CHAPTER – 1

INTRODUCTION

"The Population that does not take care of their elderly, children and their young has no future because it abuses both its memory and its promise"- **Pope Francis**

Sir James Sterling Ross has very rightly commented that "You do not heal old age; you protect it; you promote it; you extend it" (Munshi & et al, 2008, pp. 2-15). 'The ageing of population' trend was a characteristic of industrial population throughout the twentieth century, but in the recent decades it has become a worldwide phenomenon. Ageing has been associated with the changes in circumstances of the individual as a member of a family, community and society. Thus, it also brings about further changes in social attitudes, income, work roles, activity and mobility, marital status, free time and societal expectations (Shankar, 2002, pp. 125-45). India was never a highly populated country as perpetual hunger, frequent famines, recurring epidemics, high infant and maternal mortality have for centuries ensured a very low population growth in the country (Moneer, 2006, pp. 29-70). But the situation saw a reversal from the early twentieth century in response to the famine control and public-health measures adopted by the provincial governments under British rule. This culminated in a mind boggling increase in the population thus bringing with it a change in population composition as well. The total population of the country grew from 238.4 million in 1901 to 361.1 million in 1951 to 1027.01 million in 2001 and which showed an increase of 51.47 percent during the first half which again increased to 184.41 percent in the next half (ibid, p.30). The total population according to the recent census is 1.2 billion.

When looking at the global scenario the population of the world in 1995 was 5.7 billion and is expected to reach 10.8 billion by 2050. It is estimated that the percentage of elderly in the world population will increase tremendously from 9.5 in 1995 to 20.7 in 2050 and to 30.5 in 2150 (Phoebe & Irudaya, 2005, pp. 1-9). Although the number of children below 15 years was estimated to be 3.3 times higher than the 60 and above population in 1995, the elderly are expected to exceed the number of children by 2050 (ibid). According to United Nation only Western Europe in the

world had a proportion of elderly above 15% in 1950. But by 2000, all three regions of Europe except Eastern Europe registered a proportion above 20%. As of now Southern Europe has the highest proportion of elderly that is 21.5% and is expected to reach 37.2% by 2050 (Irudaya & et al, 2005, pp. 11-30).

Asia as a whole accounts for only 9% of elderly population but there are variations in the distribution of the said population. Eastern part of Asia leads, with 11%, out of 36 countries under study in Asia none had a proportion of elderly above 10% in 1950. According to the United Nations records by 2000 Japan had the highest percentage of elderly population that is 22.6 which is estimated to rise to 32.1 by 2025 followed by Cyprus 15.3 and Hong Kong 15.0 in 2000 (Irudaya & et al, 2005, p. 14).

Ageing is a universal phenomenon, in India the process of ageing is still in its early phase but it is increasing at a fast pace. According to 2011 census the percentage of elderly population has gone up from 6.0% in 1991 to 8.0% in 2011 with Gujarat state showing an 8.3% of elderly in its fold. While the 2001 census showed the aged population as seventy seven million, in 1961 it was merely twenty four million. According to the population projection, this is estimated to increase to 301 million by 2051 (Shanthi & Irudaya, 2010, pp. 1-20). Currently 1 in 12 Indians is elderly and this ratio is likely to rise to 5 in 12 by 2050. According to the 1991 census India had an elderly population of 56 million with Kerala showing the highest percentage of 60+ populations that is around 8.77 and Andaman and Nicobar Islands showing the least that is 3.55 (Irudaya & et al, 2005, pp. 16-17). India is also one of the few countries in the world where males out number females at birth but at the same time female life expectancy at the age 60 and 70 is slightly higher than that of males (ibid, pp. 16). India is a land where traditionally the elderly enjoys a place of honour, respect and power prescribed by the social values and norms. However Indian society is dynamically changing at a fast pace in the social, economic and political context, the major cause of this change can be attributed to rapid industrialization, urbanization, westernization, globalization and liberalization. Though these factors are responsible for the development of the nation, it has also brought changes like break-up of traditionalism, joint family system and traditional values, thus bringing about tremendous alteration to lifestyle and social activities particularly putting the aged at a

disadvantage. Under these circumstances, the problems of aged and aging have become a matter of great concern and calls for special attention.

The increase in the number of older population has resulted in the study of 'aged' in general as well as their challenges. In 1990, the General Assembly of the United Nations designated 1ˢᵗ October as the International Day of older persons. Eighteen principles have been adopted by the General Assembly which have been organised into five main clusters that is independence, participation, care, self-fulfilment and dignity of older persons (Suguna & Sandhya, 2002, pp. 101-17).

Who are 'aged', 'elderly', and 'senior citizen' or 'geriatric'? At what age do the people become 'old' is not very clear. There is no single point at which people cross a magic line and become aged or elderly. The elderly life span depends on the average life anticipation in a particular society. This in turn, is related to the societies overall standard of living and technological ability to control diseases and other threats to human life. Reaching the age of 40 was rare until the late middle ages but the control of many killer diseases has increased the average life expectancy to 60 years, and so this age is viewed as old age and those who reach this age are labelled 'old' (Shankar, 2002, pp. 125-45).

Systematic approaches to the study of ageing are relatively of recent origin, it began with research on biological and psychological aspects followed by studies of behavioural and social science phenomenon. Research on ageing in the social sciences has sprung from several developments which occurred within a short span of time. In America there was a sheer increase in the older population which doubled between 1900 and 1930 and again 1930 and 1950 (Tibbitts, 1970, pp. 3-26). This increase brought forth attention to some of the problems like employment, housing, economic dependency, long term illness and care taking. Thus an effort was made to find the causative factors as the need for societal action was very evident. In India scientific interest in ageing is a post-independence phenomenon. It was in 1950's that a few articles on ageing appeared in journals. The United Nation's 'Vienna Declaration' of the International year of the elderly in 1982 spurred research activity in the area (Ramamurti, 2005, pp. 31-43).

1.1 Concepts of Gerontology and Social Gerontology

Ageing of an individual can be termed as a process or a series of change that takes place in a life span. Gerontology is concerned with a period of an individual where he/she has attained maximum growth and function. Gerontology taken from the Greek word 'Geron' meaning old men and 'Logia' meaning study of, was coined by Ilya Ilyich Mechnikov in 1903 ("Gerontology", 2014). Gerontology deals with social, psychological, and biological aspects of ageing. Every area dealt has a different approach and perspective on the subject. Biologist looks at the progressive changes in cellular composition while psychologist studies the changes in the capacities to utilize and organize information as well as changes in personality. Behavioural aspects of ageing deal with inner reactions with regard to changing self-image, feelings, ego balance, maintenance of mental well- being and tolerance of stress (Tibbitts, 1970, pp. 3-26). Lansing (1951) says that 'ageing is a process of unfavourable, progressive change usually correlated with the passage of time, becoming apparent after maturity and terminating invariably at the death of the individual'(ibid, p. 8).

Gerontology is an inter-disciplinary subject and includes various aspects like:

- Studying physical, mental, and social changes in people as they age.
- Investigating the ageing process itself.
- Investigating the psycho-social impacts of ageing.
- Investigating the psychological effects on ageing.
- Investigating the interface of normal ageing and age related disease.
- Investigating the effects of an ageing population on society ("Gerontology", 2014).

Social Gerontology in Gerontology is again many faceted and complex, the two broad aspects of the field are (1) Ageing as a phenomenon of the individual organism (2) Ageing as a phenomenon of society (Tibbitts, 1970, pp. 3-26). The position or status of older people in a particular society is determined by the roles and functions assigned to them by that society. The fact that man is culture-building as well as culture-bearing has made it possible for him to have an old age that is vastly different from that of any other living species including his own kind (Leo, 1970, pp. 62-91). Success with the last span of life depends on a two- way relationship. On the one hand the environment must permit it, culture must provide for and sustain it and on the

other hand, the aged person must fit in and fulfil his functions within the social setting. Social Ageing can be defined as the life span process of change in the amount, content and meaning of a person's social behaviour produced by the person's decision and carried out in the communities within which the person lives (ibid, pp. 65).

Social networks are important for welfare, according to Gangrade 'Social networks in Indian situation provide vitality to social work in managing crisis situation in Indian families' (John & Chadha, 2005, pp. 109-24). Shankar Das and Kumar found in their study that active support network greatly influenced the social well-being of the elderly (ibid, p. 114). It is a fact that even in primitive society humans succeeded in ensuring a very long and fruitful old age for its members (Leo, 1970, pp. 62-91). In fact in certain societies the aged years were considered as the best part of life. Older people gained influence and security with the gradual establishment of permanent residence following which there was an achievement of a stable food supply, herding of animals and cultivation of soil. The functions and securities of the aged were further enhanced by the growth of magical and religious beliefs and practices and by the accumulation of knowledge and technical skill (ibid, p. 69).

An early instance of emerging rights of the aged was the special assurance of food as with advancing age food becomes a matter of increasing concern, its provision at frequent intervals in suitable form and in proper amounts depends more and more upon the efforts of others who are in a position to provide it or withhold it (Leo, 1970, pp. 62-91). The ancient Hebrew made certain provisions for the unfortunate in their code of laws. According to Enock (1912) their law decreed that the poor, the blind, the lame, the aged and the infirm who could not till their own lands so as to clothe and feed themselves should receive sustenance from the public stores (ibid, p. 70). A social expedient of some special advantage to the aged has been food taboos. Many food taboos deprived the young and able-bodied of delicate morsels and favoured the aged. The customs of food sharing with the aged have been strongest on a conventional basis where the food supply has been less constant and where types of economic activities have been less developed. With the higher civilization, support of the aged through communal sharing of food appears to have taken on features of an organized group support (ibid, p. 71).

1.2 Definitions of Gerontology, Geriatrics, Geriatric, Health and Illness

Definitions are formed to capture essential nature of phenomena and describe it precisely. Several definitions have been coined to give a better idea and understanding of the major concepts used in the study.

1.2.i Gerontology

Collins English Dictionary of Medicine defines the term as "the scientific study of ageing and the problems associated with older people" ("Gerontology", 2015).

Random House Kernerman Webster's College Dictionary defines gerontology as "Study of ageing and problems of aged people" ("Gerontology", 2015).

The American Heritage Dictionary defines Gerontology as "the scientific study of the biological, psychological, and sociological phenomena associated with old age and ageing" ("Gerontology", 2015).

1.2.ii Geriatrics

The Collins English Dictionary defines Geriatrics as "The branch of medical science concerned with the diagnosis and treatment of diseases affecting older people" ("Geriatrics", 2015).

According to Random House Kernerman Webster's College Dictionary Geriatrics is "The branch of medicine dealing with debilities and care of aged person" ("Geriatrics", 2010).

According to the American Heritage® Dictionary of the English Language Geriatrics is the "The branch of medicine that deals with the diagnosis and treatment of diseases and problems specific to the aged ("Geriatrics", 2015).

1.2.iii Geriatric

According to Collins English Dictionary Geriatric is "an elderly person" ("Geriatric", 2015).

Random House Kernerman Webster's College Dictionary defines Geriatric as "of or pertaining to Geriatrics, old age or old person" ("Geriatric", 2015).

According to the American Heritage® Dictionary of the English Language Geriatric is "of or relating to the aged or to characteristics of ageing process" ("Geriatric", 2015).

Geriatric is defined as "an older person considered as one who may be disregarded as senile or unable to look after his or her own best interests" ("Geriatric", 2015).

1.2.iv Health

Bircher defined the term as "a dynamic state of well-being characterized by a physical and mental potential which satisfies the demands of life commensurate with age, culture and personal responsibility" (Ustun & Jakob, 2015).

The World Health Organization presents an absolute ideal situation by giving a holistic definition of health "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Ustun & Jakob, 2015).

Parsons defined health as "the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized" (Marcus, Sean, & etal, 2010, pp. 3-16).

"Health is the ability to adapt and self-manage in the face of social, physical and emotional challenges" (Huber & etal, 2015).

1.2.v Illness

According to Thesaurus illness is defined as "Impairment of normal physiological function effecting part or all of an organism" ("Illness", 2015).

The American Heritage Dictionary defines it as "an abnormal process in which aspects of the social, physical, emotional, or intellectual condition and function of a person are diminished or impaired compared with that person's previous condition ("Illness", 2015).

According to Merriam Webster Dictionary "illness is a condition of being unhealthy in your body or mind" or "a specific condition that prevents your body or mind from working normally" ("Illness", 2015).

1.3 Sociology of Health and Illness

Historically, the word health appeared approximately in the year 1000 A. D. The word originally came from Old English and it meant the state and the condition of being sound or whole. For the ancient Greeks, health was always an attribute of paramount importance (Boruchovitch & Mednick, 2002, pp. 175-83). Their initial ideas of health as a divine responsibility and illness as a supernatural phenomenon were replaced by their recognition of the relevance of personal life habits and environmental factors in health status (ibid, p.175). The earliest notion of health as a disease-free state represents the traditional medical concept. This view of health was largely accepted during the first half of the twentieth century, mainly between physicians and medical personnel. Such a traditional medical concept of health was based on the assumption that health and disease were objective and observable phenomena (ibid, pp.176). With the advancement of research in the fields of medicine, science, sociology, psychology, and politics, philosophical theories of health began to be questioned and challenged and was substituted by more scientific ones.

According to Burney (1956) 'Health is a central factor in every aspect of the older person's life. It cuts across every social, occupational and economic line. It effects every proposal for improving the lot of older people in family life, employment, recreation and participation in community affairs' (Tibbitts, 1970, pp. 3-26). According to World Health Organization 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'. What is 'Health'? It is very difficult to describe or define the condition, but the absence of it can be easily recognized. The word 'Healthe' means hale, hearty, sound in mind and limbs.

"Illness' or 'diseases' are socially produced and distributed, they are not just part of nature or biology, it occurs in patterns which can be caused by factors like gender, class, ethnicity etc. (White, 2009, pp. 1-13). Sociologists, depending on the model of society, develop different explanations of the social shaping and production of diseases; Marxists emphasize the role of class; Feminists, the role of patriarchy; Foucauldians, the way society is administered by professionals; and those focusing on ethnicity, the impact of racism (ibid, p.6). Illness and inequality are closely linked

since the outcome of unequal distribution of political, economic and social resources is the social gradient of health. Labelling and stigma derived from the interactionist sociological perspective; focus on the importance of the symbolic meanings of health and illness. That is the shared social connotations and imagery that are associated with particular events and objects and upon which our actions are largely based (Crinson, 2007).

20th Century gave way to a better health status by an increase in life expectancy and quality of life but 21st Century saw an increase in heart diseases, cancer, chronic obstructive lung diseases and diabetes. For sociologist illness or disease is an outcome of the societal structure i.e. poor working and living conditions and structures produce illness and sickness. Sociologist have laid claim on the term illness as it is a presentation of a medical condition that limits the functional capability of an individual in the society (White, 2009, pp. 1-13).

The characteristics of illness are classified by Boorse (1975):

- Illness can be reasonably serious disease with incapacitating effects that make it undesirable.
- Illness requires treatment; it is conditions which can be described as a medical problem in terms of impairment, defect or disability thus require medical attention.
- Illness is often a valid excuse for deviant behaviours, thus exempting the ill person from performing the normative roles and expectations.
- Determination of illness is bound by appropriate normative judgments or socio-cultural context as illness is a relative term and could vary by culture, place, individual and time (Boorse, 1975, pp. 49-68).

According to Goffman, Taylor and Field's 'Stigmatisation Model' (Figure 1.1) gives a clear picture on how the labelling of a disease can affect an individual socially as well as personally. All of us, including health professionals does not exist in a cultural vacuum so there is a tendency to perceive certain conditions and disabilities as stigmatizing; when a disease label is attached to a person, the very label itself has the power to spoil the sufferer's identity both personal and social. The social stigma that results from this labelling process derives not only from societal reaction which may

produce actual discriminatory experiences but also the 'imagined' social reaction which can drastically change a person's self-identity (Goffman, 1963).
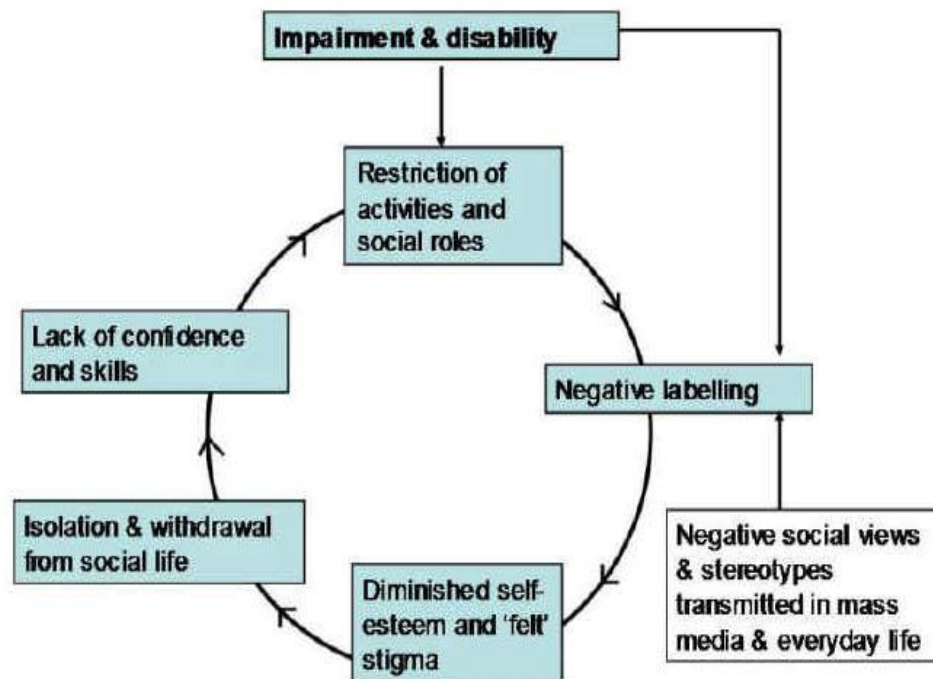
Figure 1.1 Taylor & Field's Stigmatisation Model

[Source: Goffman, E. (1963)]

Public conceptions of health and illness vary according to the immediate material & social circumstances in which people find them. These circumstances can act to constrain the possibilities for action to change an 'unhealthy lifestyle'. Nevertheless, health promotion strategies have in the past assumed that persuading people to adopt healthy lifestyles was largely about changing individual attitudes (Crinson, 2007). According to Zola's help seeking model (Figure 1.2) people`s responses to symptoms of illness are largely based on their cultural values and beliefs concerning health. That is, the general perception of what is 'normal', likewise the decision to seek professional medical help was either promoted or delayed by social factors (Zola, 1973, pp. 89-677).
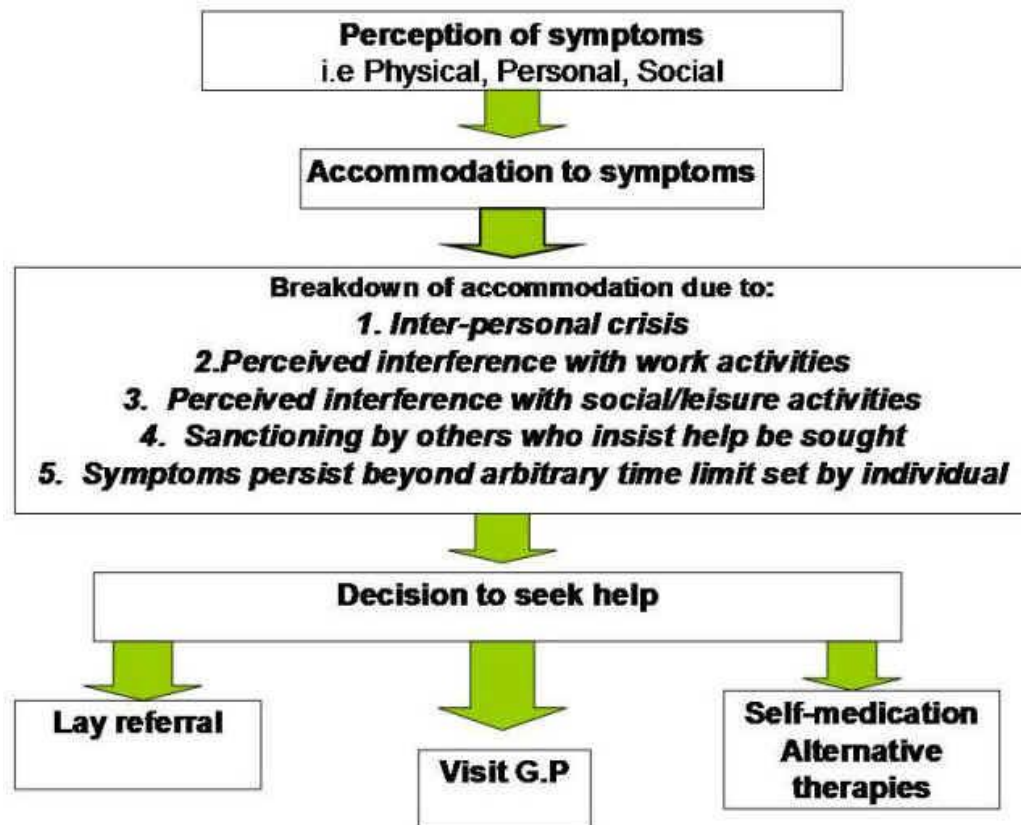
Figure 1.2 Zola's Help Seeking Model

[Source: Zola, K. (1973)]

The findings from a large number of epidemiological studies have concluded that social and psychological stress is one of the major factors impacting upon an individual's ability to maintain his/her health. Sociological and socio-psychological research has concluded that while we all experience such 'stresses' or 'life events', their effects are magnified for those individuals and social groups that have limited social support, a limited ability to control one's social situation/environment, poor social networks, and low levels of social integration (Wilkinson & Marmot, 1998, pp. 22-23). The main source of social support in chronic illness comes from the family or other close social networks. Brown and Harris' classic research into clinical depression amongst working class women recognised that differential availability of social support was a critical factor in a person's relative 'vulnerability' to stressful life events. They saw social support acting through what they termed intimacy, serving as a powerful mediator between the stressor and the onset of illness (Oatley, 2007, pp. 228-31).

Durkheim (1899) in his classical study of suicide argued that an individual's integration into society is essential for their health and well-being. More recent sociological studies of mental health and illness have also supported this original hypothesis. The family, spirituality and work/employment, bind individuals into wider social contacts and relationships and offer a sense of belonging and meaning. This serves to protect individuals from the consequences of anomie by providing a sense of structure and social status. Stresses within the family, unemployment, conflicts etc. effect health as they tend to reduce or strain social ties and relations (Stroebe, 1995).

1.4 Historical Development of Sociology of Health and Illness

Every society through experience evolves ways to cope with illness and physical disorders. Medicine is a part of a civilization. These medical practices vary from one culture to another. At the beginning of civilization medical practice consisted of what Sigerist (1960) calls "a mishmash of religion, magic and empirically acquired ideas and practices…" The treatment in primitive society was magical rather than rational and religion played a major part in it (Banks, 1953). Even before Sociology emerged as a subject and dealt with and discussed illness in context of the social, economic and political situation and environment, the scholars of ancient and medieval times related illness to these factors (Dak, 1991, pp. 3-43). Classic works on the historical development and production of medical knowledge defines what is termed as 'medical cosmologies'. These frameworks describe the way in which historically, developments in medicine have been intimately linked with the particular social relations and dominant ideas that existed within the society at the time. That is, the production of medical knowledge is rooted within social, rather than the popular notion of a progressive march of science towards ever greater knowledge of the functioning of the human body (Jewson, 1976, pp. 225-44).

Study of various literatures shows that throughout history, attention has been directed in controlling diseases by improving the environment and other social factors. The best example is the Indus valley civilization, excavations show toilets drained by covered sewers which dates back to 4000 years. In 2000 BC, cities including Troy had highly developed water supply system (Rosen, 1958). At the time of Joshua when Israelites settled in the Holy land, there were rules governing the settlements (Kottek, 1995). Greeks believed that ill health developed from an imbalance between man and

his environment. In his book, "On Airs, Water, and Places", the author summarizes factors important to diseases including climate, soil, water, mode of life and nutrition (Hippocrates, 1938). Prior to industrialization and 'age of enlightenment' physicians were required to recognize the patient as a holistic entity. Medical judgments were made in terms of the personal attributes of the sick person (Jewson, 2009, pp. 622-33). Hospital based medicine developed in the late eighteenth or early nineteenth centuries and is largely associated with the broader social changes that is, the rise of capitalist forms of production, industrialization, the growth of towns and cities, and the increasing dominance of scientific knowledge and explanation occurring within British society at that time (ibid, pp.624-25).

During the latter part of 1800's and the early 1900's, scientific advances particularly in microbiology brought in a new dimension to social health (Affi & Breslow, 1994). This phase was led by discoveries of Louis Pasteur and Robert Koch and germ theory of diseases. The development of antitoxin and immunization in 1920's prevented wide range of communicable diseases (Rosen, 1958). The bacteriologic discoveries became a marker between 'old' and 'new' system of health (Fee, 1994). The association between bacteria and disease causation drew attention away from the sanitary and social problems, but gradually public health professionals realized that disease though caused by germs could not be separated from living and working conditions (Rosner, 1995).

1.4.i Historical Development of Sociology of Health and Illness Globally

The systematic investigation of health by Sociology began only in the 18th Century (Sigerist, 1960). The idea of systematically investigating medical problems in the light of social science was conceived by Alfred Grotjhan in 1915. He advanced several principles basic to the study of illness from the social point of view (Dak, 1991, pp. 3-43). The relationship between Sociology and medicine can be broadly schematized as having three phases. In the first phase, the discipline established a disciplinary base within the universities of the USA. Though it found expressions in the works of Wirth in 1931 and Henderson in 1935-1936, it was only in the 1950's following Parson's work on the medical profession "The Social System' the field started to develop a clear identity (White, 2009, pp. 34-54). Throughout the 1950's Sociology was subordinated to medicine and was mainly used in dissemination of

medical knowledge and to encourage patient compliance with medical directives. Medicine incorporated many sociological insights without problems and thus schools of behavioural medicine, community medicine, and primary care medicine were established throughout the late 1960's and 1970's (ibid, p. 35). During 1950's Sociology saw itself working with medicine with biasness like (1) Acceptance of every illness as a form of deviance and believing that doctors are the only appropriate group capable of dealing with it (2) Complex social problems were defined and treated individually by administering drugs rather than looking into and modifying the social environment (3) Sociological research was geared towards ensuring patient compliance with the doctors' orders and (4) Only problems defined by medicine as a problem were studied (ibid, p. 35).

The second phase of Sociology's relationship to medicine started in the 1960's and 1970's. During this period sociologists argued that social role of medicine was to control sectors of the society and developed a critical perspective on the organization and practice of medicine (White, 2009, pp. 34-54). Erving Goffman's book 'Asylums' in 1961 opened up the critique of medicine as a value loaded system of social control operating under the guise of science. They argued that medicine categorize or label a person and some of these labels do not have an underlying biological reality rather reflects the social values and prejudices of the medical professionals (ibid, p. 36). This started raising questions about the neutrality of or the necessity in technological intervention in treating patients, it was argued that technology and science were connected for professional requirement and smooth functioning of the institution. Thus Sociology started to distance itself from medicine (ibid, pp. 36-37).

The third phase in 1970's and 1980's saw the development of a new confidence in the relationship between medicine and Sociology such that the sociologist working in the area of health and illness started questioning the medical model which explained diseases and illness as the outcome of the invasion of germs or virus and the treatment as administration of drugs or technology (White, 2009, pp. 34-54). Sociologists argued that germs or virus may be necessary for a disease to occur but they are not sufficient in themselves, Sociology of Health carries out researches to explore the relationship between social conditions as causes or facilitators of diseases (ibid, pp. 38). The sociologists think of society not as individuals who conglomerate into groups

but as a set of structures that will produce certain life chances for the individuals within groups. The key element in a sociological perspective on diseases is to see the ways in which we label and treat illness as a form of social control. What gets defined and treated as sickness may not always be a product of biological necessity but may be an aspect of wider social assumptions (ibid, p. 41).

1.4.ii Historical Development of Sociology of Health and Illness in India

India has a rich and ancient heritage of medical and health services. The science of Ayurveda and the surgical skills enunciated by Charak and Sasruta bear testimony to our ancient tradition in the scientific health care of our people (National Health Policy, 1983). The dynamic and continuous trade and cultural interactions which India maintained with many parts of the world ensured the growth of many health systems which continue to be practised even today. These systems are closely interwoven with the existing social structure, religious beliefs and social values of the society (Shukla & Mishra, 1991, p. 106). Besides medical and health agencies most of the curative and preventive health services reach the community through home care, traditional healers and indigenous practitioners cultivated as part of an area's socio-cultural setting (Marwah, 1975).

The process of health planning in India began with the work initiated by the well-known Bhore committee in 1946. In the following years, several other committees were set by the central government to review the implementation of various aspects of health in the country. Some of the other committees formed were Mudaliar Committee (1961), Chadha Committee (1963), Mukherjee Committee (1965), Jungalwala Committee (1967), Jain Committee (1968), Kartar Singh Committee (1973) and Srivastava Committee (1975) (Nagla & Madhu, 1991, pp. 44-69). The Bhore committee pointed out the link between the socio-economic conditions and health of the people and the Mudaliar committee pointed out that doctors were concentrating on curative work and suggested that they should share responsibilities with the auxiliary health personnel. The Bhore committee identified two aspects of social policy which was accepted and pursued in free India. The first recommendation says that every person suffering from a disease should get immediate medical attention irrespective of his socio-economic status. Another recommendation of the committee was that the doctor of the future should be a social physician. It has been

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recognized that if the quality of the lives of the people is to be improved their health status must be raised (ibid, pp. 61-65).

Low accessibility to basic health care facilities is a common phenomenon in most of the developing countries including India. In order to combat low accessibility to health care and to provide minimum basic health facilities, Health Assembly of the World Health Organisation (WHO) decided to launch a movement known as 'Health for all' by the year 2000 A.D and make it a major social goal for all governments. In 1981, a global strategy for this programme was adopted by WHO, which was later endorsed by the United Nations Central Assembly (Nagla & Madhu, 1991, pp. 44-69). India who is a signatory to this declaration had its first National Health Policy (NHP) in 1983. Before it only vertical health programmes like National Malaria Control Programme (NMCP), National Leprosy Eradication Programme, National Tuberculosis Control Programme, National Cancer Control Programme, etc. existed, which were meant to address only specific diseases. The first National Health Policy came in the aftermath of the Alma Ata declaration of 1978 and specified the target of health for all by 2000 as its specific goal (ibid, p. 57). However, health was not seen in a holistic perspective and the focus always remained on clinical treatment of 'diseases'. The Primary Health Centres (PHCs) and sub-centres could never attract the attention that they deserved in many parts of the country even after the comprehensive recommendations made by the Alma Ata Declaration (Mohammed, 2014). The second National Health Policy (2002) came in the aftermath of Millennium Development Goals (MDGs). It incorporated many of the health related goals and objectives suggested by the MDGs. The National Rural Health Mission (NRHM) was launched in 2005 to ensure participation of the local self-government institutions at village and Panchayat level in a meaningful way. Although the NRHM claimed to make an architectural correction in the health policies and plans, it again grossly missed the recommendations of the Alma Ata declaration for taking a comprehensive approach on health and primary care (ibid).

A group was set up by the ICSSR and ICMR with Dr. Ramalingaswami as the chairman, who came up with an alternative strategy to achieve health for all citizens. It suggested certain steps for re-structuring the health care services infrastructure based on the principle of promoting preventive and curative aspects of health. The

group recommended that the government of India should formulate a comprehensive national health policy in dealing with all its dimensions, that is philosophical, cultural socio-economic, nutritional, environmental, educational etc. (Nagla & Madhu, 1991, pp. 44-69).

Cultural anthropologists Marriot (1955) and Carstairs (1955) were the first to carry out a formal social science studies on health and medicine in Indian rural setting. Most social science studies in India were undertaken by medical organisations on medical and nursing professions, patients, hospital staff or hospital wards, relationship in hospital setting etc. (Pokarna, 1991, pp. 85-86).

1.5 Ageing and Sociology of Ageing

Ageing is a multi-dimensional process that affects every aspect of an individual; it represents the accumulation of changes in a person over time. Some dimensions of ageing grow and develop over time, while some decline. Reaction time, for example, may slow with age, while knowledge of world events and wisdom may not (Papalia, 2014). Aged according to their chronological age is categorised in to young-old, old-old, oldest-old which falls into 65-74, 75-84, 85 and above respectively. Research shows that even late in life, there is a potential for physical, mental, and social growth and development. In primitive societies and among pre-literate agrarian people well up to historical times an aged man or women had a distinct advantage in experience, knowledge and wisdom. Without written records or with poor access to them what was known had to be retained by memory (Leo, 1970, pp. 62-91). Old people were repositories of valuable information and were in favoured positions to make good judgments. The possessors of such qualification were in great demand for imparting general knowledge, interpreting strange and mysterious phenomena, deciding between right and wrong, diagnosing ailments, providing comfort and guidance to the distraught and bereaved (ibid, p. 82). The aged in this period had their fullest opportunity for prolonged and useful physical employment, they shifted to lighter and lighter tasks as they aged but never lacked something to do. They seldom suffered from abrupt retirement and usually turned their hands to useful efforts until very near the end of life. Opportunities to keep on working are essential and light tasks are obvious psychological and social assets in old age but labour which continues far into senescence may quite often become very burdensome (ibid, pp. 72-74). Complete

release from enforced labour may sometimes prove more rewarding than repeated demotions into lower levels of drudgery. In most primitive societies, the aged commonly possessed degrees of expertness that enabled them to be leaders in certain specialized functions but in complex or contemporary civilization with all its modern facilities and specialization the aged find very few opportunities to compete successfully with the youthful experts. With the introduction of modern systems of industrial production and with the growth of corporate forms of organizations older workers were confronted with changing expectations of role performance which found them at a competitive disadvantage with younger men (ibid, p. 74). The segmentation of tasks minimized the importance of craft skills and experience; rather it gave more importance to the effectiveness of performance and the pace in the productive system. Declining speed in effective out-put placed the older worker at a competitive disadvantage.

Prestige for aged is a complex matter involving many aspects of a culture. The problem is further complicated by the fact that certain kinds of treatment of the aged may be considered as marks of either esteem or of abuse depending upon social interpretations and local standards of propriety (Leo, 1970, pp. 62-91). Some societies have provided honourable, though abrupt and violent forms of death for their old folks. Relatives and friends have regarded these acts as deeds of mercy and aged have sometimes welcomed and even demanded such a death as their right. According to Hawkes (1916) the older Labrador Eskimo were treated with great respect, but that does not prevent them from putting the old folks out of the way when life becomes burden to them. But the act is usually done in accordance with the wish of the persons concerned and is thought to be proof of devotion. According to Simmons (1945) and Turner (1894) the aged were once buried alive, it was even considered a disgrace to the family of an aged chief if he were not so honoured (ibid, pp. 85-86).

India with its demographic and epidemiological transitions will have an ageing population which would require specialised care and care takers. The change in the demographics would give rise to a sandwich generation who would have to take care of their children as well as their parents. Elder care in India consists of three broad types i.e. care by adult married children and their families, care by the spouse, and institutional care. India is a culture rich country with joint family system which proves

to be an ideal situation for elderly care and protection, patriarchy that gives power and authority to the eldest male in the family, traditional values that respects and serves the aged etc. These situations are slowly giving way to compact nuclear family system that is self-centric, western outlook by adopting and enjoying individualism, and more over change in value system that gives very less or no respect to the aged. In a study of attitudes towards elder care issues and living arrangements carried out in 1984, 91% of the adult children surveyed said it was their duty to care for their elderly parents. A repeat survey in 1994 showed that only 77% of the adult children held the same view (Jamuna, 2005, pp. 125-42). In 1984 study the younger age groups stated that it is not proper to send the elderly to Old-age homes but in the 1994 study 23% felt that more homes for the elderly might be needed in future as many are unable to keep their elderly at home due to various reasons (ibid, p. 129).

In mechanics of care giving the most significant determinant of good care is compatibility or inter-relationship between the care giver and care receiver. In the Indian context usually it is a dyadic relationship between the care giver and care receiver; it is either between the husband and wife or between the elderly and the daughters-in-law. The dyad care giving relationship can be affected due to health status of the dyad members, time spent in caring, effort and human resource costs, economic costs, health maintenance etc. The relationship can also be affected by issues like level of disability of the elderly, mental disorders, dementia etc. (Jamuna, 2005, p. 130).

Growth in the size of the elderly population and increase in life expectancy have led to population ageing, or an increase in the proportion of older people relative to younger people. These changing demographics create challenges for many social institutions like health care system, retirement benefits, families, and the labour force, and therefore have important policy implications, especially in the areas of social security, pension, and health care policy. However, population ageing is often exaggerated as a social problem, and demographic facts have been used to create irrational fears that the rapidly increasing costs of pension plans and health care, and intergenerational conflict created by the burden of caring for the elderly, will strain our institutions to the breaking point. It is within this context of demographic change that the sociology of ageing research evolved (Andrea, 2006, p. 148). Sociology of

Ageing deals with the social aspects of ageing whereby, it is seen as a subjective series of a social processes as it interprets and negotiates to make sense of the biological development in relation to the existing social environment at a certain age. Over time, the study of ageing evolved from a social problem to an interest in age as a characteristic of social structure and personal biography. Two factors made this shift possible. First, by understanding the impact and dynamics of the baby boom cohorts that played an influential role in the transformation of the field both theoretically and empirically. In the 1960s, social scientists attempted to understand generational differences and how this might affect social change, focusing particularly on the cohorts of the baby boom in each phase of their lives. Theories sought to explain the divergent ideas and values of baby boomers from their parents and grandparents and how this affects social change (ibid).

Sociology superimposed ageing as a phenomenon in which there is a natural physiological process of change which is conditioned as a response to their social environment. An individual is only as old as he feels but it largely depends on how the society expects him to feel and act (Tibbitts, 1970, pp. 3-26). Most writers in the field of ageing hold that old age is a period of social withdrawal, either voluntary or imposed. The retirement procedure prevalent is instituted for the convenience of the industries which has often proved contrary to the wishes of the people concerned. Retirement brought with it a sense of financial insecurity and separation from a status and satisfaction defining activity (ibid, pp. 3-26). To top it the social change in the familial functions, with many functions like productive, protective and recreational being taken over by secondary agencies the role expectations of the elderly in the house have greatly altered.

1.6 Health and Ageing

Health in later life is the result of multiple factors and their effects over the life course. These may include aspects like socio-economic resources and risks, behavioural risk factors, and biological processes. Although health naturally declines with age, it does not decline at the same rate for all people. Old age is often accompanied by sickness and immobility due to some chronic illness. Gerontology or the study of ageing is relatively new in India so Geriatrics which is a specialised branch of medicine that deals with illness and problems specific to old age has not yet

received much importance. Most of the existing practitioners have little or no knowledge on the special health needs of the geriatric population (Gangadharan, 2005, p. 144). They often tend to view the geriatric issues with a preconceived mind set or mostly ignore the problems considering or typecasting it to old age. The few geriatricians practicing in India have been educated in western countries and have very less exposure and experience of the innumerable health challenges in the country. India where 70% of the population live in rural areas, accessibility to basic health care itself is problematic. The health of older persons in India has attracted little or no attention till recently but the consistent rise in the proportion of the elderly population in the country, there has been an evident change in the attitude and approach to the group.

Older persons were never considered as a target group for welfare measures in the five year plans, however after the seventh five year plan Ministry of Social Justice and Empowerment constituted a separate sub group to study the welfare of the aged (Sureender & Khan, 1996, pp. 9-11). In 1999 the government of India formed the National Policy for Older Persons (NPOP). The goal of the policy is to strengthen the legitimate place of older persons in society and help them live their last lap of life with purpose, dignity, and peace (Gokhale, 2005, p. 226). NPOP views the life cycle as a continuum in which the period beyond 60 years of age is also included, rather than looking at the period beyond 60 as a stage of disengagement and inactivity. It should be seen as a phase with choices, opportunities for creative and productive involvement (Gokhale, 1992). Health care and nutrition is a major focus in NPOP with emphasis on long term management of illness at home. NPOP aims to provide good affordable health services which are heavily subsidized for the poor and a graded system of user fees for others, public health services and insurance, non-profit private healthcare services etc. (Gokhale, 2005, p. 226). The policy envision to provide primary health-care system with greater orientation to the needs of older persons, geriatric facilities at secondary and tertiary levels, special counters for elders at public hospitals and trained medical and Para-medical personnel for the special needs of geriatric population (ibid, p. 226).

Health is a very important factor in the lives of the aged. Health is very subjective, what constitutes good health for one may not be good for the other, people accept

different physical states as normal and healthy depending on their past health history and also on the basis of current demands and expectations (Priya & Chadha, 2009, pp. 218-19). Health is an important factor that affects every aspect of our lives; it can determine what activities or tasks we can engage in and also the way we perceive ourselves. In the context of 'aged or geriatric' health is said to consist mainly of two aspects:

1) Actual health status which comprises of the individuals physical state.
2) Perceived health status which is the individuals own perception about his/her health with respect to others of his/her age (ibid, p. 219).

1.7 Study Location: A Brief Sketch

Gujarat (Figure 1.3) is a state in western India with an area of 75,686 square miles. Gujarat borders with Pakistan's province of 'Sindh' in the northwest, bounded by the Arabian Sea in the southwest, the state of Rajasthan in the northeast, Madhya Pradesh in the east, and Maharashtra and Union territories of Diu, Daman, Dadra and Nagar Haveli in the south. Historically, the north was known as "Anarta", "the Kathiawar peninsula", "Saurastra", and the south as "Lata". Gandhinagar is the capital of the state which is a planned city. Historically, the state of Gujarat has been one of the main centres of the Indus Valley Civilization. It contains major ancient metropolitan cities from the Indus Valley such as 'Lothal', 'Dholavira', and 'Gola Dhoro' ("Gujarat", 2014).

Gujarat played an important role in the economic history of India and has the fastest growing economy in India. It is one of the most industrialized states with a per capita GDP that is almost twice that of the national average. The density of population is 310 per square kilometre which is lower compared to other states. Hinduism, Islam and Jainism are the major religions in this state. Gujarat comprises of thirty three districts of which Ahmadabad, Anand, Vadodara, Surat, Gandhinagar, Rajkot etc are the major cities. Bharuch one of the coastal cities in Gujarat has carried on trading through its ports during the 'Maurya' and 'Gupta' empires ("Gujarat", 2014).
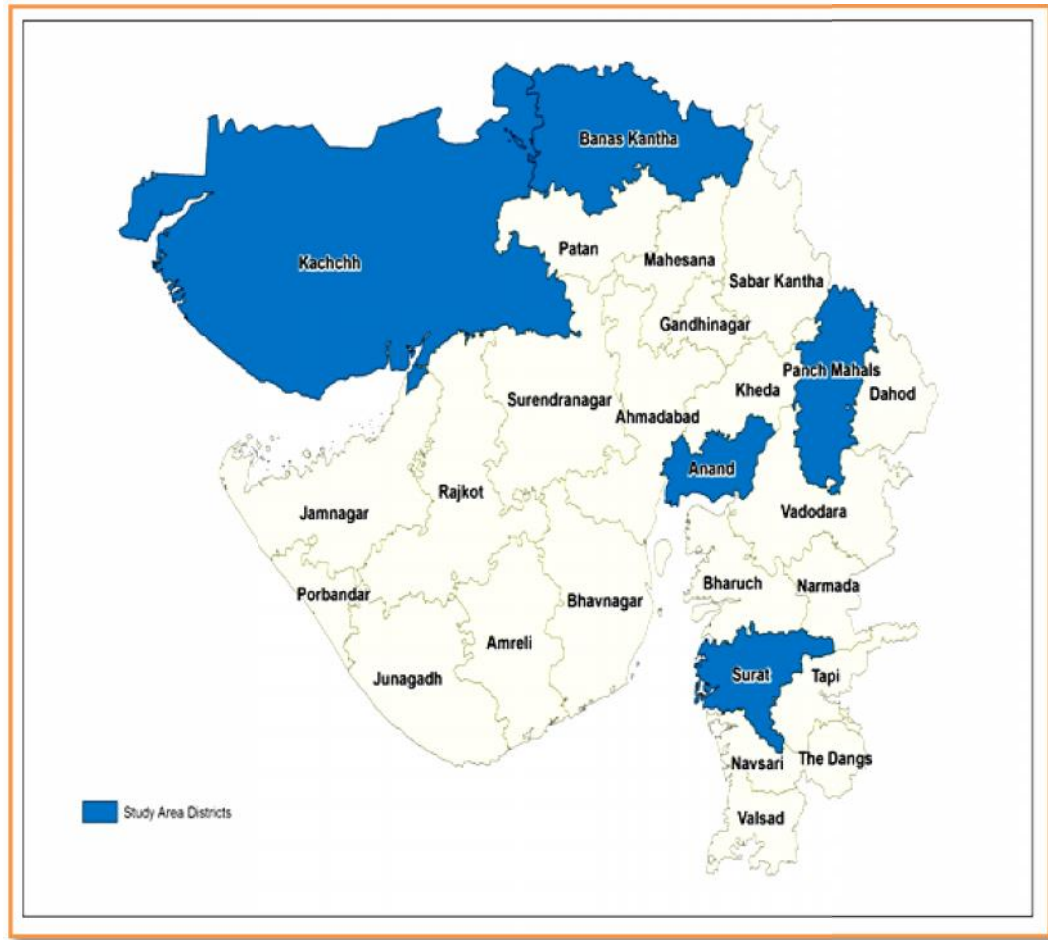
Figure 1.3 Map of Gujarat State Showing the Study Locations

Gujarat can be divided into five geographical regions such as the north, south, east, west and central Gujarat. The study has selected one district from each of these regions to get a better representation of the sample population cutting across the difference in regions, culture and living conditions. The study tries to understand whether the regional variations show any specific difference in the conditions of the sample population.

1.7.i Banaskantha

Banaskantha (Figure 1.4) which is in the northern part of Gujarat is the third largest district in the state. The administrative headquarters of the district is at Palanpur which is also its largest city. The district is located in the northeast of Gujarat and is presumably named after the west 'Banas River' which runs through the valley

between Mount Abu and Aravalli Range, entering into the plains of Gujarat in this region and flowing towards the Rann of Kutch.

Banaskantha shares its borders with Rajasthan state in the North, Sabarkantha district in East, Kutch district in West and Patan and Mehsana districts in the South. The economy of the district is based on agro & food processing, tourism, textile and mineral based industries. According to the 2011 census Banaskantha district has a population of 3,120,506, and the density of population is 290 persons per square kilometre ("Banaskantha", 2014).

Figure 1.2 Map of Banaskantha District

According to the census there are 198286 of 60+ populations in the district out of which 5.1% are old males and 7.1% are old females. The district has 63 Primary Health Centres, 422 Sub-Centres, 13 Community Health Centres and a network of private medical care institutions and trust hospitals (Census India, 2014). The district has only one Old-age home registered in the online list of Old-age homes in Gujarat.

1.7.ii Kachchh

Kachchh, (Figure 1.5) located on the western most tip of India, is the largest district in India. The administrative headquarters is in Bhuj which is geographically in the center of the district. Other main towns are Gandhidham, Rapar, Nakhatrana, Anjar, Mandvi, Madhapar, Mundra and Bhachau. Kachchh is virtually an island, as it is surrounded by the Arabian Sea in the west, the Gulf of Kachchh in south and southeast and Rann of Kachchh in north and northeast.

The district also borders with Pakistan along the northern edge of the Rann of Kachchh. Kachchh has 969 villages; Kandla and Mundra the two ports present in the district support the industrial and commercial activities in the state ("Kachchh", 2014). This district is famous for its palaces, museums, handicrafts, royal heritage, wild life, etc. According to 2011 census Kachchh has a population of 2,092,371 out of which 146216 are 60+ populations, the density of population is forty six persons per square kilometre. According to the census India report, there are 6.0% of elderly men and 8.0% of elderly women in the district (Census India, 2014).

Figure 1.5 Map of Kachchh District

Madhapar village in Kachchh is considered to be Asia's richest village due to foreign remittance by NRI's in Africa, the Gulf countries , UK and USA. This district has ten community health centres and thirty seven primary health centres. Tele-Consultation in health care is gaining popularity in the district; Appollo hospital international limited in association with Indian Space Research Organization (ISRO) is spreading awareness on health issues through tele-medicine in remote regions of Kachchh. There are 12 Community Health Centres, 48 Primary Health Centres and 251 Sub-Centres in the district (NRHM, 2014). The list of Old-age homes on websites has 2 Old-age homes registered in the district.

1.7.iii Surat

Surat (Figure 1.6) located in the southern part of Gujarat is the second largest commercial hub in the state with its textile and diamond processing industries. It is surrounded by Bharuch and Narmada in the North, Navsari in the South, Tapi in the east and the Gulf of Cambay in the west. It is the second-most advanced district in Gujarat ("Surat", 2014).

Figure 1.6 Map of Surat District

According to 2011 census report it has a population of 6,081,322 out of which 329746 are of 60+ populations. The density of population is 14,000 persons per square kilometre. The Census 2011 distribution of population by age and sex shows that there are 4.6% and 6.3% of elderly males and females in the district. There are 14 Community Health Centres and 52 Primary Health Centres and 601 Sub-Centres; the Lions Cancer Detection Centre Trust has been providing specialized treatment to cancer patients since 1968 (Census India, 2014). The list of Old-age homes on websites has only two Old-age homes mentioned in the district.

1.7.iv Panchmahal

Panchmahal, (Figure 1.7) also known as Panch Mahals, is a district in the eastern part of Gujarat State with administrative headquarters in Godhra. Panch-mahal means "five tehsils/talukas" (5 sub-divisions), and refers to Godhra, Dahod, Halol, Kalol and Jhalod that were transferred by the Maharaja Jivajirao Scindia Gwalior to the British. It is bordered by Dahod District in the north-east & east, Vadodara District in the south, Kheda District in the west and Sabarkantha District in the northwest, Banswara District of Rajasthan State also borders the district in the northeast ("Panchmahal", 2014).

Figure 1.7 Map of Panchmahal District

Panchmahal has a population of 2,390,776 and a density of 458 persons per square kilometre. According to 2011 census report the district has 184795 of 60+ populations. The distribution of population by age and sex according to 2011 census there are 7.0% of older men and 8.4% of older women. In 2006 the Ministry of Panchayati Raj named Panchmahal as one of the country's 250 most backward districts out of a total of 640. Major occupations in the district are dairy farming and agriculture. It has 9 Community Health Centres, 43 Primary Health Centres and 400 Sub-Centres (Census India, 2014). The district has only one Old-age home registered in its fold.

1.7.v Anand

Anand (Figure 1.8) is an administrative district of Gujarat state which is situated almost in the centre of Gujarat, and is popularly known as Charotar. It was carved out of the Kheda district in 1997. Anand is the administrative headquarters of the district. It is bounded by Kheda District in the north, Vadodara District in the east, Ahmedabad District in the west, and the Gulf of Khambhat in the south. Major towns are Khambhat, Tarapur, Petlad and Sojitra.

Figure 1.8 Map of Anand District

Anand is also known as milk capital of India because of Amul Dairy and its white revolution which is famous all over the world ("Anand", 2014). Economy of Anand is very vibrant which ranges from farming to big scale industries. Major crops include Tobacco and Banana. Vitthal Udhyog Nagar which is a very big industrial belt is located on the outskirts of the city. Many famous industries including ELECON, Warm Steam, Milcent and Atlanta Electrics are situated in this industrial belt.

According to 2011 census Anand district has a population of 2,092,745 out of which182502 are 60+ populations. The density of population is 711 inhabitants per square kilometre. According to 2011 census in Anand the 60+ population comprises of 7.7% of men and 9.8% of women of the total male and female population respectively (Census India, 2014). The district has 48 Primary Health Centres, 274 Sub-Centres and 11 Community Health Centres. The online list of Old-age homes shows only two organisations in the district.

The following Census data clearly indicates the distribution of Geriatric population of Gujarat state (Table 1.1 & Table 1.2).

DISTRICT WISE DISTRIBUTION OF GERIATRIC POPULATION IN GUJARAT (2011)

No	Area Name	Total			Rural			Urban		
		Persons	Male	Females	Persons	Male	Female	Persons	Male	Female
	Gujarat	4786559	2245601	2540958	2884326	1327258	1557068	1902233	918343	983890
1	Kachchh	146216	66253	79963	97909	43677	54232	48307	22576	25731
2	Banaskantha	198286	91019	107267	171644	78651	92993	26642	12368	14274
3	Patan	111653	50860	60793	87623	39911	47712	24030	10949	13081
4	Mahesana	186090	85461	100629	143373	65390	77983	42717	20071	22646
5	Sabarkantha	202827	93627	109200	174242	80405	93837	28585	13222	15363
6	Gandhinagar	110034	50340	59694	66092	29391	36701	43942	20949	22993
7	Ahmedabad	577602	283813	293789	96622	44732	51890	480980	239081	241899
8	Surendranagar	147905	68631	79274	103918	47951	55967	43987	20680	23307
9	Rajkot	337124	159373	177751	156888	72911	83977	180236	86462	93774
10	Jamnagar	189802	87751	102051	109879	50408	59471	79923	37343	42580
11	Junagadh	55663	25611	30052	29636	13474	16162	26027	12137	13890
12	Amreli	243013	111668	131345	170056	78001	92055	72957	33667	39290

Table 1.1 [Source: Compiled from the Ministry of Home Affairs, Census Data (2011)]

DISTRICT WISE DISTRIBUTION OF GERIATRIC POPULATION IN GUJARAT (2011) CONT.

No	Area Name	Total			Rural			Urban		
		Persons	Male	Females	Persons	Male	Female	Persons	Male	Female
13	Bhavnagar	237341	110153	127188	146674	67834	78840	90667	42319	48348
14	Anand	182502	83757	98745	124343	56454	67889	58159	27303	30856
15	Kheda	193782	89810	103972	146652	67592	79060	47130	22218	24912
16	Panchmahal	184795	86895	97900	161695	76071	85624	23100	10824	12276
17	Dahod	125489	57713	67776	111151	51094	60057	14338	6619	7719
18	Vadodara	355752	171045	184707	175118	81527	93591	180634	89518	91116
19	Narmada	47519	22564	24955	42661	20354	22307	4858	2210	2648
20	Bharuch	124078	57269	66809	87777	39941	47836	36301	17328	18973
21	The Dangs	12790	6072	6718	11661	5540	6121	1129	532	597
22	Navsari	130245	60288	69957	94147	43267	50880	36098	17021	19077
23	Valsad	126609	59474	67135	85044	39292	45752	41565	20182	21383
24	Surat	329746	159460	170286	99868	45387	54481	229878	114073	115805
25	Tapi	70546	32454	38092	64413	29639	34774	6133	2815	3318

⬭ Selected Districts

Table 1.2 [Source: Compiled from the Ministry of Home Affairs, Census Data (2011)]

1.8 Operative Definitions of Key Terms

The terms used in the title has been defined here to project the perspective or understanding with which the researcher has conducted the study.

1.8.i Geriatric

Geriatric is the normal, semi-official term used in Britain and the US when referring to the old people and their health care ("Geriatric", 2015).

1.8.ii Health

Mosby's Medical Dictionary defines health as "relative state in which one is able to function well physically, mentally, socially, and spiritually in order to express the full range of one's unique potentialities within the environment in which one is living" ("Health", 2015).

Mosby's Medical Dictionary also defines it as "a state of dynamic equilibrium between an organism and its environment in which all functions of mind and body are normal" (ibid).

1.8.iii Illness

The American Heritage® Medical Dictionary defines illness as "poor health resulting from disease of body or mind; sickness" ("Illness", 2015).

Mosby's Medical Dictionary has also defined illness as "an abnormal process in which aspects of the social, physical, emotional or intellectual condition and function of a person are diminished or impaired compared with that person's previous condition" ("Health", 2015).

Mosby's Dictionary of Complementary and Alternative Medicine defines it as "malady of either body or mind the symptoms of which may be physically unobservable. Within general medical practice, disease is nearly synonymous; however, illness has a more general connotation encompassing the subjective aspects of the patient as a whole rather than just physical or diagnostic symptoms" (ibid).

1.9 Aim of the Study

Change is the permanent truth of life. Just as nature changes or seasons change human society changes from one historical epoch to another, the human being changes from 'young' to 'old'. According to Seneca, old age is an 'incurable disease' (Suguna & Sandhya, 2002, pp. 101-17). Ageing is not a new phenomenon, the western societies had been dealing with the issues and consequences of ageing population for a very long time but for developing countries like India this phenomenon is relatively new and is gaining attention. Our ancient culture demands that the aged should be respected and looked after by their children. In the past joint family was the common pattern in family life, with the aged commanding obedience and respect and enjoying rights and responsibilities. Today with the advent of nuclear families they no longer enjoy the rights and responsibilities they once had, apart from facing specific difficulties like scarce accommodation, high cost of living and expensive medical care, many also feel unloved and uncared for (Moorthy, 2002, pp. 121-23).

Ageing process is multi-dimensional; the biological age of a person may not be identical to his chronological age. While ageing merely stands for growing old, 'senescence' is an expression used for the deterioration in the vitality or the lowering of the biological efficiency that accompanies ageing (Viswanathan, 1969). Ageing is associated with the changes in circumstances of the individual as a member of a family, community and society therefore bringing about changes in social attitudes, reduced income, work roles, activity and mobility, loss of spouse, free time and absence of societal expectations (Shankar, 2002, pp. 125-45). Keeping these factors in mind, the study tries to analyse the 'Health and Illness' of the geriatric samples in the present scenario from the perspective developed in Sociology of Health.

1.10 Focus of the Study

The main focus of the study is on assessing the health and illness of the elderly/ geriatric living in family settings and Old-age homes in relation to their different social settings like religion, class and caste and also their level of activity or disengagement.

1.11 Hypotheses

Elderly are becoming one of the significant group in the society. The number of elderly or aged is increasing day by day thus also increasing the dependency ratio. The role of the old and the young are complementary to each other; the relationships are based on the support they get from one another especially from the primary group (Radcliffe, 1964). The traditional joint family acted as a support system and protected the dependent members by providing income, health care, personal, physical and emotional security for all its members (Vijay, 2003, pp. 45-65). Variety of factors like migration, education and employment of women, urbanisation, and individualisation has affected the traditional customs and bonds.

The study was carried out keeping in mind the following hypotheses:

- The aged parents of the migrated youths feel unwanted, uncared and lonely and thus suffer from illnesses.
- Weak economic support and inter-generational ties affect the health of the aged.
- The aged residing in homes with their family enjoys better health and is well taken care during illness.
- The aged residing in Old-age homes are depressed and suffer from illnesses as they feel desolate, and lead an undignified life.
- The policies and programmes for the aged are not effectively implemented.