Living Arrangement and Treatment Seeking Behavior of the Elderly in India

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Abstract:

Elderly-hood is characterized by various chronic and multiple morbidities. There is a dearth of studies which look into economic condition and living arrangement simultaneously to explain treatment seeking among elderly. The present study explains intra-economic group differential in treatment seeking due to living arrangement using NSS 60th round (25.0 sub-round) data. MPCE and place of residence have direct influence on treatment seeking behavior of the elderly. But, with the similar level of MPCE, elderly living with spouse or with children receives treatment higher than those living alone or in old age home or with other relatives and non-relatives in both rural and urban settings. Treatment rate is significantly higher among elderly living with spouse than living alone in low MPCE households. Elderly of age 65+ years are less likely to receive treatment than those in age group 60-64 years. Elderly women are neglected in treatment seeking in low MPCE households.

Keywords: Living Arrangements, Elderly, Health, Treatment seeking.

Introduction:

Increasing elderly population is a growing concern in almost all the developing countries. The rate of growth of the elderly in developing countries is much higher than that of developed countries. In most of the developed countries major economic development and improvement in health infrastructure preceded population ageing transition. On the contrary, in developing

countries ageing transition seems to outpace economic development and health infrastructure development. Due to insufficient support system, ageing transition in the developing countries is characterized by very poor health and economic condition. India's workforce comprises nearly 90 percent in the unorganized segment, with the entire farm sector falling under the informal category, while only one-fifth of the non-farm workers are found in the organized segment (Sakthivel and Joddar, 2006). These huge bulks in the workforce do not receive any pension or social support provision from the employer or from the government.

Issues related to care giving are major concerns in ageing societies. Chronological aging brings certain life cycle changes, some of which are physically imposed, while others are culturally defined or set by statutes. Among these life cycle changes are declining health status, retirement, and declining roles and status in family and society. Thus, old age often brings with it dependency and disengagement, and everywhere, including in India, people and governments are concerned about the provision of care for the growing number and proportion of the aged. Whatever be the answer of the question whether family care is a sustainable option given various demands on the family and declining family sizes in India, family members have often been identified as the care providers of choice by individuals and governments. The fluid and complex nature of intergenerational relationships diversifies family relations and affects family support and care of aged relatives.

In India, the population under age 15 is expected to be halved from 33 percent in 2005 to 18 percent by 2050 and that of aged 65 or above is expected to be triple from 5 percent in 2005 to 15 percent by 2050. The share of working age population will continue to increase till 2040 and thereafter will follow a reverse declining order. As a consequence of this age-structural transition the elderly population of India is expected to increase at annual rate of 2.8 percent until 2050,

while the child population is expected to decline at an annual growth rate of 0.4 percent (UN; 2006).

In India, living with children, spouse and other family members during old age is a common cultural practice. Usually, the younger family members take care of the economic, social, emotional and health needs of the elderly members of the family. Living with family members also facilitates older persons with social support. On the other hand, the elderly look after their grand children and help in household chores. They also relocate their life-time savings and property to their children and make themselves dependent on family members, especially on children.

Focus and Objectives: In a country like India, where government intervention to provide Institutional care is very limited, family and relatives are the only destination for the citizens in their later ages. Very few people work in organized sector and enjoy regular pension benefit. Again, the cash received as old age pension under the National Old Age Pension Scheme (NOAPS) is neither universal nor adequate. The inattention is rationalized on two grounds. First, family values remain strong in Indian culture and sustain the traditional institution of family care for the elderly. Although it may erode over time, there is already a well-functioning, deeply rooted informal old-age security system in Indian system. Second, any formal public policy response to the needs of the elderly may undermine the existing private arrangements. For example, state transfers to the elderly may crowd out existing transfers from younger family members. So, family plays a very important role to support elderly members of the households.

Previous studies have analyzed the effect of living arrangement and economic status of the household individually to explain the health seeking behaviour of the elderly. But, within the

similar economic status, living arrangement can make a difference in treatment seeking behaviour among the elderly. It is worthy to find the factors, responsible for discrimination in treatment seeking within the similar economic group but with different living arrangements.

Specific Objectives: The specific objectives of this paper are:

1) To assess the inequalities in treatment seeking among the elderly from intra-economic groups but with different living arrangements.
2) To study the factors responsible for inter economic group discrimination in treatment seeking with different living arrangement among the elderly.

Data & Methods: Data for the present study has been extracted from the 60th round (25.0 sub-round) of National Sample Survey Organization (NSSO). It collected information on the curative aspects of the general health care system in India, utilization of health care services provided by the public and private sector and the expenditure incurred by the households for availing these services. A special section dealt with the condition and problems of the aged persons (age 60 years or more). Information was collected from 34831 elderly (17750 males and 17081 females) throughout India. The sample for analyses contains 22265 elderly from rural area and 12566 from urban area (Table 1).

Monthly per-capita consumption expenditure (MPCE) is considered as proxy indicator of household economic status. MPCE tertile has been calculated for rural and urban areas separately. Households having MPCE ` 400.00 or less and ` 667.00 or less has been considered as low MPCE household in rural and urban areas respectively. On the other hand, high MPCE

households are those households which are having MPCE more than ` 583.00 for rural areas and ` 1071.00 for urban areas.

The living arrangements among the elderly has been classified into four categories according to the expected level of availability of assistance - living alone and not as an inmate of old age home, living with spouse, living without spouse but with children, and others. Other includes those living alone as an inmate of old age home, living with other relatives and non-relatives. Treatment rate is defined as,

$$\text{Treatment Rate} = \frac{\text{Number of ill persons sought treatment from a specific category}}{\text{Total number of persons ill from that particular category}} * 100$$

Bi-variate Analysis: Economic Status and Treatment seeking among Elderly

Among all the elderly included in the sample, 37 percent from low MPCE household, 39 percent from medium MPCE household and 44 percent from high MPCE household reported any ailment during the date of surveys. Treatment rate of the elderly from low MPCE households was 64 percent, 76 percent from medium and 83 percent from high MPCE households (Table 1). On the whole, treatment rate among the elderly increased with economic conditions of the households.

Instead of dealing with differentials in treatment seeking among elderly from households with different economic status, the present paper focuses on the treatment seeking behaviour of the elderly with different living arrangements but within the same MPCE tertile. This presents an opportunity to find out whether with similar MPCE level, living arrangement makes any difference in treatment seeking among the elderly. In rural as well as urban areas treatment

seeking is higher among high MPCE households (79 percent in rural and 90 percent in urban) and lower among the low MPCE households (59 percent in rural and 72 percent in urban). Two-fifth of the elderly from rural area and half of the elderly from urban area who live alone and belonging to low MPCE households do not receive treatment. Irrespective of economic status of the household, treatment seeking is highest among the elderly who reside with spouse and with children in the absence of spouse and lowest among those who live alone or with other relatives or non-relatives.

Multivariate Analysis: Factors affecting treatment seeking among elderly by household MPCE tertile

Low MPCE Households

Living arrangement plays an important role in explaining the treatment seeking behaviour of the elderly from low MPCE households. Elderly, living with spouse (spouse only or spouse with children) are 69 percent more likely to receive treatment than those living alone. Again, those who live with children only are 29 percent less likely to avail treatment. In low MPCE households, living arrangement has a significant positive effect on treatment seeking among the elderly. Elderly women are 14 percent less likely to avail treatment than their male counterparts. In low as well as high MPCE households, religion shows an impact on treatment seeking but does not show effect for medium MPCE households. Age, place of residence, religion and social group (i.e. caste) are significant predictors of the treatment seeking behaviour among the elderly from lower MPCE households. Elderly who are economically fully dependents on others are 21 percent less likely to receive treatment than the independent one.

Medium MPCE households

Elderly living without spouse but with children and those living with others are less likely to avail treatment than those who live alone in medium MPCE households. Age, place of residence and caste has statistically significant impact on treatment seeking among the elderly from this economic stratum. Elderly from more advanced age groups are less likely to receive treatment than those from 60-64 years age group. Urban elderly from medium MPCE households are two times more likely to avail treatment than their rural counterpart. Sex, religion and economic dependency are not significant contributors in explaining the treatment seeking behavior in these households.

High MPCE households

Elderly, living without spouse but with children are 28 percent less likely to get treatment than those living alone. Age, place of residence, religion and caste are significant factors explaining treatment seeking behaviour among elderly in high MPCE households. In high MPCE households, Muslim elderly are about two times more likely to avail treatment than those belong to Hindu religion. Gender and economic dependency are not significant predictors of treatment seeking.

Summary:

Overall treatment rate is higher in urban area compared to rural area among elderly from all three MPCE categories. Treatment rate is lowest among the low MPCE households and highest among high MPCE households in both rural as well as urban area. Treatment rate is highest among those elderly who live with the spouse only or with spouse and children, followed by those who live with children only.

Utilization of health care is significantly higher among elderly living with spouse than those living alone in low MPCE households. Irrespective of economic status, treatment seeking is

relatively lower among those living with children than living alone. Treatment seeking is significantly lower among elderly in older ages than those from 60-64 years age group. Likelihood of treatment seeking among elderly from scheduled tribe households is less compared to other caste groups.

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Table 1: Prevalence of any ailment and treatment rate among elderly from different MPCE tertile in India, 2004.

	MPCE Tertile	Percentage	N
Any Ailment	Low	37.3	11901
	Medium	39.1	11247
	High	44.2	11554
	Total	**40.2**	**34702**
Treatment Rate	Low	63.7	4393
	Medium	75.6	4348
	High	83.3	5075
	Total	**74.6**	**13816**

Table 2: Treatment rate among rural elderly by living arrangements within similar MPCE category, India, 2004.

MPCE	Living Arrangement	Treatment rate	N

Low	Alone and not as an inmate of old age	40.3	72
	With spouse	62.2	1514
	Without spouse but with children	56.2	1009
	Others	45.7	151
	Over all	**58.5***	**2746**
Medium	Alone and not as an inmate of old age	62.7	83
	With spouse	73.9	1485
	Without spouse but with children	67.9	944
	Others	57.7	130
	Over all	**70.6***	**2642**
High	Alone and not as an inmate of old age	68.5	181
	With spouse	80.7	1738
	Without spouse but with children	77.9	1018
	Others	77.6	134
	Over all	**78.9***	**3071**

***** significant at 5 percent level

Table 3: Treatment rate among urban elderly by living arrangements within similar MPCE category, India, 2004.

MPCE	Living Arrangement	Treatment rate	N
Low	Alone and not as an inmate of old age	50.0	48

	With spouse	74.3	848
	Without spouse but with children	71.4	639
	Others	72.3	112
	Over all	**72.3***	**1647**
Medium	Alone and not as an inmate of old age	72.3	65
	With spouse	86.1	915
	Without spouse but with children	80.4	639
	Others	80.4	87
	Over all	**83.2***	**1706**
High	Alone and not as an inmate of old age	81.9	72
	With spouse	92.9	1206
	Without spouse but with children	86.5	630
	Others	86.5	96
	Over all	**90.2***	**2004**

***** significant at 5 percent level

Table 4: Logistic regression analyses of treatment seeking among elderly from different MPCE households in India, 2004.

	Odds ratio of treatment seeking		
Predictors	**Model 1**	**Model 2**	**Model 3**

	(N=4391)	(N=4346)	(N=5072)
Elderly from low MPCE household and			
Living alone and not as an inmate of old age®			
With spouse	1.69*		
Without spouse but with children	0.71*		
Others	0.80		
Elderly from medium MPCE household and			
Alone and not as an inmate of old age®			
With spouse		1.00	
Without spouse but with children		0.57*	
Others		0.71*	
Elderly from high MPCE household and			
Alone and not as an inmate of old age®			
With spouse			1.42
Without spouse but with children			0.72**
Others			0.91
Age groups *60-64 years ®*			
65-69 years	0.69*	0.54*	0.65*
70-74 years	0.76*	0.64*	0.59*
75-79 years	0.72*	0.61*	0.65*
80 years or above	0.86	0.65*	0.71*
Place of residence *Rural ®*			
Urban	1.79*	2.02*	2.14*
Sex *Male ®*			
Female	0.86*	0.88	1.00

Religion *Hinduism* ®			
Islam	1.55**	1.23	1.81*
Christianity	1.73*	1.14	1.10
Others	1.44	1.31	1.54**
Social groups *Scheduled Tribe* ®			
Scheduled caste	1.80*	2.36*	3.22*
OBC	1.75*	1.60*	1.56*
Others	1.51*	1.35*	1.47*
Economic Dependency *Not dependent on others* ®			
Partially dependent on others	1.05	1.19**	0.99
Fully dependent on others	0.79*	0.93	1.18
-2 log likelihood values	**5566.98**	**4636.18**	**4316.21**

***** significant at 5 percent level**,** ****** significant at 10 percent level