

LONG TERM FAMILY CARE AND WELLBEING OF ELDERLY WOMEN – CHALLENGES AND POSSIBILITIES

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ABSTRACT

Increase in average life expectancy of the population does not necessarily imply well being. Problems faced by elderly women are more critical in the backdrop of long years of widowhood and dependency. Profound changes in family structure have adversely influenced long term care, quality of life and well being of elderly. Following a cross sectional design, primary data was collected from rural Kerala to analyse major factors of elderly health, family care and subjective well being. Quantitative data collection was completed by interviewing 300 respondents using a structured interview schedule. Life course Perspective was the theoretical consideration. The study identified that subjective assessment of QOL and wellbeing of elderly women was poor. They were under the strong fear about periods of dependency and were more concerned in the sole manifestation to be “worthy” of living in the family until their last breath. Power relations within the family changed negatively for elderly widows. Traditional rules and customs of elderly care seemed vanishing from rural families due to modernisation and migration. Willingness of family members to extend quality care for their elderly gained an upper hand over their ability to provide such a care. Day to day activities, discussions, resource allocation and prioritizations reflected ‘Emotional Vacuum’.

Keywords: Elderly Women, Long Term family care, Wellbeing

INTRODUCTION

Population ageing which was initiated in the developed countries is now continuing to increase rapidly in the less developed nations also. There are 77 million elderly in India alone and over 40% of them are living below poverty line. The magnitude of such a global transition will have profound consequences for every aspect of individual, community, national and international life that are inevitable. When describing the demographic characteristics of the elderly population, it is important to take into account the changing proportion of females to males. In 2016, the percentage of elderly female population in India surpassed those of elderly male population in

the total population. Among the states, in Kerala and Tamil Nadu, one in every eight persons was at least 60 years of age. Kerala has made remarkable progress in its demographic transition. The state has achieved below replacement levels of fertility two decades ahead of the all- India target year of 2011. Among all the states in India, longevity is the highest in Kerala, for both men and women (Zachariah and Irudaya Rajan 1997). Hence the state was selected for collecting the primary data. Study adopted the definition given by Nagpal and Sell (1985), whereby quality of life is viewed as a “composite measure of physical, mental and social well being as perceived by each individual or by a group of individuals – i.e., to say happiness, satisfaction and gratification experienced in such life concerns as health, marriage, family, work, financial situation, educational opportunities, creativity, belongingness and trust in others”.

STATEMENT OF THE PROBLEM

Increase in the average life expectancy of the population does not necessarily imply a healthy living, a positive quality of life and well being. Social changes had produced many variations in the structure and functions of informal networks like family and neighbourhoods that are considered as predominant informal care giving agencies in rural societies. Growing number of older persons has also brought about dramatic changes in the structure, nature and extent of necessary supportive services and the roles played by family and society in providing these needs.

OBJECTIVE OF THE STUDY

- To examine the extent to which social changes have affected the concepts of social duties and responsibilities linked to traditional family care for aged women.

DATA COLLECTION AND ANALYSIS

Present study was substantiated using primary as well as secondary sources of data. Primary data was collected from the state of Kerala, using a well designed interview schedule. Percentile analysis and chi square tests were done to examine relationship among variables. Multistage sampling procedure was adopted and sample frame was constructed from the panchayath level list of households in each district. Giving geographical representation, 300 respondents from three districts were selected through simple random sampling. Variables used were: age, income – individual and familial, education, marital status, family type.

FINDINGS AND DISCUSSIONS

Perhaps more than any other issue in aging, healthcare has attracted attention of policy makers and policy analysts, because it has a direct bearing on the factors that decide the sense of

wellbeing for a person. Interest in health care of elderly has developed as a consequence of rising costs of healthcare and a growing awareness that elderly experience health related problems more often than younger adults. Especially in the case of elderly women, their health status is determined by their own and their family income, sanitation, living standards, living arrangements, personal hygiene, health consciousness, accessibility and utilisation of medical facilities. India's health sector faces the daunting challenges of meeting health care needs of its population and ensuring accessibility, efficiency, equity and quality of health care. Current health expenditure in India is estimated to be around Rs. 1030 billion. Even though India spends 6% of its GDP on health, the share of Govt. is less than 2%. WHO has recommended that government must spend at least 5% of GDP on the health sector. In this situation, it could be understood that the bulk of healthcare spending is from direct out-of-pocket household expenditure.

Self-perceived or self-rated health condition is one of the most commonly used measures of elderly health. In the views of Sen (2002), "Health is among the most important conditions of human life and a critically significant constituent of human capabilities which we have reason and value". The study found that perceived health status of the respondents was poor across the age groups and within the age groups. 57% respondents perceived their health as poor, 36% considered to have only moderate health condition and only 7% perceived their health as very good. A number of studies have attempted to explain why morbidity is higher in Kerala than elsewhere in India. On one hand, many of the studies attribute the phenomenon to a higher perception of illness and good health in Kerala society (Kannan et al. 1991; Gumber and Berman 1997; Michael and Singh 2003). Others argue that Kerala has the potential for higher real morbidity (Kumar 1993; Panikar and Soman 1984; Panikar 1999). Hence the socio-economic determinants of health and well being will show the detailed picture.

MARITAL STATUS

Marital status is an index of one's place in the broader social system of legal, institutional and informal access to resources. Quality of life of the elderly varies largely by their marital status. Living arrangements, life satisfaction and issues of health care receives a different dimension in the case of married elderly women when compared to that of widowed/separated/divorced elderly women.

With a lion's share of the respondents (66.7%) in the widowed group, the study confirmed that most of the elderly women had to live longer periods without their spouses. Women are generally the "kin keepers" and hence after being widowed, they do not get remarried anticipating support from their family in later periods of hardships.

Widowhood apparently increases the provisions for social support. But with changing family norms and social responsibilities, the ability rather than willingness of the support mechanisms decides the reciprocity of getting quality care. Widowhood and duration of widowhood thus showed a negative influence over the health status of the respondents. These women had been widowed at relatively younger ages and probably had faced severe emotional and social problems at very early age and this would have affected their health status negatively.

FAMILY STRUCTURE

Living arrangements of older persons emphasised the benefits and costs associated with different types of families and household conditions. There is interplay of constraints and preference. While identifying the type of family of the respondents, it is seen that 64.7% of the respondents belonged to nuclear families and 29% belonged to joint families. Extended families were reduced to a mere percentage of 5.3. This gives the picture of structural changes happening to the families of rural areas. More and more families were broken into single units of nuclear families. Many of the families consisted of only the elderly couple or the elderly living alone or the families in which the young-old couples lived with their oldest-old parent. Most probably this would be a mother. Missing generations of children who were independent and living separately or migrated to other places, produced one to three member families in rural areas. This peculiar situation compelled to consider such families also as nuclear families or “modified nuclear families” rather than considering them as extended families or modified extended families.

Among the respondents, majority lived with their son/ daughter in law. Traditionally, in a patriarchal society like India, authority and responsibility for delivering care was associated as a male role to perform. However, contradictory to the belief that this type of a living arrangement may be backed up by traditional norms and culture, 43% replied the absence of any traditional rules behind the reason. This showed that such rules are rather depreciating in rural set ups. Withering of rural family authority even in assigning elderly care to its members was visible in the opinion of the respondents. More than being guided by traditional norms and cultures, elderly care is viewed as a matter of convenience and willingness in modernised rural families.

At the same time, elderly still considered family as the main supporting agency, even though spatial proximity is not possible at all times. Being in low economic strata, widowed and frail, many of the respondents did not have financial backups in their old age. Their only hope for survival was their expectations on children.

Analysing the living arrangements of elderly women, it was observed that most of the families considered elderly as ‘housekeepers’ when their movements are temporary. Especially while migrating to urban areas, high cost of life and congested living arrangements available in the

cities made additional responsibility of elderly care unaffordable to most of the families. Inability of elderly women to adjust with constrained atmospheres in cities also holds the elderly to stay back. Hence spatial proximity of the children for elderly care is getting reduced and this adversely affected timely health care of elderly women. Special tabulation from the Kerala migration surveys also shows that in both all - India and Kerala, 2.5 percent of the elderly live alone in their respective households (Rajan and Kumar, 2003).

Furthermore, while the care of the child was direct responsibility of the parents, care of old persons was only considered as a social obligation which does not carry with it any legal sanction (Kerala Development Report, 2008). A change to this situation had been brought about by the enactment of **Maintenance and Welfare of Parents and Senior Citizens Act, 2007 by the Central Government**. Elderly abuse and mal-treatments were reported when elderly women have lost their control over family assets. Often these elderly women are not ready to approach the court of law with a complaint against their children, as their value system does not permit. There was also a felt deficit of awareness among the elderly women in rural areas regarding the legal provisions available.

POWER RELATIONS BETWEEN MEMBERS

Information about household headship has often been used as an indicator of levels of dependency for the older population. Head of the household exercises control over resources and decision making is likely to vary according to cultural norms and values. 37.3% of the respondents considered their son/daughter in law as the head of the family, while 26% considered themselves as the family head. 24 % respondents accorded headship of the family to their husbands.

Family headship is notionally related to power relationship between the members. In male dominated Indian society, women hardly head their families. However, in their old age, many women found themselves as head of their families, due to widowhood. But they always depended upon other members in family matters, due to internalised feeling of lack of financial intelligence or independence. When these women get widowed, most of the families rearrange themselves for the possession of family property rather than for the care of the elderly women. Elderly abuse and neglect were reported by many when property rights and possessions are shifted from the elderly women to their successors.

CONCLUSION

Informal support agencies do provide help for the elderly population in the rural areas; however, quality of care provided is under strain. Earlier studies also show that this type of support

required from children and other informal networks include participation from the part of the elderly women. However, the degree of support and the levels of involvements keep on changing in pace with social changes. When functions performed by family are being transferred to other institutions, like public and private care systems, appropriate modifications and adaptations have not been properly articulated.

From the analysis, it was seen that the concept of wellbeing and quality of life had different meaning for different respondents. The parameters used for assessing personal satisfaction, sense of happiness and sense of well being defined QOL of that particular individual. It consisted of the matrix created by personal experiences during the life course, social environment at present, socio-economic status, accumulated past information like customary rules, traditions etc. It makes a frame of reference within the elderly by which the subjective assessment of their QOL is being done. Shift of responsibility for care generated considerable ambiguity and uncertainty in the minds of the elderly women. At extremes, this lead to anxiety, fear for dependency, mental trauma and depression. Severity increases particularly in the expectations for support and assistance from their own kin for aged and widowed women.

The study suggests a life course approach for long term care and maintenance for elderly women. It is high time that we cease considering families in rural areas as perfect oases for care. Accepting the flaws in family care of elderly and devising new interventions are urgently warranted. Care givers perspective should also be analysed so that sensible approaches are made available for all those in need. State should take its stand for inclusive care provisions for its senior citizens through appropriate and adequate policies.

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