result remains the same.

Functional assessment of elderly with activities of daily living (ADL) and instrumental activities of daily living (IADL)

The study assesses the functionality based on the level of independence to carry out the various activities. Around 10 per cent elderly (9.5% males and 10.7% females) need partial or full assistance in walking, and 6 per cent each in getting in or out of bed, dressing, walking, getting to bathroom, toilet use and bathing. Gender-wise there is a marginal difference in performing ADL activities independently. Women are more impaired in activities like walking, getting in-and-out of bed and toilet use which require use of lower limbs. In line with general expectations, IADL impaired women outnumber men. This holds true for all IADL except preparing meal and doing household work. Even cooking and household work are found to be difficult for about one-fifth of the elderly women. Age appears to be a significant influencing parameter in performing any type of activity.

Around 43 per cent of elderly do not require any help for doing ADL or IADL and are independent. Compared with them, 3 per cent elderly need help in doing all the mentioned activities which shows that they are not functionally independent. But 20 per

cent elderly need help from others for doing at least any two activities and 34 per cent elderly for doing more than two activities. Almost half the elderly male and 37 elderly females don't need any help in doing any activity. However, more of elderly females (41.8%) than elderly males (26%) need help in doing more than two activities. So more elderly women need assistance for doing ADL or IADL compared with elderly males.

Awareness among elderly and views of tomorrow's elderly

The data on awareness among the elderly about percentage of the elderly population in Pune reveal that only 5 per cent of them knew that the elderly population of the city is 10 per cent or less whereas, 36 per cent of them reported it to be more than 10 per cent. About 35 per cent elderly have knowledge about the old age saving plans and more men (47%) than women (25%) have knowledge about them. Bearing this in mind, only 38 per cent elderly (28% women and 50% men) reported that they planned for financial security for old age when they were young. This gives us the idea about the lack of awareness among the people about the financial security planning for old age.

Nearly 62 per cent elderly have heard about the old age homes with 69 per cent elderly men and 56 per cent elderly women. Little more than half of the elderly (53%) reported that it is a good idea for elderly to live in homes or institutions which are specially organized for them. However, about half of the elderly think that staying in the old age homes is not a good idea.

Similarly, about half of the elderly (57% men and 42% women) have heard about the day care centres or hobby centres. The knowledge is more among elderly males than elderly females. Of them, only 14 per cent showed willingness to join a day care centre if available in their locality, 24 per cent can't say whether they are willing to join a day care or hobby centre and the remaining 63 per cent would not like to join these centres.

About 6 per cent elderly women and 11 per cent elderly males have heard about policies for the elderly person. It shows the lack of awareness towards elderly policies among the city elderly. About 45 per cent of elderly feel that the family members should get training for handling of them. Of them, 42 per cent elderly women and 50 per cent

elderly men feel that training is required for family members for handling of the elderly person, which necessitates the need for handling and caring of the elderly.

As for the awareness among the elderly about the government facilities for them, shows that a sizeable proportion is aware about the railway and bus reservation and ticket concessions. Beyond these two concessions, the elderly are little aware about the preference in telephone facility, additional interest on bank or post office deposits and concession in income tax.

In view of this, the study collected information about the factors which contribute towards providing care to the elderly from non-elderly household members and also how the future elderly look at their own ageing which is going to occur. We define a non-elderly member i.e., tomorrow's elderly, as a person aged between 25 and 59 years and living with an elderly person in same household. After excluding households where either the elderly live alone or they stay only with spouse and a non-elderly person was not present at the time of the survey, the study collected data for 543 non-elderly or tomorrow's elderly.

Data are collected for 333 non-elderly males and 210 non-elderly females of the average age 37 years at the time of the interview. Among the non-elderly, 44 per cent each are aged 25-35 years and 35-45 years and 13 per cent are aged 45 to 59 years. Of non-elderly male respondents, 96 per cent are sons and 1 per cent sons-in-law. Of non-elderly female respondents, 29 per cent are daughters and 66 per cent are daughters-in-law. About 85 per cent non-elderly are married and almost all of them (97%) are literate.

When interviewed regarding their awareness about self-ageing and whether they have prepared themselves for it, about 81 per cent non-elderly (83% males and 77% females) mentioned that they are prepared. However, about 6 per cent of them are not sure about their preparedness for self-ageing. About 93 per cent non-elderly agree to go for planned ageing. There is not much difference between non-elderly males and females about their views on planned ageing. The preparedness and plan for old age suggest a greater acceptance and awareness among non-elderly respondents about the need for planned and secured ageing. Not surprising, data reveal that about 90 per cent non-elderly reported that the family should be responsible for caring for the elderly and another 8 per

cent non-elderly think that along with the family, the Government should take the responsibility for providing old age security and support. The relationship between the elderly and non-elderly family members is mostly cordial, with about 5 per cent non-elderly reporting non-cordial relationship with the elderly.

Data reveal that an overwhelming majority of non-elderly (95%) denied that caring for the elderly is a burden. However, 5 per cent of non-elderly respondents reported that it is becoming burdensome for them.

Religious and moral factors help at the motivational level for the non-elderly. However, 12 per cent non-elderly reported that in return for the care they received from the elderly when they were young, they are motivated to take care of the elderly. Social obligation as a motivational factor is reported by 6 per cent respondents. So religious thought and institutions which value the elderly inculcate these values in the next generation.

As for the non-elderly thinking whether the elderly persons should be kept in the old age homes established for them, only 4 per cent of them spoke in the affirmative. However, 39 per cent respondents did not answer this question. This may further raise many issues about the support and care of the elderly. About 57 per cent respondents don't think that an elderly person should be kept in an old age home.

Profile and case studies of old age homes

We also included qualitative information about the formal living arrangements, i.e., the profile of old age homes in Pune and the case studies of old age homes which provide care to the elderly. There are 41 registered old-age homes in Pune. Almost all the old age homes give admission to both men and women. Some of them are only meant for admitting elderly who needs assistance for daily activities and other specifically admits the elderly with diseases or illness. The capacity of these homes varies from 10 to 100 persons. All homes have the facility of a medical doctor either visiting regularly or as and when required. Most of them have tie-up with multi-speciality hospitals for emergency care. The first old-age home has started in Pune in 1864. The three case studies of homes are included which provide professional services to the elderly. *Niwara* is the oldest - old

age home in Pune. *Athashri* is for the elderly who afford professional services, *Janseva* *Ambi* is an old age home providing services to the destitute as well as elderly from well-to-do families.

Limitations of the study

The present study tried to analyse related issues in detail. But the in-depth analysis is difficult for a variety of reasons. Many of the issues relating to the living arrangements have not been covered in great detail in all India studies like NSSO, NFHS, etc., because of the different survey objectives. Besides, there are few studies specially focusing on living arrangements. The recently conducted UNFPA survey covers seven states along with Maharashtra which included 1280 elderly households from each state from 80 Primary Sampling Units (PSUs) from urban areas. Hence, in order to understand issues regarding the elderly in a progressive city like Pune and to fill the knowledge gaps identified by these surveys, the present study examines significant correlates of living arrangements.

Besides the large sample size selected from the city covering one hundred PSUs, an important limitation of this analysis is the non-coverage of the rural area. Hence, any generalization of the results needs precaution. As per the methodological needs for the inclusion criteria, the study includes more than one elderly from a household and thus accounts for 294 couples among included elderly. But the investigator reserves the couple analysis for next in-depth study. Also the study has not greatly focused on the expenditure of elderly, economic resource transfer from the elderly to the non-elderly family members, and elderly abuse which is having a relation with the living arrangements mentioned in the literature. It necessitates in-depth investigation into the income and expenditure, data on the needs of the elderly and their comparison with the elderly living alone or living with spouse and living in family. The study collected the data on various economic aspects but their magnitude is not taken into account here. Transfer of the assets from the elderly to the next generation is not included in the study. Data on household wealth and assets should be collected for a clear understanding of the issue.

Another point to be mentioned here is that the data on health and morbidity are based on self-reporting and not on clinical testing confirmation. But, wherever possible, the investigator made sure about diseases and conditions by the probing method. Also, lack of knowledge about a disease might lead to under-reporting. There is also a possibility of over-reporting because of some other disease conditions with similar symptoms. Commonly understood local terms for the mentioned ailments were used in the study. However, no clinical tests were done to check for any of the morbidities. So it is equally important to recognise that reported ailments among the elderly might not be as accurate as clinical measures.

However, on the background of the lack of data, especially on elderly focusing on living arrangements and health outcomes, the present study provides an opportunity to examine the factors associated with the health of the elderly and the effect of the elderly living arrangements on it. Further, the use of self-rated health condition which, in the absence of autopsies and physician examinations of elderly, might represent lacunae in data on the conditions affecting the elderly. More detailed studies are needed, other than surveys, to extract information on the epidemiology of health conditions experienced by the elderly.

Policy implications

The rising percentage of the elderly which is a huge absolute number, along with the various sources of vulnerability, make the ageing of the population a compelling reason for priority attention at policy planning and programme levels. There is a need to focus on ageing issues and to take effective measures for improvement in the conditions of the elderly in general and elderly women in particular.

In the elderly population, females outnumber males. They are found to be mostly deprived due to many socio-economic reasons, including those arising due to widowhood, lack of education and dependence on children. In view of the higher longevity of women in general, elderly women from lower SLI households need special care as their dependence on other family members increases significantly with age.

In addition, significant differences between men and women by marital status are noticed in workforce participation. Vulnerability is greater among elderly women and it adversely affects their access to, and utilisation of services, resources and opportunities. There is an urgent need for policy-makers and planners to initiate policies and programmes specially designed to take care of elderly widows at advanced ages. At the policy level it implies that we are moving towards accelerating growth in ageing and also towards high share of ageing widows requiring specific policy initiatives to ensure their well-being. Hence, there should be special provision in social security for elderly women in the policy.

Even if the share of the elderly in formal education is higher; simultaneously the share of semi-literates (those below or up to 7 years of schooling) is also higher. It opens up many issues at macro and micro levels. In view of the plan of action by Second World Assembly on ageing in Madrid with Indian endorsement, at the macro level it may be difficult for the semi-literate elderly to bring them into the developmental process. Low levels of education and illiteracy have correlation with low productivity and unemployment which eventually increases the risk of diseases and disability among the elderly. The programme of exchange of knowledge and experience between two generations - like use of technology for elderly and elderly the latter acting as mentors and advisors- should be initiated.

Because of continuing increases in life expectancy, the number of eligible retirees is rising more rapidly than the tax revenue available to finance benefits. Ailment of non-working members causes disruption of usual activity of the working members of the household which, in turn, results in loss of household income.

Even if house ownership is common in urban areas, due to overcrowding and lack of resources with urban administrators, houses in urban areas are hardly large enough to accommodate more than one nuclear family. Ageing may produce demand on certain types of housing. The emerging system of smaller families with more widowers and increasing incidence of solitary living among young adults may reduce the demand for large houses. Today's housing developments are generally designed to meet the requirements of younger who is actually departing from the large family and are physically fit and can use the transportation and other such facilities very well. But, for

the elderly who live without support, the provision of domestic assistive aids to enable daily living, appropriately designed houses can make life easy and will help in improving the quality of life.

In Pune, over 46 per cent of the economically dependent elderly are supported by their children. This indicates the major reliance on the family in the case of the elderly. A longer life span of the elderly implies a longer period of dependency on children in the traditional Indian family setting, and thus higher costs to meet their healthcare and other needs. The study confirms that the elderly view children as their most preferred source of support and they have given the last option to the institutional care. Efforts are, therefore, necessary to strengthen inter-generational bonds across generations. Family erosion and women's participation in work force may result in the need for trained caregivers for the elderly in the public and the private sectors. Government should promote traditional family system which is also relatively cost effective policy.

In the context of an urban area with educated and earning (income from pension) elderly around, where property rights are well-established and inheritance practices are not fully formalized, they are holding assets. However, it is possible that if property rights were more explicit and formalized with awareness generation, the status of many elderly within their households would improve considerably. Additionally, the Indian Government introduced the National Policy on Older Persons in 1999 which has provisions for tax relief for children who co-reside with their parents, allowing rebates for medical expenses and giving preference in the allotment of houses (MOSJE, 1999). This policy needs to be enforced and awareness about the same needs to be created among the non-elderly or adult children.

Improving the health status of the elderly is one more area where we need to focus more. The burden of multiple illnesses places the elderly at risk. The streamlining of the healthcare facilities is a challenge and to initiate measures for geriatric support provision is important in urban areas of Pune. With a large percentage of ailing and disabled elderly, there is a need to provide training to family members on elderly care and support. The inference may serve as a pointer to the fact that the issue of old age health cannot be tackled without a focus on later life as a major public health issue.

However, the use of self-rated health condition which, in the absence of autopsies and physician examinations of the elderly, represents lacunae in data on the conditions affecting the elderly. More detailed studies are needed, other than surveys, to have information on the epidemiology of health conditions experienced by the elderly. All this, and particularly the conditions of widows with economic dependency warrants sustained corrective measures directed at improving the economy through appropriate investment for old age and creation of elderly healthcare infrastructure, perhaps as a part of some of the Government programmes like National Urban Health Mission. It is important to create public health awareness, particularly on risky health behaviours among the elderly.

Programmes that promote healthy lifestyles, assistive technology and supportive environment are required to foster healthy and active ageing. Priority should be given, as MIPAA also stressed, to advancing health and well-being in old age.

The elderly functionality issues necessitate the need for elderly care and support. More importantly, there is a strong socio-economic gradient for both IADL and ADL with illiterate, oldest-old and female elderly being more affected by these limitations. The magnitude of functional disability is an indicator of the huge gap that may be created between care providers and care receivers in the future.

In the background of lack of awareness about the old age saving plan, it is suggested that Government should include awareness generation in all their schemes initiated for the welfare of elderly. Most of the elderly are aware about the old age homes, but, only half of them think that it is a good idea to stay in them. Based on these findings we can foresee that the cost of care, especially health-related care, is on the rise and there is going to be a burden on the family members for providing care and support to the elderly. Hence, for tomorrow's elderly, viz., family members, who today provide care to the elderly, need to consider the self-planned ageing. There is a need to bridge the gap between the weakened family system and informal support mechanism. However, in India family is recognized as the main provider of old age support. Apart from the motivational factors, the policy should consider the family inter-generational embeddedness and support in this regards. Religious thoughts and institutions which value them might play a further role in inculcating these values in the next generation.

It is not an easy task to develop and effectively implement schemes for the elderly. They are little aware about the various schemes and facilities. The reach and implementation of these schemes should be improved. Capacities for implementing various elderly programmes vary widely among the states. At times political considerations may rule out some of the attractive options. Despite these difficulties, the Government and NGOs must work concertedly to improve the condition of the elderly where ageing is recognized as a 'triumph of society'.

Ageing issues being multi-disciplinary, no single disciplinary focus gives a holistic understanding. Therefore, approaches to understand ageing related issues from multi and inter-disciplinary perspectives need to be initiated. On account of the increasing tendency of living alone or only with the spouse, a longitudinal study specially focusing on this particular issue will be helpful. Further, focus on some of the issues like the elderly living with their married daughters or son-in-laws will definitely help in improving understanding about the living arrangements, well-being and quality of life of the elderly in India.