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Health of the Ageing in India: A Case Study of Dakshina Kannada district

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Abstract:
Ageing brings both physical ailments and social problems. The major social problem of the old people is their fine-tuning to their nearby social world in common and their immediate families in particular. This study was undertaken to understand the health status of older adults and their satisfaction of health in Dakshina Kannada district. The study is descriptive an analytical based on primary sources. The various types of physical disabilities blindness, deafness, dumbness, disability from accident, congenital disabilities, speech defects, etc., the majority, i.e. 64.3 percent of total respondents had found with no physical disability. The various types of chronic diseases are high blood pressure, arthritis, asthma, kidney disease and peptic ulcer, diabetes, heart disease, etc. It shows the presence of chronic diseases in the respondents. Out of the total respondents, the majority of respondents (56.3 percent) had been suffering from chronic diseases. The study depicts the type of the acute diseases. Majority of the respondentssuffered from joint pains followed by fever, cough, common cold, heartburn, diarrhea etc. Out of total respondents, 73.3 percent respondents weresuffering from acute diseases. The data shows the distribution of respondentsaccording to the type of medical institutions they visit during illness. Themajority of respondents (72.3 percent) preferred to visit private medicalinstitutions compared to government medical institutions (i.e. 27.7 percent)because many of public health care centres have problems like improperhygiene, overcrowding and inadequate infrastructure regarding health,availability of doctors, medicines and necessary medical equipment. Thestudy reveals that out of the total respondents, 55.1 percent respondents had been found economically independent and only 44.9 percent wereeconomically dependent. Besides, among the respondents, 35.7 percent wereentirely dependent, and 9.2 percent were partially dependent. There is anemerging need to pay more significant attention to ageing related issues andits socio-economic effects and to promote the development of policies andprogrammes for dealing with an ageing society.

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INTRODUCTION

"Health is a state of complete physical and social well-being and not merely the absence of disease", according to the world health organization, Better health is a central value of human happiness and well-being. It also makes a unique contribution to economies of scale, as healthy populations live longer more productive and save more.

Long-living consists of people ages nearing the average life span of human beings. With the impact of industrialization, globalisation

March – April 2020
ISSN: 0193-4120 Page No. 9460 - 9465

and economic liberalisation showed fast ageing of the people in the developing economy. Moreover a higher degree of physical and mental stress in the near future. Consequently the older people have remarkable experience in their socio-economic circumstances.

Growth ofageing in all over the world is at an alarming rate due to therapid decline of quality health care services. While improvement of the Quality health care can see in the increase in the older population's age. Due to rapid economic growth in the21st century may call the 'Era of Population Ageing'(Ponnuswami 2005).Population ageing involves a shift from highmortality/high fertility to low mortality/low fertility and consequently anincreased proportion of the older population to the total population (Prakash,1997).

India stands at the second position among most populous countries in the world after China. Our population is projected close to 1.37 billion in 2019, compare to 1.35 billion in 2018.Today, the world's average population age is increasing at anextraordinary rate. The number of persons worldwide ages 65 andolderestimated at 506 million as at mid-year 2008; by 2040, that quantitywill hit 1.3 billion. Thus in just over 30 years, the quantity of the olderpeople will growtwice from 7 to 14 percent of the total world population.(NIA, 2009) Older people often have age-related diseases with complexmultisystem problems and at increased risk for morbidity and mortality(Stuck AE and Iliffe, 2011).

The older Indian population is currently the second largest in theworld, the first being China with 150 million population. The 1901 censuspresented there were only 12 million people above the age of 60 years inIndia. In the next fifty years, the populace aged increased to 20 million.

Furthermore, in the next five decade, it has been increased almost three times andreached around 77 million in 2001 (Census, 2001) and 93 million in 2011(Sarasa, 2011). Thus India's demographic landscape has witnessedunprecedented changes.It predicted that the number of older people in lessdeveloped countries would increase more than 250%, compared with a 71%increase in developed countries in between 2010 and 2050 (NationalInstitute on Aging, 2011).A few important characteristics of the old population in India are noteworthy. Of the 7.5% of the population who are old, seventy five percent live in villages and nearly half are of poor socioeconomic status (SES) (Lena et al., 2009).

Ageing diminishes the volume to work and earn. The presence of theelderly makes several implications on the production function within thehousehold and thus on overall work effort that reflects in the income andproduction. (Chambers 1995) The lives of many older people are affectedmore frequently by the social and economic insecurity that accompanydemographic and development process (World Bank 1994).

In India majority of the people lives in rural areas below the poverty line and in they even don't have enough resources of finance their health expenditure. Thus, it is time to review the current health status of older people in India, in the light of Dakshina Kannada District.

OBJECTIVES OF THE STUDY

This paper has been undertaken to address the following objectives

- To study the socio-economic status of the rural elderly of Dakshina Kannada District

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March – April 2020
ISSN: 0193-4120 Page No. 9460 - 9465

- To understand the health problems faced by the rural elderly persons
- To find ability to perform physical work of elderly persons
- To know the primary sources of income of elderly persons
- To examine the satisfaction of the health status of elderly

METHODOLOGY

The study is both descriptive and analytical based on primary sources. The present study conducted in rural areas of Dakshina Kannada District.Simple random sampling selected the sample respondentswith the total 250old age respondents selected from the district selected for thepresent study. A structural interview scheduled prepared for relevantinformation collected from an older adult who belongs to the age group above 60. This study discusses the socio-economic background of theselected elderly persons living in the families in Dakshina Kannada District. It is purely a descriptive study, the primary data relates to January 2020.Percentage, standard deviation, t test, chi-square test, and probabilityanalysis used.

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TABLE NO: 01

SOCIO-PERSONAL CHARACTERISTICS OF RESPONDENTS (N=250)

Variable	Categories	Percentage
Sex	Male	76.0
	Female	24.0
Education	Illiterate	11.6
	Primary	17.2
	High school	49.6
	College	15.2
	Technical	06.4
Marital Status	Married	74.0
	Unmarried	22.0
	Widow/Widower	04.0
Family Size	Below 2	22.8
	2-3	45.6
	3-4	24.0
	4 and above	07.6
Family type	Nuclear Family	42.8
	Joint Family	52.0
	Separated	05.2
Source of Payment	Self	57.1
	Spouse	07.1
	Children	35.7
Presence of Physical Disability	Yes	35.7
	No	64.3
Presence of Chronic Disease	Yes	56.3
	No	43.7
Type of Medical Institutions visit during illness	Government	27.7
	Private	72.3
Distribution of respondents according to their economic Dependency	Fully Dependent	35.7
	Partially Dependent	09.2
	Independent	55.1
Main Sources of Income	Pension	58.2
	Property or house rent	05.5
	Employment	18.2
	From others	06.8
	No Income	11.3

Source: Primary Data

RESULTS AND DISCUSSION

The socio-economic characteristics of respondents were analysed and presented in the

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above table. From the table, it has inferred that out of 250respondents in the Dakshina Kannada District, the majority of 76.0 percent aremale and rest 24.0 percent is female respectively. Out of the 250respondents, 11.6% are illiterate, 17.2 completed their primary school level.49.6% have completed their high school education, 15.2% have finished adegree, and 6.4% have finished technical level education.

The table reveals that42.8% has a joint family system, 52.0% have anuclear family system, and 5.2% belonged separated. It reveals that majorityof respondents belonged from a nuclear family. It could be evidence that the majority of the respondents are married.They constitute 74.00 percentof the total. It was followed by unmarried andwidow/ widower, which constitute 22.00 percent and 4.00 percentrespectively.

A maximum of 45.6 percent of respondents has a family size of 2- 3members, followed by 24.0 percent having a family size of 3 - 4 members.22.8 percent have a family size of below 2; and only 7.6 percent having afamily size of 4 and above. It observed that the majority of them have afamily size of 2- 3 members. The average size of the family worked out to be2.814.

The various types of physical disability are blindness, deafness, dumbness, disability from accident, congenital disabilities, speech defects,etc. The majority, i.e. 64.3 percent of total respondents had found with nophysical disability. The various types of chronic diseases are high blood pressure, arthritis, asthma, kidney disease and peptic ulcer, diabetes, heart disease, etc.

The table shows the presence of chronic diseases in the respondents. Out ofthe total respondents, the majority of respondents (56.3percent) had beensuffering from chronic diseases.

The table depicts the type of the acute diseases. Majority of therespondents suffered from joint pains followed by fever, cough, commoncold, heartburn, diarrhea etc. Out of total respondents, 73.3percentrespondents were suffering from acute diseases. The table shows the distribution of respondents according to the typeof medical institutions they visit during illness. The majority of respondents(72.3percent) preferred to visit private medical institutions compared togovernment medical institutions (i.e. 27.7percent) because many of publichealth care centres have problems like improper hygiene, overcrowding andinadequate infrastructure regarding health, availability of doctors, medicinesand necessary medical equipment.

The table depicts the distribution of respondents according to theireconomic dependence/independence. The table reveals that out of the totalrespondents, 55.1percent respondents had been found economicallyindependent and only 44.9percent were economically dependent. Besides,among the respondents, 35.7percent were entirely dependent, and 9.2percentwere partially dependent.

The respondents were further asked to mention the primary sourcesof their income. The table depicts the distribution of respondents accordingto the primary sources of their income. It has found that 58.2percent of thetotal respondents had pension/ old age pension/ widow pension as theirprimary source of income followed by 18.2percent from employment and5.5percent from property or house rent. 6.8percent of the total respondentshad receive income from others (i.e. from relatives, neighbors etc.) and11.3percent had no source of income.

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March – April 2020
ISSN: 0193-4120 Page No. 9460 - 9465

The table shows the distribution of respondents according to thesource of the payment of medical expenses. It has observed that(57.1percent) made payment for their medicine themselves. The majority ofthe elderly were dependent on their children (35.7 percent) and spouse(7.1percent) for the payment of their health expenditure.

Null Hypothesis

There is no considerable relationship between sex and the abilityto perform physical work

TABLE NO: 02

ABILITY TO PERFORM PHYSICAL WORK SUCH AS BATHING/DRESSING (PERCENTAGE)

Ability	Males	Females
Can do without any difficulty	69.33	63.33
Can do with the difficulty	24.67	25.33
Cannot do without help	6.00	11.53
Total	**100.00**	**100.00**

Source: Computed from Primary Data

In the evident from the table that compared to men, the percentage of women who cannot perform regular tasks such as dressing, bathing and go tothe toilet, without help from others, is more. A majority of the elderly canperform their physical work without any difficulty. However, there is also asignificant percentage of elderly who reported that they could perform thesetasks with difficulty. From the above Table, it is shown that the calculatedvalue of chi-square (131) is higher than the Table value of X^2=9.488 at 4degrees of freedom with a 5% level of significance. Hence the null-hypothesis is rejected. There is a significant relationship between age andscore levels of ability to perform the physical work of elderly respondents.

TABLE NO: 03

SIGNIFICANT DIFFERENCES IN SATISFACTION OF HEALTH STATUS OF ELDERLYBASED ON SEX

Sex	N	Mean	S.D	't' value	Interpretation
Male	190	45.23	21.02	0.6391	Not significant
Female	60	14.81	6.17		

Source: Computed from Primary Data

In order to find out the significant difference in satisfaction of healthstatus among thesample elderly respondents based on gender status, the 't' value calculated, and the calculated 't' value was found to be 0.6391 which islower than the table value 1.97 which is significant at 0.05 level. Therefore, the null hypothesis is accepted and concluded that there is no significantdifference in satisfaction of the health status of elderly between sex statuses.

CONCLUSION

There is an emerging need to pay more significant attention to ageingrelated issues and its socio-economic effects and to promote thedevelopment of policies and programmes for dealing with an ageing society.Economic status of people declines in their old age. Along with economicstatus, widowhood and social condition are some other contributory factorsin health outcomes. As female life expectancy is higher among the old, theprogrammes for the aged should adequately take care of the particularproblems of women. Encouragement should be given to the family membersin the first place to take care of their aged parents and

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incentive schemewherever feasible and possible. Value education, advocacy on the rights ofthe aged has got to be given priority in all the programmes. Social securityhas to integratewith anti-poverty programmes. Economic security shouldprovide to the elderly, NGOs and social workers should come forward forthe help of elderly who do not have anyone in their family to support.

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