Building knowledge base on
Population Ageing in India

Series II, Working Paper-4

Health status, Care Giving and Receiving among Elderly with Migrant Children

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UNFPA

Editor's Note

Dear readers,

In most countries of the world, including India, population ageing is likely to become a serious policy and programmatic issue in the coming decades. UNFPA in collaboration with the Institute of Social and Economic Change, Bangalore, the Institute of Economic Growth, Delhi and Tata Institute of Social Science, Mumbai has launched a major research project to build a knowledge base on population ageing in India (BKPAI). The study focuses on social, economic, health and psychological aspects of elderly. This peer reviewed publication is second in the series of working papers based on the data gathered from seven Indian states. We are sure that the findings of this publication will help in generating a healthy debate and policy response amongst a wider cross-section of scholars, professionals, policy makers and civil society.

Editorial Team

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Disclaimer

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Health status, Care Giving and Receiving among Elderly with Migrant Children

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ABSTRACT

The paper explores the health status and management of care among elderly persons with migrant children by adopting a mixed methodology: in- depth interviews (37), qualitative GIS, support network mapping and a survey among the elderly (477). The mixed methodology approach provides a unique perspective to understand the perceived impact of children's migration on the health of the elderly. In the survey, both men and women who reported that their health is poor, is getting worse or is poor compared to their age mates, in contrast with those who felt that their health is good, are comparatively more among the eldest of the elderly, women, widowed and the less educated. Around 18 percent fell sick during the previous 15 days and 12 percent had to be hospitalised during the preceding year. This was more among women, widows and the less educated. Common ailments experienced were respiratory and nervous or musculoskeletal problems. The elderly performed both care giving and receiving roles. The care giving roles for the elderly included delivery and new born care, which was also one of the motives for migration, both within and outside India. Care giving roles for the elderly also extended towards their spouse, siblings and extended family who were ill or required long-term care. The care received by the elderly was both from kin and non-kin sources. Through the qualitative interviews, we see a movement from kin to non-kin care givers for the elderly. Elderly perceived that the migration of their children was inevitable, and women both in the interviews and in the survey reported a negative effect on their health. Through this paper we can conclude that health care access, costs and perception on health are differently experienced by elderly men and women living in migrant households.

CONTENTS

Introduction

The increasing life expectancy and availability of better medical facilities have resulted in the elderly living longer but in many cases requiring care to manage day-to-day activities. The lowering of fertility in certain states in India and among middle classes has led to nuclear families where adult children and the aged spouse are the principal care givers (Bhat and Dhruvarajan, 2001). Bloom et al (2010) observe that increased longevity has meant that taking care of the elderly has become more expensive due to chronic health conditions, and because of reduced childbearing the inter-generational care network has further reduced. With migration of adult children, the tasks of care giving are left to the aged spouse or to hired non-kin caregivers. Studies carried out by NSSO (2010) as well as by Rajan (2010 & 2011) show increasing trends in migration in recent years. Currently, people aged 60 years and older in India constitute over 7 percent of the total population (1.21 billion) and is projected to triple in the next four decades, from 92 million to 316 million (James, 2011). In the past, the family has been the major source of support in later life. However, increased mobility may challenge the continued reliance on family in the future. Kleinman (2010) defines care giving as the day-to-day provision of material and emotional support necessary to enable life and alleviate suffering in particular social institutions. In the Indian context, elderly care is expected from adult children. The elderly see this as part of the care cycle where they now see their role as care receivers. Jamuna (2013) finds that in the Indian ethos, elder care was generally seen as a duty of the adult children, which meant that the primary care giver was usually the daughter-in-law. Armstrong and Armstrong (2001) point out that to a large extent, various kinds of care giving activities are performed by women and that such activities in the domestic sphere are often unpaid. The cultural norms and values that are passed on through generations are changing, and this gets reflected in the care giving and receiving roles performed both within and outside the family (Bengston et al , 1997).

With a specific focus on international migration in this study, we apply the concept of **'global householding'** which according to Douglass (2006; 2007) includes: marriage, child bearing and rearing, adoption, hiring foreign domestic helpers and care giving of elderly. These dimensions are the new motives for transnational movements and linkages among people. The linked lives in global householding include: 1) for marriage: Indian spouses in foreign countries, parents/siblings arranging marriages in India; 2) for child care: grandparents providing culturally appropriate care; 3) for elderly care: traditionally the cultural duty of children but now more non-kin helpers in India. Through these householding tasks and linkages emerges the global Indian household. For the project in Dharwad, the primary focus is on the care for the elderly. However related to the global householding, the elderly living in migrant households will be asked their migration history between the homes of their sons/daughters and for what reasons they moved.

This study, using a mixed methodology approach, aims to find out how elderly perceive the impact of adult children's migration on their health, well-being and care giving. By applying a theoretical framework which incorporates migration, linked lives from the life course approach and global householding, a study was conducted in Dharwad district, Karnataka, India, to understand the management of care among dispersed household members. The study was done as a part of the research project funded by UNFPA "Building knowledge base on ageing in India". Elderly persons whose children have migrated outside the state or country formed

the sample, and issues related to health and care giving and receiving have been analysed here. Two groups of elderly - those living with children and those living on their own - are examined here by taking into account both internal and international migration of adult children.

Objectives:

- To explore the reported and perceived health status of the elderly with migrant children
- To understand how elderly living in migrant households manage care giving and receiving
- To understand the perceived impact of migration on the health of the elderly

Methodology and sample size

The study was conducted in Dharwad district of Karnataka, India using a mixed methodology; the qualitative study (37 in-depth interviews) was followed by the individual survey interviews of elderly persons. The data gathered from in-depth interviews and support network mapping fed into the formulation of the survey instrument. It was proposed to cover around 300 households having at least one elderly person so as to interview 600 individuals. The focus of the quantitative survey was on the elderly, both male (60+) and female (55+), staying in urban Dharwad whose children have migrated outside. Hence, the purposive sampling method was used after complete house listing of the area while selecting such households. The field data collection was done between 30th July and 4th September 2012.

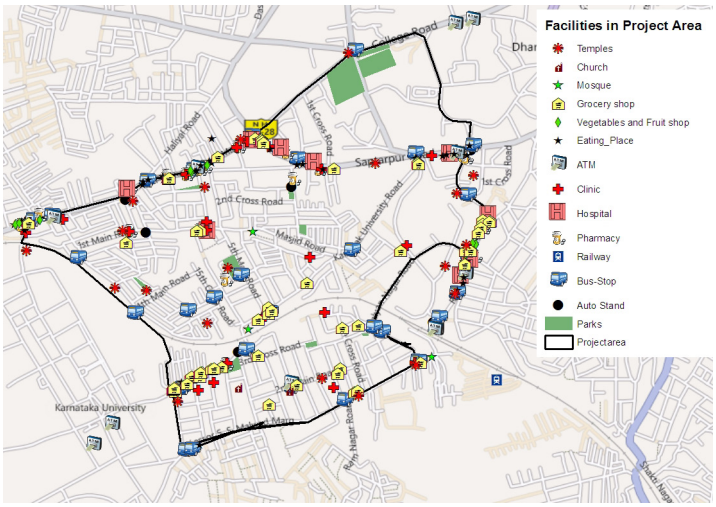
Qualitative methods

Selection of the participants: During the mapping and listing of the study area, the pockets where the elderly are residing were identified. Eligible households were then identified and listed through personal visits and appointments sought for the in-depth interviews. We used a snow-ball technique for identifying participants. In the first instance, we asked the participants themselves, then the association president, secretary and other concerned persons in the area. In addition to this, the team also approached the small shops in the particular areas. The final list was prepared and discussed with the project team. During the field work, non-listed households were also interviewed because of non-co-operation from the listed households. At the end of each interview, the interviewee was asked to mention any person they know or their friends in the selected area. For completing one eligible interview, the team approached at least 4-6 households. Some households refused to be interviewed or were not interested as they did not trust the researchers. Hence, each interviewer was given a badge and a letter of reference about the study. Given all the constraints, we could still interview 37 individuals in 19 households.

In-depth Interviews: Participants were asked about what meaning they give to the situation of living away from their children and how this shapes their social ageing process. The interviews explored the various domains where elderly perceive the absence of their children. The interviews ranged from 30 to 90 minutes. They were conducted in Kannada by trained interviewers. Each household was visited by one male and one female interviewer. Where possible, the interviews were held at the same time in separate rooms, and in other cases the interviewers made appointments to do the interview at a later point. The main sections in the interview guide included: daily life activities in the neighbourhood, economic situation, living arrangements, information on migrant children and their family, marriage of children, care giving during child birth, provision of elderly care, perceptions on the impact of their children's migration, autonomy and decision-making, health

problems and treatment and comparison with elderly having different living arrangements. The interviews also focused on the manner in which elderly manage care giving and receiving through both kin and non-kin members through the exchange of both material and non-material resources. We conducted 37 in-depth interviews with elderly couples, widows and widowers. Participants in this study include both the elderly co-residing with kin and the elderly residing on their own. **Qualitative GIS and support network mapping:** To better understand the spatial and cultural context of the neighbourhoods in which the elderly were residing, the project team undertook mapping of the facilities in these areas. Figure 1.1 shows the range of facilities in these areas. We first delineated the areas, and then four members of the project team on their two-wheelers visited these neighbourhoods and made a list of all the available facilities. These facilities were then tagged on a Google map which was further processed to create a file format which could be then imported into a GIS program. The maps presented in the chapter are outputs from this process. The maps provide us the context in which the elderly live. During the interviews, we asked the elderly where they would buy their groceries or where they go for walking which we can now map on these areas to look at the use of the neighbourhoods. To better understand the support the elderly received for their day-to-day activities and the people they considered crucial to provide emergency help, a set of questions and a table were included with the interview. The visualization of the networks will shed light on the care received by them and how much of this care is paid for and how much is dependent on social capital.

Figure 1: Facilities listed and mapped in the project area



Ethical considerations: The interviewers were trained to ask for consent. Before the interview could start, the interviewer explained the nature of the project, assured the elderly that the information would remain anonymous and sought their consent to digitally record the information. During the interview, if the elderly person was seen to experience any physical discomfort or turned emotional, then the interviewer halted the recording and offered to do the interview later. The interviews were transcribed and translated by the project staff. All identifying information was taken out of the transcripts. Each transcript was assigned a code and linked personal information was stored safely with the principal investigators.

Analysis of Qualitative Data: The analysis has followed the principles of grounded theory and derived a range of codes, categories and themes. The interview transcriptions were analysed using qualitative data software Atlas-ti. The first cycle of coding involved identifying both inductive and deductive codes, and in the second cycle the codes were grouped together in code families.

Quantitative methodology

Totally 3 areas were selected for the study, and all the households coming under these 3 areas were listed. While listing the households, details were sought on the head of the household, total persons staying in that household, individuals above the age of 60 years in the HH, households with any of the sons staying at Bangalore/outside Karnataka and households with any children staying outside India. Further, all those households having at least one elderly person who has at least one son staying at Bangalore/outside Karnataka or at least one son/daughter staying outside India are considered here as eligible households for further household as well as individual interviews.

On the whole, 3,867 households were listed in the study area comprising 14,934 usual residents which make the size of a household 3.9. Among the listed households, there were a total of 2,425 elderly, and hence around 16 per cent of the population was elderly in the study area. Further, 618 households were identified as eligible households as per the above mentioned criteria. The total number of eligible households to be interviewed was targeted at 300 households with an equal number of each of the above mentioned categories (75 each). As we could not get this minimum required number of households among the category of 'International with children', only 57 households were interviewed in this category and the remaining number was replaced with other categories. On the whole, 324 households were interviewed.

Table 1: Details on House listing and Households interviewed

Households Listed	3867
Population among listed HHs	14934
HH size	3.9
Elderly population among listed HHs	2425
Proportion of elderly population to the total population	16.2
Eligible HHs (elderly persons with migrated child)	618
Households selected for interview	324

Table 2: Coverage of elderly persons for individual interviews by sex

	Combined		Male		Female	
	Number	Percent	Number	Percent	Number	Percent
Elderly persons listed	556		276		280	
Elderly persons interviewed	477	85.8	233	84.4	244	87.1
Type of child's migration						
Son-Bangalore	161	33.8	81	34.8	80	32.8
Son-Outside state within India	97	20.3	47	20.2	50	20.5
Son-Outside India	156	32.7	75	32.2	81	33.2
Daughter- Outside India	63	13.2	30	12.9	33	13.5
Living arrangement						
Internal with children	110	23.1	51	21.9	59	24.2
Internal without children	151	31.7	78	33.5	73	29.9
International with children	80	16.8	38	16.3	42	17.2
International without children	136	28.5	66	28.3	70	28.7

Among the interviewed households, a total of 556 elderly persons were identified as eligible (276 male and 280 female) of which 477 individual interviews were completed (233 men and 244 women) which makes the coverage rate 86 per cent for all, with a slightly higher rate among women (87 per cent) than men (84 percent). If we analyse the distribution of individuals interviewed by household type, 23 percent comprised those having Internal migrated sons and staying with other children, 32 percent those having Internal without children, 17 percent those having International migrated children and staying with children and 29 percent those having International migrated children but staying without any children.

Background of households

All the interviewed households were asked about selected background characteristics like ownership of a house or agricultural land, primary source of income, annual income and size of the household. The details are presented in Table 3. Among 324 interviewed households, as high as 88 percent were living in their own house, and apart from the house in which they were staying, 24 percent reported that they own another house somewhere else. Around 28 percent of the households had some agricultural land.

Table 3: Percent distribution of households interviewed by selected socio economic characteristics

	Percent
Number of households	324
Prop. Own a House	88.3
Prop. Having Agri. Land	28.4
Primary source of income	
Cultivation	2.2
Agriculture/Non-Agri. coolie	1.2
Business related	4.9
Salaried Employed	11.7
Self employed	2.5
Pension	75.6
Other	1.9
Mean annual income (INR)	272,366
Mean number of persons in the HH	
All	3.1
Male	1.4
Female	1.6

As the households covered in this study are that of elderly persons in an urban area, as high as 76 percent reported that their primary source of income was pension; 12 percent of them had salaried employment and 5 percent of the households had business as their primary source of income. Mean annual income of the interviewed households was Rs. 2,72,366. The average household size of the interviewed households was 3.1 with 1.4 males and 1.5 females.

Background of elderly persons

Among the interviewed 477 elderly persons, 233 were men and 244 women. Fifty percent of the individuals were in the age group 60-69, 29 percent in the age group 70-79 and

Table 4: Percent distribution of elderly persons by background characteristics and sex

Background characteristics	Combined	Male	Female
Total	477	233	244
Age			
55-59	13.6	0.0	26.2
60-69	49.7	52.8	46.7
70-79	29.4	36.1	23.0
80+	7.3	10.7	4.1
Marital Status			
Currently married	87.0	94.0	80.3
Widowed	13.0	6.0	19.7
Education			
Never gone to school	1.5	0.0	2.9
Less than high school	14.3	4.3	23.8
High school	22.0	13.3	30.3
PUC	9.4	7.3	11.5

Background characteristics	Combined	Male	Female
Graduation	28.1	33.9	22.5
Post-graduation	13.0	18.9	7.4
Ph.D	5.7	11.2	0.4
Professional courses	5.9	10.7	1.2
Main occupation			
Business related	1.9	3.0	0.8
Agr/Non Agri coolie	0.8	1.3	0.4
Retired	49.5	88.8	11.9
Salaried employment/self employed	2.3	3.0	1.6
Household/No work	45.3	3.4	85.2
Sources of income			
Salary/wages	1.7	2.1	1.2
Employer's pension	49.7	80.7	20.1
Social/Mutual fund pension	7.5	10.3	4.9
Rental income	6.7	7.7	5.7
Business income	2.3	3.9	0.8
Agri/Farm income	7.3	13.3	1.6
Returns from Shares/Dividends/Bonds	1.5	3.0	0.0
Remittances	4.4	5.6	3.3
Interest on savings	2.3	2.1	2.5
No income	34.8	1.3	66.8

another 7 percent in the age group 80+ (Table 4). On the whole, 87 percent of the individuals were married and the remaining 13 percent widowed. The percentage of widowed is higher among women (20 percent) than among men (6 percent). Only 2 percent of the elderly persons had never gone to school and all of them were women. As high as 53 percent of the elderly had at least graduation, and around 6 percent of men and women each were Ph.D or professional degree holders. Seventy-five percent of the male elderly persons were at least graduates with 11 percent having Ph.D and professional degrees. Though the percentage of women having Ph.D or professional degrees is comparatively less, as high as 32 percent of the women had at least graduation including 7 percent with post graduation.

Further, 50 percent of the elderly were retired and another 45 percent had only household work or no work. Among men, as high as 89 percent reported that they retired from the services and currently not doing any work. Among women, 12 percent had retired from the services and 85 percent of them were housewives. Only 8 percent of the men are found to be engaged in income generating activities like business, labour work, salaried employment or self-employment. This clearly shows that usually the elderly population - even the men among the interviewed households - do not have to work much at the age of 60+.

Regarding sources of individual income, 81 percent of the male elderly reported that they are getting employer's pension, which is only 20 percent among women. Further, 67 percent of the female elderly did not have any individual income. Next to employer's pension, other important sources of individual income were social/ mutual fund pension (8 percent), rental income and agricultural income (7 percent each).

Hence, a majority of the households belonged to a higher socio-economic status, depending mainly on pension for their day-to-day expenses. Further, the background characteristics of elderly persons clearly indicate that almost all the interviewed persons were educated with quite a high proportion having higher education like post-graduation, PhD or professional courses like M.B.B.S or engineering. Though more male elderly had higher education compared to their female counterparts, the educational level of the female elderly was also quite high.

Health status and access to facilities

To understand the health condition of the elderly parents, 4 types of analyses have been done here. First, they were asked to rate their present health condition, compared with that of previous year, and compared to the health condition of their age mates. The responses given by them are presented in Table 5 by various background characteristics. Around 30 percent of the individuals had an opinion, rating their present health condition as very good or excellent. Fifty-five percent said that it is good. The proportion of individuals feeling that their health condition is better is comparatively more among men than among women. More than 20 percent of the women had a feeling that their health condition is fair or poor.

Compared with their own health condition of previous year, 45 percent felt that it is same and 30 percent said it has deteriorated now compared to that of last year. When asked to compare their health condition with that of their age mates, nearly two-thirds felt that they are better than their friends. When the responses of the individuals are analyzed according to background characteristics, it is observed that the eldest of the elderly, widowed, and the less educated women have a feeling that their health is poor. Further, elderly parents staying without children rated their own health condition as better, compared to those who stay with other children.

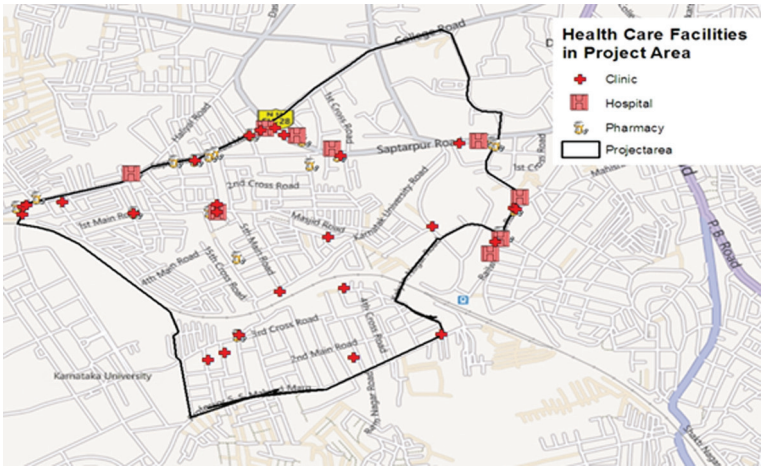
To assess the health condition of elderly persons, a second set of questions concentrated on recent ailments experienced by them. These questions asked the elderly whether they fell sick during the last 15 days, and if so, what type of ailment and treatment they had (Table 6 and 7). Among the interviewed elderly persons, 18 percent fell sick during the previous 15 days, and it was again comparatively more among women, the widowed, the eldest of the elderly, the less educated and those who stay with children than with their counterparts. More common ailments experienced by the elderly were respiratory problems and nervous/musculoskeletal related problems. More women and those having internationally migrated children and staying without children reported experiencing nervous/musculoskeletal problems in the recent past.

Table 5: Perception of elderly persons about their own health status, present health compared to previous year and own health compared to age mates according to selected background characteristics

Particulars	Number	Perception about own health			Health compared to prev. year			Health compared to age mates			
		Excellent/ Very good	Good	Fair/ Poor	Better	Same	Worse	Better	Same	Worse	DK
All	477	30.2	54.9	14.9	26.0	44.2	29.8	61.4	26.6	9.9	2.1
Age											
55-59	64	21.9	60.9	17.2	25.0	45.3	29.7	60.9	25.0	9.4	4.7
60-69	238	34.0	52.5	13.4	28.6	46.6	24.8	62.2	29.4	7.6	0.8
70-79	140	28.6	57.1	14.3	24.3	40.7	35.0	62.1	23.6	12.1	2.1
80+	35	25.7	51.4	22.9	17.1	40.0	42.9	54.3	22.9	17.1	5.7
Sex											
Male	233	44.6	47.2	8.2	23.6	52.4	24.0	61.4	27.5	9.4	1.7
Female	244	16.4	62.3	21.3	28.3	36.5	35.2	61.5	25.8	10.2	2.5
Marital status											
Currently married	415	31.3	55.9	12.8	27.0	44.8	28.2	61.7	28.0	8.2	2.2
Widowed	62	22.6	48.4	29.0	19.4	40.3	40.3	59.7	17.7	21.0	1.6
Education											
Less than high school	75	16.0	60.0	24.0	22.7	36.0	41.3	68.0	18.7	12.0	1.3
High school	105	26.7	52.4	21.0	26.7	36.2	37.1	57.1	26.7	15.2	1.0
PUC/Graduation	179	29.6	59.2	11.2	26.3	47.5	26.3	58.1	31.8	7.8	2.2
PG/Ph.D/Professional	118	43.2	47.5	9.3	27.1	51.7	21.2	66.1	23.7	6.8	3.4
Economic self sufficiency											

No income	166	14.5	66.3	19.3	27.7	36.7	35.5	61.4	26.5	10.8	1.2
Not sufficient	5	20.0	40.0	40.0	0.0	40.0	60.0	20.0	60.0	20.0	0.0
Partially sufficient	58	27.6	51.7	20.7	22.4	53.4	24.1	56.9	25.9	12.1	5.2
Fully sufficient	248	41.5	48.4	10.1	26.2	47.2	26.6	63.3	26.2	8.5	2.0
Having own house											
Own house	421	29.9	55.8	14.3	25.9	44.9	29.2	61.3	27.6	9.0	2.1
No own house	56	32.1	48.2	19.6	26.8	39.3	33.9	62.5	19.6	16.1	1.8
Loans or obligations											
No loans	434	28.8	56.2	15.0	26.5	43.8	29.7	61.1	26.5	10.1	2.3
Having a loan	43	44.2	41.9	14.0	20.9	48.8	30.2	65.1	27.9	7.0	0.0
Living arrangement and type of migration											
Internal with children	110	23.6	61.8	14.5	24.5	40.0	35.5	61.8	24.5	12.7	0.9
Internal without children	151	31.8	53.0	15.2	24.5	47.7	27.8	57.0	31.8	8.6	2.6
International with children	80	27.5	56.3	16.3	30.0	32.5	37.5	65.0	25.0	7.5	2.5
International without children	136	35.3	50.7	14.0	26.5	50.7	22.8	64.0	23.5	10.3	2.2
Type of migration											
Bangalore	162	28.4	56.2	15.4	26.5	43.2	30.2	64.2	25.9	9.3	0.6
Outside state within India	96	29.2	58.3	12.5	20.8	47.9	31.3	51.0	33.3	11.5	4.2
Outside India	219	32.0	52.5	15.5	27.9	43.4	28.8	63.9	24.2	9.6	2.3

Figure 2: Health care facilities in the project area.



In figure 2, we see the availability of health care facilities for the elderly. The facilities ranged from clinics, hospitals, and pharmacies. As seen in figure 2, within the project area there are many clinics and some major hospitals. Depending on the nature of illness, the elderly decided which doctor to consult. They preferred to consult the doctors that they knew within Dharwad before going to other doctors or specialists. The case below illustrates the route to health care access as reported by the elderly. In this case, we also see the change in the route of moving from a hospital that was in the project area to a more specialist hospital in Hubli and then finally to Bangalore where his son is living.

I: Do you go daily to Sharada School?

P: Yes. It is near and daily for one or the other reason I was going once or twice. But now as I got stroke in the month of September, I have stopped going.

I: Where did you consult? Which hospital?

P: Here only. I have showed in Spandana Hospital. My daughter and son-in-law are both working as doctors here only. First night we went there, next we stayed there for one week and then we went to Hubli to a scan centre and did the scanning and then consulted Dr. Dugani and got admitted for one week. Then my son took me to Bangalore and there we stayed for 15 days

Among those who experienced health problem during the previous 15 days, 85 percent had sought treatment, and the proportion seeking treatment is comparatively more among men and

Table 6: Percent of elderly persons who reported falling sick during previous 15 days and got hospitalized during previous one year by selected background characteristics

	Number	Percent sick during previous 15 days	% hospitalized during previous one year
All	477	18.2	11.9
Age			
55-59	64	17.2	7.8
60-69	238	13.0	9.7
70-79	140	23.6	15.7
80+	35	34.3	20.0
Sex			
Male	233	15.5	7.7
Female	244	20.9	16.0
Marital status			
Currently married	415	16.9	10.8
Widowed	62	27.4	19.4
Education			
Less than high school	75	25.3	17.3
High school	105	21.9	9.5
PUC/Graduation	179	19.0	15.1
PG/Ph.D/Professional	118	9.3	5.9
Economic self sufficiency			
No income	166	20.5	16.3
Not sufficient	5	40.0	0.0
Partially sufficient	58	24.1	10.3
Fully sufficient	248	14.9	9.7
Having own house			
Own house	421	17.6	11.6
No own house	56	23.2	14.3
Loans or obligations			
No loans	434	17.7	12.9
Having a loan	43	23.3	2.3
Living arrangement & type of migration			
Internal with children	110	23.6	13.6
Internal without children	151	17.2	13.9
International with children	80	18.8	11.3
International without children	136	14.7	8.8
Type of migration			
Bangalore	162	17.9	11.7
Outside state within India	96	24.0	16.7
Outside India	219	16.0	10.0

Table 7: Percent distribution of elderly persons by health problems experienced during last 15 days and details on treatment sought according to sex and type of household

	All	Sex		HH Type			
		Male	Female	Internal with children	Internal without children	International with children	International without children
Number	477	233	244	110	151	80	136
Prop. Sick during last 15 days	18.2	15.5	20.9	23.6	17.2	18.8	14.7
Type of ailment							
Respiratory problem	6.9	7.3	6.6	10.9	6.6	8.8	2.9
Nervous/Musculoskeletal related	5.5	3.0	7.8	6.4	4.0	5.0	6.6
Digestive system related	2.3	2.1	2.5	2.7	2.6	0.0	2.9
Diabetes problem	0.8	0.4	1.2	0.0	0.7	2.5	0.7
Low/high BP	0.6	0.4	0.8	0.9	0.0	2.5	0.0
Kidney problem	0.6	0.4	0.8	0.0	0.7	0.0	1.5
Other	1.3	1.3	1.2	2.7	2.0	0.0	0.0
Number	87	36	51	26	26	15	20
Prop. Received treatment	85.1	97.2	76.5	92.3	92.3	86.7	65.0
Person accompanied							
Number	74	35	39	24	24	13	13
None	24.3	31.4	17.9	16.7	25.0	38.5	23.1
Spouse	40.5	48.6	33.3	29.2	41.7	38.5	61.5
Son	13.5	8.6	17.9	25.0	4.2	15.4	7.7
Daughter	10.8	5.7	15.4	16.7	12.5	0.0	7.7
Other	10.8	5.7	15.4	12.5	16.7	7.7	0.0
Amount spent for treatment (Rs)-Mean	1277	1238	1311	1615	1213	1079	965
Person paid the amount for treatment							
Self	48.6	82.9	17.9	37.5	58.3	61.5	38.5
Spouse	27.0	0.0	51.3	20.8	29.2	7.7	53.8
Son	21.6	17.1	25.6	33.3	12.5	30.8	7.7
Daughter	1.4	0.0	2.6	4.2	0.0	0.0	0.0
Son/Daughter in law	1.4	0.0	2.6	4.2	0.0	0.0	0.0
Reason for not taking treatment							
Total	13	1	12	2	2	2	7
Lack of faith	15.4	0.0	16.7	0.0	0.0	0.0	28.6
Ailment not serious	84.6	100.0	83.3	100.0	100.0	100.0	71.4

Table 8: Percent distribution of elderly persons by hospitalization details during last 1 year according to sex and type of household

	All	Sex		HH Type			
		Male	Female	Internal with children	Internal without children	International with children	International without children
Number	477	233	244	110	151	80	136
Prop. Exp. Major health problem during last one year	11.9	7.7	16.0	13.6	13.9	11.3	8.8
Nature of ailment							
Nervous/Musculoskeletal related	2.3	1.7	2.9	1.8	2.6	1.3	2.9
Heart problem	1.7	1.3	2.0	2.7	2.0	2.5	0.0
Eye problems	1.5	1.3	1.6	0.0	1.3	0.0	3.7
Digestive system related	1.5	1.3	1.6	2.7	2.0	1.3	0.0
Respiratory problem	1.3	0.4	2.0	2.7	0.7	1.3	0.7
Kidney problem	1.0	0.4	1.6	0.0	1.3	2.5	0.7
Low/high BP	0.6	0.0	1.2	0.9	1.3	0.0	0.0
Diabetes problem	0.4	0.0	0.8	0.0	0.7	1.3	0.0
Other	1.5	1.3	1.6	1.8	2.0	1.3	0.7
Person stayed in the hospital							
Number	57	18	39	15	21	9	12
No one	1.8	5.6	0.0	0.0	4.8	0.0	0.0
Spouse	42.1	50.0	38.5	53.3	38.1	22.2	50.0
Son	19.3	33.3	12.8	20.0	14.3	11.1	33.3
Daughter	26.3	5.6	35.9	20.0	28.6	44.4	16.7
Son/Daughter in law	8.8	0.0	12.8	6.7	9.5	22.2	0.0
Other	1.8	5.6	0.0	0.0	4.8	0.0	0.0

Amount spent for treatment-Mean	54429	30706	64769	24467	41905	55000	118727
Person paid the amount for treatment							
Self	24.6	55.6	10.3	26.7	38.1	11.1	8.3
Spouse	22.8	0.0	33.3	20.0	28.6	22.2	16.7
Son	36.8	33.3	38.5	40.0	14.3	66.7	50.0
Daughter	5.3	0.0	7.7	6.7	9.5	0.0	0.0
Insurance/Employer	10.5	11.1	10.3	6.7	9.5	0.0	25.0

Among those having internally migrated children than their counterparts. Usually it is the spouse who accompanies them while going to the hospital, and on an average they spent Rs. 1277 (monthly?) towards such treatment. Most of the male individuals themselves met the cost of treatment while women got help from their spouse (51 percent) or their son (26 percent). The main reason for not seeking treatment was the feeling that the ailment was not serious. In the qualitative study, it was seen that

Participants who had a pension paid their medical bills through this source; other participants were dependent on their children to pay for their health care.

Further in the third way of assessment, all the individuals were asked whether they had experienced any major health problem requiring hospitalization during the last one year. If so, details on ailment and the person who accompanied them and paid the hospital expenses were sought (Table 6 and 8). Around 12 percent of the individuals had to be hospitalised at least once during the previous year and again it was more among women (16 percent) than among men (8 percent). The proportion hospitalised was comparatively more among those whose children have migrated within the country than those whose children have migrated outside the country.

The nature of problem related to nervous, musculoskeletal and heart diseases, eye problems and digestive system related disorders. For half of the individuals, the person who stayed at the hospital was the spouse. For male members, it was usually the wife or son and for the female elderly it was their husband or daughter. On an average the amount spent for hospital expenses was Rs. 54,429, and it was more among female individuals and among those having internationally migrated children. Among men, hospital expenses were paid by self or by son, and among women it was either the son or the husband who paid the amount. When the son stays with them it is usually he who makes the payment. Sometimes sons staying abroad also paid such hospital expenses.

Health insurance is a form of remittance that was also extended to the elderly. There were two versions reported, one where the elderly parents had been insured separately and could claim their expenses from the insurance provider, and the second where a family insurance was part of the benefits of those working in multinational and software companies in Bangalore or other bigger cities in India. The latter enabled the parents to seek yearly medical checkups. The yearly checkup was also one of the reasons for parents to visit their children.

I: If you get any health problem, how do they help you?
P: My son has made some health insurance and if I get any problem then he will claim from that insurance.
P: He is living in Bangalore. In their company they have some insurance and in that his wife, children and parents have benefits. (13, male)
I: In case of any emergency would you like to go there?
P: Yes, last time I had a leg operation we had gone there only, they have insurance, they will take care of me (14, male)

Finally all the individuals were asked whether they undergo routine medical checkup and if so, how frequently. As seen in Table 9, more than three-fourths of the individuals undergo routine medical checkup, and it is usually once in 6 months.

Table 9: Percent distribution of elderly persons by frequency of undergoing routine medical checkups according to sex and type of household

	All	Sex		HH Type			
		Male	Female	Internal with children	Internal without children	International with children	International without children
Number	477	233	244	110	151	80	136
Prop. Undergo routine medical check up	78.2	79.8	76.6	78.2	80.1	75.0	77.9
Frequency of medical check-up							
Weekly/Fortnightly	1.3	1.3	1.2	1.8	1.3	1.3	0.7
Monthly	17.0	12.9	20.9	19.1	17.9	18.8	13.2
Once in a three months	12.6	10.7	14.3	13.6	11.3	12.5	13.2
Half yearly	33.3	39.1	27.9	30.9	33.1	31.3	36.8
Yearly	11.7	14.2	9.4	10.9	13.2	8.8	12.5
Other	2.3	1.7	2.9	1.8	3.3	2.5	1.5

The proportion undergoing routine medical checkup is slightly more among men than among women. In the interviews, participants also reported going for check-ups in the project area or the clinics close by.

P: I am a diabetic patient but till now I have not faced any major health problem.

I: Then your expenses, your medical expenses, how do you manage?

P: I use it from my pension amount itself, no funds (aid) will come. 400/-Rs every month from my pension I have to spend. As I am a diabetic patient I have to spend. Sandhya Kulkarni hospital we go, she is a heart specialist, and a diabetes specialist also. Here only in line bazaar Sandhya Kulkarni hospital is there. Every month I go for a check-up there. When I was in service, once in two months I used to go for checkups. Now monthly once I go, but I am diabetic from long back. (1Male)

I: Any minor health problems?

P: After 40 we will be having BP, Sugar, so I have both the things. We consult the doctor in Hubli Tabib.

I: How do you go there?

P: We go by bus. If necessary we go by car. For that we need a driver, so if we don't get any driver means no other option, so we go by bus.

I: With whom you go?

P: My husband and myself. (13 female)

Hence, based on the above discussion, we can say that those elderly persons belonging to the eldest of the elderly, women, widowed, and the less educated suffer from poor health and it matches with their perceptions also.

Care giving and receiving on health

In this study we take a holistic approach to care giving and receiving. Regarding health, we specifically highlight the role of the elderly both as care givers and as care receivers. In the different households that we have considered in this study, we have observed that the elderly perform often both these roles simultaneously. For example, they may be having a chronic health condition which requires them to take the help of others to perform some daily activities. At the same time, they may also be providing care to the spouse or to a

daughter during delivery and for child rearing. In the following sections, we first present the care giving role performed by the elderly and in the next section, discuss the care received by the elderly both from kin and non-kin relations.

Care giving by the elderly

In line with the global householding theory, the participants in this study provided care during pregnancy and child-birth. This was seen as one of their responsibilities. Elderly couple with children living abroad had travelled to those countries to provide care. In other situations, the daughters had come to their natal home for care. In some of the cases, the daughters-in-law had preferred to stay with the parents-in-law for delivery and post-natal care.

I: Where did your daughter deliver?

P: Here only, first delivery has to be in mother's place, so here only we did. In our home only we did all the things, in Hubli hospital she had delivered.(..) Care after delivery (banantana), everything was here only. Five months, four months completed and in fifth month her in-laws came and she went with them.

I: Daughter-in-law's delivery?

P: Daughter-in-law's delivery happened in their own maternal home (…) Dharwad hospital only, so we used to visit regularly till they were in hospital, I think for 10 to 12 days. Afterwards she went to her mother's place for delivery care (banantana). Elder daughter-in-law's delivery was conducted in America. I did not go. Her mother had gone.

Some of the participants who could not provide the care themselves hired domestic helpers to prepare food and take care of the new born. Among 394 elderly persons having a married migrated child, 310 (79 percent) had at least one grandchild (to the migrated son/daughter) (Table 10). Among those having at least one grandchild (for the reference child only), half of the deliveries had taken place at the migrated place and 43 percent of the children were born at the in-laws' place of their son. The proportion of births at migrated place was as high as 65 percent among internationally migrated households, and for 60 percent of the deliveries the daughter-in-law went to her maternal home.

After the delivery, it is usually the mother (79 percent) followed by father (66 percent) who visit their grandchild. As a majority of the deliveries had taken place at the maternal home, the elderly parents of the migrated son had to visit either the migrated place or the maternal home of daughter-in-law. Further, the elderly parents were asked who actually took care of the mother and the newborn. It is usually the mother of the woman who has delivered the baby. Ninety-four percent and 85 percent of the elderly persons whose sons are staying at Bangalore or outside the state, respectively, mentioned that the in-laws of their son, mainly the mother-in-law, took up post-natal care. Similarly during the delivery of their own daughter, either they visit her migrated place or the daughter comes to her maternal home and thus the mother (elderly woman herself) takes care of her daughter.

Care giving was not only to the mother and the new born but was also provided to spouses, extended family members and those family members who were not able to care for themselves. In situations where the elderly were living on their own it was the spouses who provided care for the elderly. Most of the care burden was borne by the women as they had to

Table 10: Percent distribution of elderly persons according to the details on place of birth of their grandchildren, and persons involved in delivery care by type of migration

	All	Bangalore	Outside state within India	Outside India
Number having married son/daughter	394	117	75	202
Prop. Having grand children	78.7	70.1	90.7	79.2
Number having grand children	310	82	68	160
Place of grandchildren's birth				
At migrated place	50.0	34.1	33.8	65.0
At the respondent's place	19.7	15.9	17.6	22.5
At the in-laws of son/daughter	43.2	59.8	60.3	27.5
Other	0.6	1.2	0.0	0.6
Persons who visited during grand child's birth				
Mother of migrated son/daughter	78.7	86.6	82.4	73.1
Father of migrated son/daughter	65.8	79.3	73.5	55.6
In laws of son/daughter	32.3	26.8	29.4	36.3
Other relatives	5.5	3.7	11.8	3.8
Paid worker	2.3	0.0	0.0	4.4
Persons who took care after the delivery				
Mother of migrated son/daughter	30.0	13.4	23.5	41.3
Father of migrated son/daughter	14.2	6.1	16.2	17.5
In laws of son/daughter	74.2	93.9	85.3	59.4
Other relatives	0.3	0.0	0.0	0.6
Paid worker	5.2	0.0	0.0	10.0

perform the gender prescribed roles as care giver to their husbands. Men generally accompanied their wives to the hospitals, bought medicines for them and paid for health care in situations where women were not financially independent.

In addition to children and spouses, the elderly also discussed their role as care givers for their siblings, parents, or in-laws during illness and severe health problems. The quote below shows the problems this elderly man encountered when he had to care for his brother.

I: How you manage health expenses?

P: Minor things I only manage, but when my brother fell sick, I had to ask every one, many people contributed at that time, we needed more money because we had to do kidney transplantation, we were not having any health insurance at that time, when we went to ask our relations they advised us instead of begging us, go and sell our property. If we had insurance we would not have asked the people (17, male)

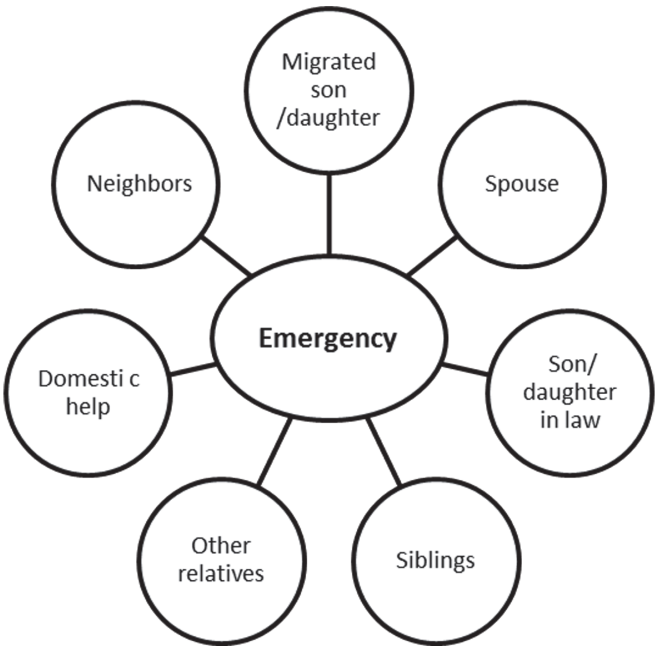
In one of the families interviewed in this study, the participant explained that the reasons they could not leave Dharwad to go and live near her daughters in Bangalore was because her husband had the responsibility to look after a sibling who was mentally challenged. This case also highlights the long-term care that the elderly have to provide to extended family members.

P: My husband and he has two sisters. One is married and the other is abnormal (mentally challenged). My mother-in-law and father-in-law both are dead, actually the sister who is abnormal used to stay with us, when my daughter came to marriage age we kept her separate because ours is a Brahmin family, so they ask about her abnormality and about my daughter, so we kept her separate. When we built this house she was with us for a few days but later in a different house.(…) I like to go (to daughter's house), I don't know of my husband because they have to look after his sister, he will say you go, I will not come. His mentality is different.

Care received by the elderly

From a care receiving perspective, the elderly who were living on their own and were physically capable of managing day-to-day activities did not perceive the need to be cared for. On the other hand, elderly with minor health issues and who lived on their own were dependent on domestic helpers or extended family members to provide care for them. To understand the nature of support that the elderly may require in case of an emergency we asked them in the interviews who they call upon in times of need. Figure 3 lists the people who the elderly would call first in an emergency. The emergency as discussed by the elderly always related to a health condition. As seen in the figure, the right side includes mostly kin whereas on the left we see non-kin members who would be called upon. Elderly participants also gave instances when such an event had taken place and the steps they took to reach a hospital. In an actual case, an elderly widow who lived on her own and had spells of dizziness rushed to the neighbour who then took her to the hospital and cared for her in the days that followed.

Figure 3: Support network called on during a health related emergency



Kin support for health care: Among the elderly living with their children, most of the care during illness or a severe health condition was provided by the co-residing son and his wife. In families where they did not have sons, it was the daughters who either co-resided or lived in close vicinity and provided care for the elderly. Relatives were the first source of help which was then followed by the son or daughter who was living internationally.

I: And if you require medicine who will bring it for you?

P: I will go or my son-in-law will call the pharmacy and they will come and give or my son-in-law will bring. All these days I was facing difficulty in walking, so either my son-in-law used to bring or I will go and bring (11, Male)

P: They care for me a lot. In 2009 I had breast cancer, all my three sons, daughters-in-law and my husband looked after me very well and helped me a lot, not only financially but physically also. They used to come in the morning, stay till late night and again go back in the bus. When I was hospitalized, they have not left me alone. I have not asked them and I did not expect also but they did it by themselves. Sometimes I was not able to go to the toilet and my sons used to help me. I am very happy with my children (16 female)

The elderly who did not have sons and had daughters living away from them preferred to visit the daughters during medical check-ups but would not prefer to co-reside with them as it was against their cultural norms and beliefs to reside with the daughters. The elderly also brought in relatives from their village who could live them and provide care. In Table 12 we provide a case study where the relative acted as a live-in care giver. The data also reveal situations where relatives came in temporarily to provide care during illness and hospitalization. The availability of extended family members acted as a crucial resource in times of need when the children were living away.

In the survey with regard to the help or care received during health problems, among those having internally migrated sons more than two-thirds and among those having internationally migrated children 42 percent felt that their children take care of them always (Table 11). The proportion feeling that their children never take care of their health problems is 9 percent, and it is 16 percent among those with internationally migrated children.

Table 11: Percent distribution of elderly persons according to extent of care received by them from their migrated child during health problems

	All	Bangalore	Outside state within India	Outside India
Number	477	161	97	219
Help/care received from child during health prob.				
Takes care always	55.3	69.6	62.9	41.6
Takes care some time	17.6	16.8	12.4	20.5
Takes care during emergency	18.0	10.6	20.6	22.4
Never takes care	9.0	3.1	4.1	15.5

Non-kin support for health: Some of the participants felt that even though they had the economic resources to buy care, there were not enough people around to provide it. Thus in many situations they had made other arrangements for getting the grocery or medicines delivered to their home. In Table ?.? we provide three case studies which illustrate the kind of support the elderly received from non-kin persons. The case studies show how within this small group of participants the nature of care giving is moving from the sphere of the family outwards to non-kin actors. This has an effect on the social structure of the household. As seen in the quotes, some of the non-kin caregivers were incorporated into the family structure by assigning fictitious kinship terms such as 'like my son or daughter'. The first two case studies are contrasting as one is a live-in care giver and was brought in specifically after a major surgery to provide care and help with day-to-day activities whereas the second is a domestic help who is a paid care provider who was brought in to provide care for an ailing parent of the elderly and then has stayed on thus continuing the caring relationship. Extending our discussion on the care provided by caregivers, many participants also started to talk about old age homes. As the quote below shows, as the son was not able to provide proper care, the participant felt his sister was better off living in an old age home.

It's ideal solution to stay in old age homes (..) even one of my sisters stayed in an old age home because she needed 24-hour service from nurse, but of course she did not live for many days after that, her son is financially fit but he was not able to look after her, so he had kept her in an old age home (14 male).

Table 12: Kin and Non-kin care and support for the elderly

Case study	Household	Nature of care	Gender of care giver	Relation to the Care giver	Quote
1	Elderly couple	Live-in care giver	Female	Person from the same village	P: because of an accident there was a hip replacement, so with her help (village girl) I complete my house work. I don't think of her as a house maid because there was a second daughter for me but she expired, so since two three decades their family was working in our house, so now as she is a girl they did not show any interest in educating her, so I brought her here and now she has completed her DEd., and is going for computer class, I don't treat her as a servant, I am giving her a life, she helps me in my work
2	Elderly couple	Visits twice a day	Female	Domestic help	P: My mother stayed with me, she lived for 97 years, we were in need of one person to look after her, bathe her and do her works etc. so we had a servant, and she is here for last 20 years.... morning comes at 9 and does all work and goes to school to work as care taker, and in the evening comes at 5 and does all cleaning up to 5.30 and goes back to her home. She does marketing of vegetables, cleaning kitchen etc.
3	Elderly couple	Live-in care giver	Female	Relative	P: Then we kept our relative's 1 girl here for 4 years and gave an education here only. She stayed in our house only and they were poor people and also they were in trouble. That's why we kept her with us. She stayed here up to 4 years. That time it was a useful for us. Completed 10th class, then that girl went. Our children advise us, to keep like this type any other to stay with us. I am suffering from a little knee pain. So, I have a little trouble to walk, or go up and down.

Perceived impact of children's migration on health

The migration of their higher educated children was perceived to be inevitable. The parents reasoned that Dharwad was too small to keep their higher-educated children. The city of Hubli-Dharwad has many higher educational institutions but not many industries. Thus the higher educated had to move to the nearest bigger cities in Karnataka such as Bangalore or outside the state to Pune or Mumbai. We observed that many of the international migrants had either lived part of the time in other cities before migrating to other countries.

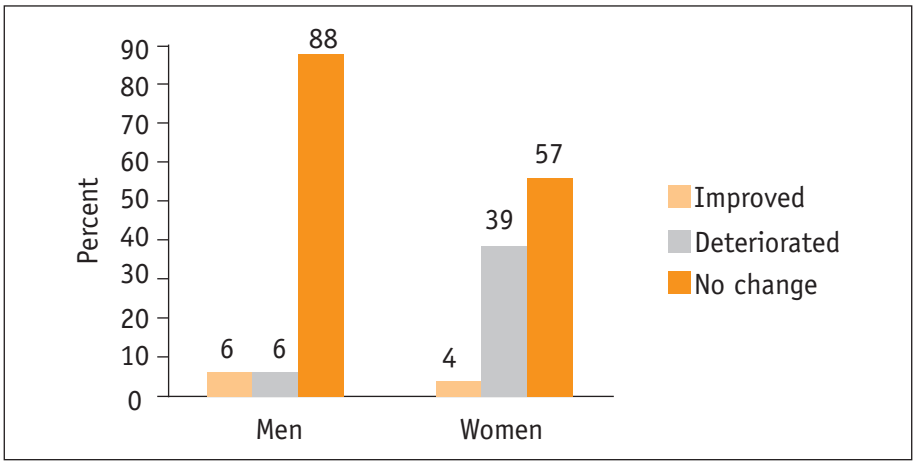
P: *Feels lonely, if one is there with us then it would have been better. We have to think about his life also, isn't it! In many families people are going to foreign, this is better. When it is the question of his career we cannot restrict him. Even though it is there in our mind (manasu) that he should work here but he may not get the job here in Dharwad according to his qualification. Because this is not an industrial area, so according to his education he may not get the suitable job. I know that he will not get a job here but still our mind thinks that it would be better if he gets the job here. (1 Male)*

In the interviews we did not specifically ask if they perceived that their health had changed due to the migration of their children. We probed them more on what they perceived to be the major change in living away from their children. With reference to health, the major discussion among participants living on their own was that in case of emergency they would prefer to have their children close by. From a perspective of emotional health what we did notice was that women reported more instances of feeling lonely.

I: After the migration of your children, are there any changes in your house or life and how do you feel?

P: First when they both had gone, I was unable to speak with my friends, my home was like death home, I felt very bad at that time, now as time passed I am getting used to it, now I pass time very easily, because I was doing a job also, morning in a hurry burry I go to office, in afternoon I am busy there only, evening I come, do some little work, then I read books, see TV, do a little exercise, I go for a walk also, so now I can spend time. (7 Female)

Figure 4: Perceived impact of child's migration on health by sex



Even in the survey, all the elderly persons were asked to rate the impact of their child's migration on their health as improved, deteriorated or No change, and responses given by the individuals are presented in Table 13 and figure 4 and 5. As high as 72 percent of the elderly persons felt that the migration of their child has not affected their health condition, and around 23 percent said their health has deteriorated because of the migration of their child. Individuals having this feeling of negative impact are comparatively more among women as 39 percent of the mothers had the opinion that their child's migration has worsened their health compared to only 6 percent among men. Further, individuals who are less educated, and who either do not have own income or have a feeling that their income is not sufficient felt that their child's migration has affected their health in a negative way compared to their counterparts. As discussed earlier, again comparatively few elderly persons having an internationally migrated child and staying on their own felt that their health has deteriorated due to their child's migration.

Figure 5: Perceived impact of child's migration on health by type of migration and living arrangement

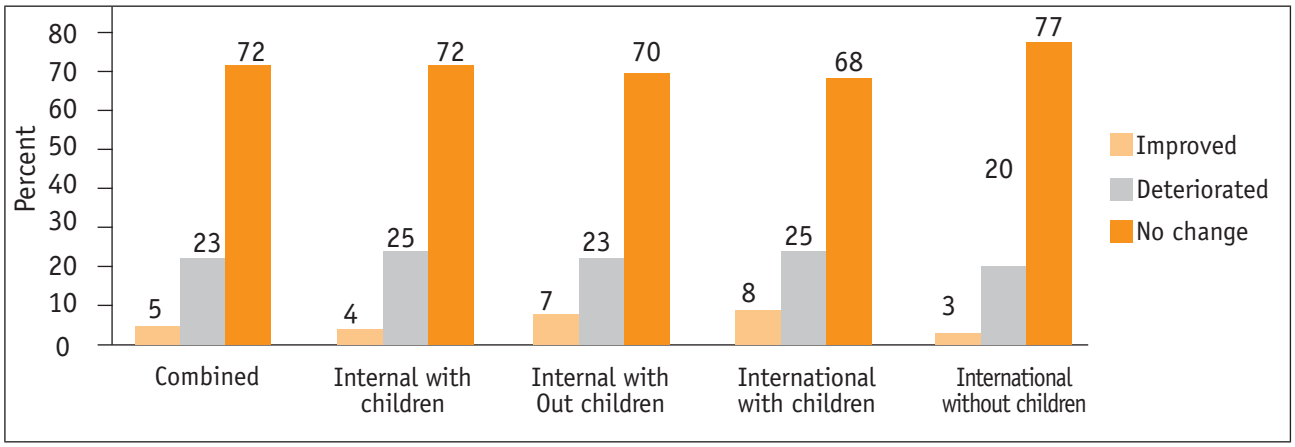


Table 13: Percent distribution of elderly persons interviewed by perceived effect of their child's migration on their own health by selected background characteristics

	Number	Improved	Deteriorated	No change
All	477	5.0	22.9	72.1
Age				
55-59	64	1.6	28.1	70.3
60-69	238	4.2	21.8	73.9
70-79	140	6.4	22.1	71.4
80+	35	11.4	22.9	65.7
Marital status				
Currently married	415	5.1	20.5	74.5
Widowed	62	4.8	38.7	56.5
Education				
Less than high school	75	5.3	36.0	58.7
High school	105	3.8	29.5	66.7
PUC/Graduation	179	6.7	21.8	71.5
PG/Ph.D/Professional	118	3.4	10.2	86.4
Economic self sufficiency				
No income	166	4.8	40.4	54.8
Not sufficient	5	20.0	40.0	40.0
Partially sufficient	58	5.2	25.9	69.0
Fully sufficient	248	4.8	10.1	85.1
Having own house				
Own house	421	4.3	22.3	73.4
No own house	56	10.7	26.8	62.5
Loans or obligations				
No loans	434	5.5	23.3	71.2
Having a loan	43	0.0	18.6	81.4
Type of migration				
Bangalore	162	5.6	24.7	69.8
Outside state within India	96	5.2	22.9	71.9
Outside India	219	4.6	21.5	74.0

Summary and Conclusion

In the qualitative component that preceded the survey, we had interviews with 37 individuals who included couples, widows and widowers and who came from households with children internally or internationally migrated. These interviews gave us rich qualitative information on the lives of the elderly and how they managed care giving and receiving. In this paper we have focused primarily on health related care giving and receiving. Utilising information gained from the qualitative interviews we further designed a survey which included a total of 477 individuals, consisting of 233 men aged 60+ and 244 women aged 55+, from 324 households of the selected 3 areas of Dharwad city, whose children have migrated to the state capital, outside the state or outside the country. This formed the sample for individual interviews. A majority of the elderly persons were from higher socio-economic status, mainly depending upon pension for their day-to-day expenses and were highly educated.

Around 15 percent of the elderly persons rated their health as poor, and elderly persons having this feeling are comparatively more among the eldest of the elderly, women, widowed and the less educated. Further, comparatively more women felt that their health condition has deteriorated compared to that of previous year. Elderly parents

staying without children rated their own health condition as better, compared to those who stay with other children. From the interviews we can contextualize this finding by underscoring the fact that elderly parents staying with children were still involved in many care giving activities such as caring for grand children or other relatives.

Among the interviewed elderly persons, 18 percent fell sick during the previous 15 days and it was again comparatively more among women and those who stay with children than their counterparts. More common ailments experienced by the elderly persons were respiratory problems and nervous or musculoskeletal related problems. Though a majority of the elderly had sought treatment for their ailments, it is comparatively more among males. In the interviews we see that elderly first consulted a health care provider from within their neighbourhood and on further referral went to bigger hospitals. For acute conditions or when required, the elderly were taken to bigger cities by their children or close relatives. Most of the time, men paid for their own expenses and for women, their spouses paid the expenses. In the interviews we found that migrant children also contributed to the expenses either directly or by insuring their parents.

Around 12 percent of the individuals had to be hospitalised at least once during the previous year and again it was more among women than men. For men, it was usually the wife or son and for female elderly it was their husband or daughter who stayed with them during the hospitalization. Further, a majority of the individuals undergo routine medical checkup and it is usually once in 6 months. The proportion undergoing routine medical checkup is slightly more among men than among women. Hence, we can conclude that migration of sons as such does not affect the health condition of elderly persons. It is usually the women, the widowed, those above 80, those having economic obligations and the less educated who suffer from health problems. The care burden on the elderly is more among women than men. It was also observed that elderly women travelled both within and outside India to provide care to their daughters who have delivered and young grandchildren. The care received by the elderly was both from kin and non-kin members. However, the role of non-kin support was more among households where the elderly were living on their own. The perceived impact of migration on health is best understood from the survey where the perception on change in health condition was measured. This study focused only on a specific set of elderly households which were relatively well off and had the means to get health care in order to get a more holistic picture. Future studies may also include households belonging to lower socio-economic households.

References

Armstong, P. & Hugh Armstrong. 2001. Thinking It Through: Women, Work and Caring in the New Millennium. Healthy Balance Research Program: Halifax.

Bailey, A., Jyoti Hallad, K. S. James (2013), Ageing and wellbeing in households with migrant children in Dharwad, Karnataka, Population Research Centre, Dharwad Report Number-155

Bengtson VL, Burgess EO, and Parrott TM (1997). Theory, Explanation, and a Third Generation of Theoretical Development in Social Gerontology. Journal of Gerontology: SOCIAL SCIENCES. 1997. Vol. 52B, No. 2, S72-S88.

Bhat, A., K. and Dhruvarajan, R., (2001), Ageing in India: Drifting intergenerational relations challenges and option. Ageing and Society, 21(5), 621-40.

Bloom D.E., Mahal A., Rosenberg L., Sevilla J. (2010), Economic security arrangements in the context of population ageing in India. International Social Security Review. Vol. 63 (3-4), 59-89.

Douglass, M. (2006) Global householding in Pacific Asia, International Development of Planning Review, 28(4): 421–445.

Douglass, M. (2007) 'The globalization of householding and social reproduction in Pacific Asia', Philippine Studies, 55 (2):157-181.

Gupta, R., & Pillai, V. K. 2000. Caregiver burden in South Asian families: A systems theory perspective. Journal of Ethnic & Cultural Diversity in Social Work. 9, 41-53.

James K S (2011) "India's Demographic Change, Opportunities and Challenges", Science, July, 29,P: 576-580.

Jamuna D. (2013) Issues of Elder Care and Elder Abuse in the Indian Context, *Journal of Aging & Social Policy*, 15:2-3, 125-142 DOI: 10.1300/J031v15n02_08

Kleinman, A. (2010). Caregiving: Its role in Medicine and Society in America and China. Ageing International. vol. 35, pp. 96-108.

National Sample Survey Organisation (2010) Migration in India 2007-08, NSSO, MoP&I, New Delhi

Rajan S. I. (ed.), (2011) Migration, Identity and Conflict: India Migration Report 2011, Routledge, India.

Rajan, S. I. (2010) Governance And Labour Migration:India Migration Report 2010, Routledge, India.

About the Project

The United Nations Population Fund - UNFPA supported project BUILDING KNOWLEDGE BASE ON POPULATION AGEING IN INDIA aims at contributing and further expanding the existing knowledge base on the emerging population dynamics in India which are resulting in significant shifts in the age structure towards higher proportions of older persons aged 60 years and above. In first stage, the project supported the preparation of a series of thematic studies using existing secondary data sources. In the second stage the project initiated a primary survey in seven states in India. Dissemination of the findings to various stakeholders is a key objective of the project to help enhance the overall understanding of the situation of elderly in the country for further research and policy analysis on the growing numbers of India's senior citizens. The project is a partnership between the Institute for Social and Economic Change (ISEC), Bangalore, the Institute of Economic Growth (IEG), New Delhi and Tata Institute of Social Sciences, Mumbai

More information on the project can be obtained from http://www.isec.ac.in/prc.html or www.indiaunfpa.org

The second phase of the project involves an updated situation analysis through the collection of primary data from seven states in India which have relatively higher proportions of elderly. These are Himachal Pradesh, Kerala, Maharashtra, Orissa, Punjab, Tamil Nadu and West Bengal. The survey data includes socio-economic characteristics, family dynamics, living arrangements, health and awareness of social security programmes of the elderly. This paper is based on the data gathered from the seven states.

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