Institutionalized Isolation Vs. Informal Precarity: The Socio-Economic Dilemma of Aging: A Case Study of Old Age Populations in Thiruvananthapuram District

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Abstract
Kerala has the largest proportion of elderly population among Indian states. As the state's population is greying naturally it is important that the society and amenities must turn ageing friendly. Kerala was one of the very first states to be implementing an Old Age Policy. It has further expanded its welfare provisions for the elderly through several other programmes like Vayomithram, Mandhahasam, Sayamprabha and so on. The provision of care is multi-staged, there is a household level, institutional level, and societal level. But as the informal care providers at household level i.e. the children, who are displaying a tendency to migrate out of the state and country, the demographic shift in the state's population will raise concern. Loss of healthy, skilled human resource is a loss for any society. The only way to cope up with the challenges thrown at the state is by improving the general health and socio-economic conditions of the greying population.

Keywords: - Care Economy, Population ageing, Migration and care, Formal and informal care

1.1 INTRODUCTION

Kerala's performance in aspects of social and economic development has been different from the rest of the Indian states. Kerala has been described as a unique case among developing countries, a society where health and demographic transitions have been achieved within a single generation, that is after the formation of the state (Krishnan, 1991). The various factors which contributed to this cause includes reduction in fertility and mortality, high female literacy and so on. One of the most important factors that contributed to Kerala's demographic changes was the labour force migration from Kerala to the Gulf countries in the 1970s. The increased international migration in search of jobs and the remittances that Kerala incurred had resulted in the state witnessing more and more investments happening in health and education. Female education increased as well and it resulted in lower infant and maternal mortality rates in Kerala.

Both international and internal migration is a flow of individuals as well as skills. From the viewpoint of the originating country or locality, the loss of skilled labour is a major disadvantage of migration and it results in an increase in its dependent population. Moreover, migration tends to create more nuclear families and more often the elderly in migrant households are left behind. The role of women has also changed, they are more educated and are full-time workers and thus the role of women as the primary

caregivers is reducing. Altogether, the elderly in migrant households face a lack of human resources for elderly care within families. Even though institutionalized care in the form of care homes is increasing in the state, the stigma associated with living in a care facility is still prominent. According to a study by Murugesan (2001) on care homes in India, the inmates tend to experience dissatisfaction in fulfilling their psychological and social needs because of regimentation, social inactivity, helplessness, lack of interest, boredom, and loneliness.

Demographic transition and population ageing are universal phenomena that every country will experience at some point in time. They are not homogeneous, different countries will experience these phenomena in different periods at different paces and are unstoppable. Population ageing is a by-product or a consequence of demographic transition. Most developed countries have started experiencing population ageing as early as 1865. Whereas, this phenomenon of population ageing has become noticeable in developing countries in the twenty-first century. Population ageing is one of the most ignored developmental issues. But as the world is advancing day by day in research and development in medical sciences and is proceeding with increasing investments in human resource development, people are living longer lives these days. Life expectancy has increased, mortality rate is falling, and declining fertility rate across the global population has resulted in sighting more grey hairs which is expected to increase even more in the near future and also increase in dependency. The year 2050 will see 10 billion people on Earth instead of the 7.7 billion present today. Owing to the advancements in modern science and medicine people will live longer. Thus by 2060, it is expected that the number of elderly per 100 working-age people will be 58 which is triple the number of elderly per working-age people in 1980 (United Nations, 2017). This is a clear indication that the global population is ageing.

Since the process of migration is reducing the role of children and other relatives as primary care givers, alternative provision of care must be ensured for the well-being of the elderly who are prone to chronic diseases, mental illness, and other morbidities in their twilight period of life. They deserve long term care such that they are provided with good care, rights and can live a life of dignity till the end of their lives. There are many researches and plans specific to this particular issue being carried out in several western nations who witnessed population ageing and its potential impacts decades ago. There are similar Asian experiences as well. Japan and South Korea are Asian countries who meticulously planned and implemented measures to ensure the well-being of their ageing population and keep them productive. India as well as the state of Kerala has so much to learn from these global experiences. Foreseeing or planning ahead is really important when it comes to public planning and policy making. The current demographic shifts the state and the country as a whole is witnessing is demanding thorough research of the problem and appropriate solutions.

Kerala has the largest proportion of elderly population among Indian states. As mentioned earlier, Kerala is a unique case. As the state's population is greying naturally it is important that the society and amenities must turn ageing friendly. Kerala was one of the very first states to be implementing an Old Age Policy. It has further expanded its welfare provisions for the elderly through several other programmes like Vayomithram, Mandhahasam, Sayamprabha and so on. The provision of care is multi-staged, there is a household level, institutional level, and societal level. But as the informal care providers at household level i.e. the children, who are displaying a tendency to migrate out of the state and country, the demographic shift in the state's population will raise concern. Loss of healthy, skilled human resource is a loss for any society. The only way to cope up with the challenges thrown at the state is by improving the general health and socio-economic conditions of the greying population. Infrastructural and policy

developments should not be confined to the conventional ways of providing care. Incorporating technology and ensuring digital well-being can also help in providing care for the elderly in future. The number of studies which focuses on the vulnerabilities of the emigrants exceeds that of the ones which focuses on those who are left behind. This study focuses on the group of people who are facing seclusion induced by migration. The study also analyses the prospects of care economy from the point of view of the ones who demands for care. It studies the attitudes and perception of the stakeholders towards availing care.
This study focuses on the care for the elderly. The elderly population has a spectrum of needs which are unavoidable. The present study has the objectives to analyse the different socio-economic issues faced by the old age population and to study the differences in attitudes and perception of the elderly in availing care both in the institutional and informal set up.

1.2 OBJECTIVES

To analyse the different socio-economic issues faced by the elderly population in formal institutionalised care facilities and those availing informal care.

1.3 METHODOLOGY AND DATA SOURCES

The study is conducted among the old age population residing in Thiruvananthapuram district, Kerala. For the study, the selected old age homes in the district as well as households were visited. There are government run as well as NGO run formal care facilities for senior citizens. There are sixteen old age homes under the Social Justice Department of the government of Kerala across Kerala. Two of them are in Thiruvananthapuram with a number of over one hundred inmates. There are forty-nine institutions, recognized by the orphanage control board of Kerala in Thiruvananthapuram. These include both paid and unpaid old age homes. Information regarding these institutions were collected from the social justice department of Kerala.
The study uses multistage random sampling to select the respondents. The district has one municipal corporation, four municipalities, and 73 panchayats. The first step in selecting the sample was selecting the appropriate administrative units in the district such that they are effective representations of urban, semi-urban, and rural areas in the district. There is only one corporation in the district and it has been selected for the study. Out of the four municipalities, two were selected. The selected municipalities are Varkala and Nedumangad. Out of seventy-three panchayats, two were selected which are, Chirayinkeezhu and Venganoor Grama Panchayath. The selection was purely random. The second stage of sampling is considered with selecting different wards from each of these administrative units with an old age home. Two wards were selected under the corporation. Two wards were selected from under the two municipalities, and two wards were selected from under the selected panchayats. A total of six wards were visited for the study, and each of the old age homes in these respective wards were visited. Thus, from the forty-nine recognized care homes in the district, six were selected from the district. In the third stage of sampling, from among these selected care homes, the respondents were selected and interviewed. Several households with elders who are above the age of sixty belonging to these selected wards were visited and interviewed. To obtain the number of households and to conduct the interviews of the elderly belonging to such households, the ward members of the respective ward were contacted.
The study has made use of both primary and secondary data. Primary or raw data are collected for the first time directly from the main sources or respondents through interviews or surveys. Here, the primary data sources are the old age population belonging to households and those who are residing in care facilities in

the district. A total of sixty respondents were obtained from the selected old age homes and a total of sixty respondents were obtained from visiting the households. Out of the total respondents from old age homes, 55 were females and 45 were males. In case of the total respondents belonging to households, 24 were females and 36 were males. The collected data were tabulated and analyzed. The Secondary data sources were also used in this study. Secondary data collected by several government departments and other institutions were used. List of recognized care institutions were attained from the department of social justice, Government of Kerala. Kerala Migration Surveys published by the Center for Development Studies, Thiruvananthapuram, Kerala Migration survey 2023 published by Gulati Institute of Finance and Taxation were used. In addition to that, data from 2011 population census, India Ageing Report, Longitudinal Ageing Study of India were also used for this study.

1.4 THE SOCIO-ECONOMIC ISSUES OF THE ELDERLY

Ageing can be defined as a decline in the level of mortality and/or reduction in fertility with advancing age (Partridge and Mangel 1999). Ageing is a multifaceted and complex process that
encompasses a wide range of physical, psychological, and social transformations. As individuals navigate this transitional phase, they inevitably encounter five universal crises that challenge their sense of identity and well-being. These crises include the loss of social status, the passing of significant others, visible bodily changes that reflect biological decline, the confrontation with mortality, and the need to adapt to new roles and activities. However, it is essential to recognize that ageing is not a uniform experience; its impact varies significantly across cultures and geographical locations. Socio-economic and environmental factors play a crucial role in shaping the ageing process, influencing how individuals experience and respond to these universal crises. In some cultures, ageing is revered and associated with wisdom, respect, and spiritual growth. In contrast, other societies may view ageing as a decline or a burden. Environmental factors, such as access to healthcare, social support networks, and economic resources, also significantly impact an individual's ability to navigate the ageing process. Furthermore, socio-economic attributes like education, income, and occupation can influence an individual's experience of ageing. For instance, those with higher socio-economic status may have greater access to resources and support, enabling them to better cope with the challenges of ageing.

Thus, ageing is a complex and dynamic process that cannot be reduced to a single, universal experience. By acknowledging the diversity of ageing experiences and the factors that shape them, we can work towards creating more inclusive and supportive environments that enable individuals to age with dignity and resilience. In this study, the different issues of the elderly in the aspect of their physical health, mental health, their social issues, economic issues, digital awareness and so on are analysed under this section.

1.4.1 Age distribution of the total respondents

In several studies, the elderly are classified broadly as youngest-old, middle-old and oldest- old, belonging to the age groups of 65-74 years, 75-84 years, and greater than 85 years. Age is a crucial factor in analysing the issues these people face in different aspects. With ageing the perceptions, the physical health, mental health, problem solving ability and more will be compromised. The effects of all these issues will be experienced differently by the elderly in different age

A total of 120 respondents were interviewed for the study. 60 of the respondents were those who availed formal care or institutionalised care which in the case of this study is old age homes. The remaining 60 belong to informal care facilities, which refers to those who are cared for by their families or are living alone.

Table.1 The age distribution of the respondents

Age	60-65		66-70		71-75		76-80		80 above		Total	
	No.	%	No.	%	No	%	No.	%	No.	%	No.	%
Informal	0	0	24	20	24	20	12	10	0	0	60	50
Formal	9	7.5	15	12.5	12	10	15	12.5	9	7.5	60	50
Total	15	7.5	13	22.5	28	30	23	22.5	41	7.5	120	100

Source: Primary data

Out of the total 120 respondents,7.5 percent are in the age group of 60-65 years, 22.5 per cent are in the 66-70 years age group, 30 per cent belong to 71-75 years, 22.5 belong to 76-80 years age group and 7.5 are above the age of 80 years. Among those who are in informal care none of them belonged to the age group of 60-65 years, 20 per cent of them belonged to the 66-70 years age group, 20 percent of them belonged to the age group 71-75 years, 10 percent of them belonged to the age group 76-80 years and none above the age of 80 years. Among those who avail formal care, 7.5 per cent of them belonged to the age group of 60-65 years, 12.5 per cent belong to the age group of 66-70 years, 10 per cent of them are those who belonged to the age group 71-75 years, 12.5 per cent were in the 76-80 years age group and 7.5 percent are above the age of 80 years. The figures in the table given above are presented in forms of pie charts for easy interpretation.

1.4.2 Sex composition of the total respondents

Kerala's sex ratio is 1084 females per 1000 males, which is higher than the national average. The matriarchal nature of the society, higher level of education and so on have contributed in achieving this feat. The sex of the respondents is an important factor as the needs, issues, and challenges that the elderly faces will also depend upon their gender. In the present study Among the total 120 respondents, 45 percent are male and 55 per cent are females, which are 54 and 66 in numbers respectively. The percentage of males under formal care is 15 and that of females are 35 per cent. Whereas the percentage of males under informal care is 30 and females account to 20 per cent. Thus, from the selected sample, women are the major recipients of formal care.

Table.2 Sex Composition of the Respondents

Sex	Male		Female		Total	
	Number	percentage	Number	Percentage	Number	Percentage
Informal	36	30	24	20	60	50
Formal	18	15	42	35	60	50
Total	54	45	66	55	120	100

Source: Primary data

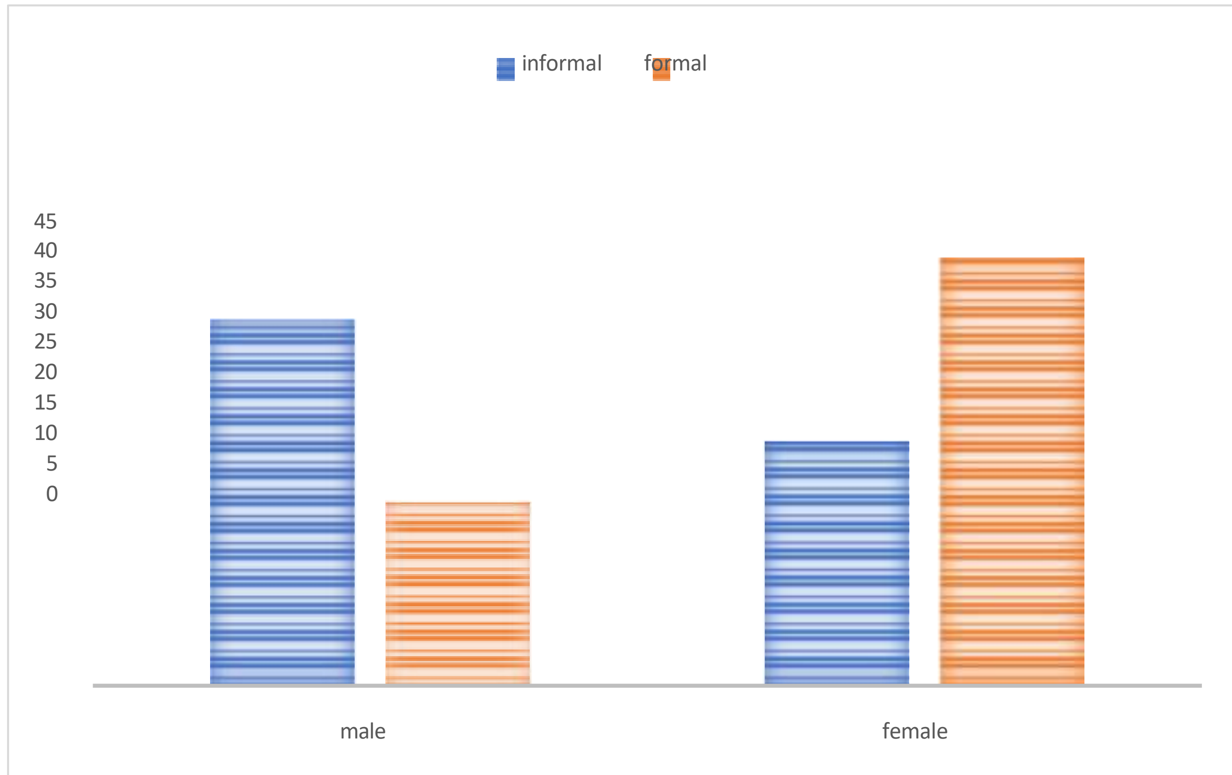

Fig.1 Sex Composition

1.4.3 Educational qualification of the respondents

The educational qualification and skills are really important factors that can influence the economic conditions of the subjects, their attitudes and perceptions towards the society, the respect that they earn from the society and so on, and these factors in turn influences the day to day lives of the elderly.

The following table represents the educational qualifications of the respondents. The educational qualifications are divided into five categories, uneducated, lower primary, upper primary, high school, and higher qualifications. Among the total 120 respondents, 5.83 per cent of them are not formally educated, 5 per cent of them has lower primary education, 25 per cent of them have attained upper primary education, 36.66 have completed high school, 27.5 per cent of them has higher qualifications.3.3 percent of the total respondents are in informal care and are not formally educated, whereas 2.5 per cent of the total respondents are not formally educated and are under formal care.0 per cent of the total respondents are in informal care and has lower primary education, whereas 5 per cent of the total respondents are in formal care and has lower primary education.10 per cent of the total respondents are in informal care with high school level education and 15 per cent of the total respondents are in formal care with high school level education. Out of the 27.5 per cent of the respondents with higher qualifications, 20 per cent lives in informal care, and 7.5 per cent is under formal care.

Table3. Educational qualifications of the respondents

Education	Uneducated		LP		UP		HS		Higher qualifications		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Informal	4	3.33	0	0	12	10	20	16.66	24	20	60	50

Formal	3	2.5	6	5	18	15	24	20	9	7.5	60	50
Total	7	5.83	6	5	30	25	44	36.66	33	27.5	120	100

Source; Primary data

1.4.4 Marital status of the total respondents

The marital status of all the 120 respondents were recorded under the categories of married, unmarried, widowed, divorced, and separated. 35.83 per cent of the total respondents are married, 16.66 per cent are unmarried, 37.5 per cent are widows and widowers, 2.5 per cent are divorced and 7.5 percent are separated. Of the 35.83 per cent of married respondents, 33.33 are in informal care and 2.5 are in formal care. Among the 16.66 per cent unmarried respondents, 6.66 per cent belongs to informal care and 10 per cent belong to formal care. Of the total widowed respondents, 10 per cent are in informal care and 27.5 per cent belong to formal care. All the respondents who are divorcees and are separated belonged to formal care.

Table.4 Marital status of the respondents

Marital status	Married		Unmarried		Widowed		Divorced		Separated		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Informal	40	33.33	8	6.667	12	10	0	0	0	0	60	50
Formal	3	2.5	12	10	33	27.5	3	2.5	9	7.5	60	50
Total	43	35.83	20	16.66	45	37.5	3	2.5	9	7.5	120	100

Source: Primary Data

The clustered bar graph shows the marital status of all the respondents under both informal and formal care. Number of married individuals are more in informal care, the number of those who are unmarried are higher among those in formal care. Divorced and separated respondents were only in formal care.

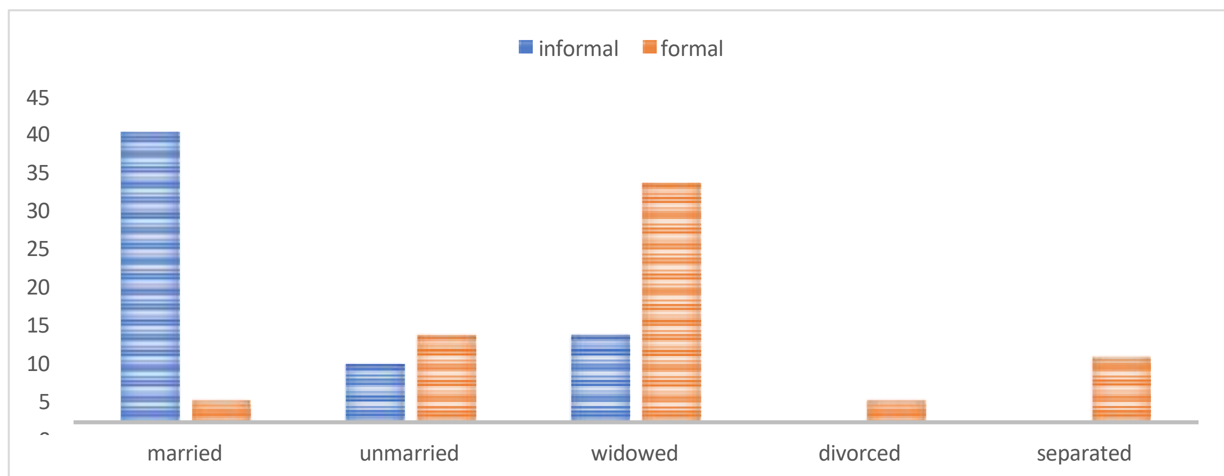

Fig. 2 Marital Status

1.4.5 Past occupation and current working status of the total respondents

The past occupation of the elderly is to be analysed because, it is a factor which can influence the economic back ground of the respondents, their retirement planning, their needs, and issues, thus influencing their perceptions, attitudes, and so on towards the society, as well as to availing care. The current working status

are to be analysed so as to understand what are the factors that are pushing these people at their senile age in which they are supposed to be living at ease, is still working.

1.4.6 Past Occupation

The past occupations of the respondents are categorised into four groups namely, Government, Private, Self-employed, and Unemployed. Out of the total respondents, 22.5 per cent worked in government sector,19.17 per cent worked in private sector,16.67 per cent were self- employed, and 36.66 per cent are unemployed. Among the 22.5 per cent who were in government sector, 20 per cent lives in informal care and the remaining 2.5 per cent lives in formal care. Among those who were in private sector, 6.67 per cent lives in informal care and 12. 5 per cent lives in formal care.

Table.5 Past Occupations of the respondents

Past occupation	Government		Private		Self employed		Unemployed		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Informal	24	20	8	6.67	8	6.67	20	16.66	60	50
Formal	6	2.5	15	12.5	12	10	24	20	60	50
Total	30	22.5	23	19.17	20	16.67	44	36.66	120	100

Source: Primary Data

1.4.7 Current Working Status of the Elderly

On analysing the data collected by interviewing the selected sample, some of those who are recipients of informal care carries out jobs. 12 out of the total 60 respondents under informal care are still working, i.e. 20 per cent of the respondents under informal care are still working. They account for 10 per cent of the total respondents.

1.4.8 Family type of the total respondents

Family type of the respondents is collected for the study to analyse its general trend among the ones availing formal care and informal care. In case of nuclear families, where the number of members is really low, the responsibility to take care of the elderly will be bestowed upon a smaller number of people, it will either end up with the stakeholder receiving good care or no care. Joint family types are getting lesser in number in the state, in case of joint family, the number of members who are physically and mentally available to the elderly are more. Being part of an extended family is when the dependent population lives in with their relatives. Those who are living alone are included under the category of single.

The type of family that the elderly are dwelling in will definitely influence several aspects of their lives. Each family type comes in with its own advantages and disadvantages, thereby influencing their freedom of choice, ability to make decisions, and so on.

Table.6 Family type of the respondents

Family type	Nuclear		Joint		Extended		Single		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Informal	44	36.66	16	13.33	0	0	0	0	60	50
Formal	48	40	3	2.5	9	7.5	0	0	60	50
Total	92	76.66	19	15.83	9	7.5	0	0	120	100

Source: Primary data

From the interviews conducted among the elderly availing formal and informal care respectively, 76.66 per cent belonged to nuclear families, of which 36.6 per cent or 44 respondents belonged to informal care and 40 per cent or 48 respondents belonged to formal care. 15.83 per cent of the total respondents belong to joint family, of which 13.3 per cent or 16 respondents are under informal care and 2.5 per cent or 3 respondents are under formal care. There were no respondents staying with extended family or single under informal care. There are 9 respondents or 7.5 per cent of the total respondents who were a part of an extended family before seeking shelter in formal care.

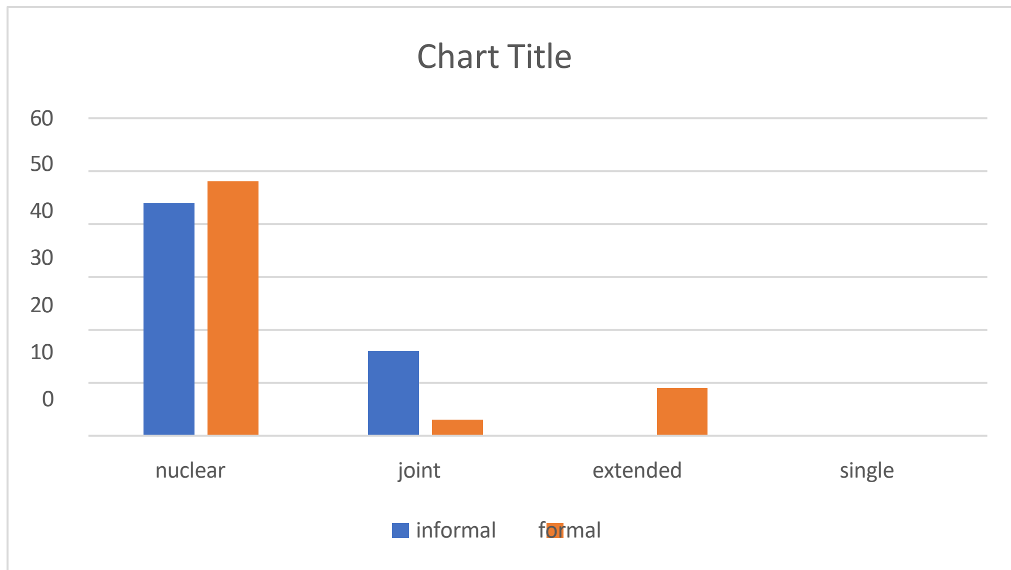

Fig.3. Family Type

The above discussed data is graphically represented with the aid of a clustered bar chart. The number of those with nuclear families are higher among those in formal care, and those belonging to joint families are higher in informal care.

1.5 HEALTH DIMENSIONS

WHO defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Health is one of the most important factors in experiencing a good life. As the saying goes, Health is indeed wealth. Only a healthy body can house a sound mind, with good health comes, better physical capabilities, mental health, and emotional well- being of a human being. Thus, taking care of one's health is an utmost priority. A good health is equally important for all across all age groups.

In the study, the respondents were interviewed and were asked questions regarding the life style diseases, other chronic diseases, and other uneasiness. They were also asked to rate their level of dependence to carry out very basic activities such as walking, eating, dressing or undressing, performing necessary chores like washing their own clothes, plates and so on, dependence to bath and so. Their ability to perform these tasks and the conditions of not having any serious illness will heavily impact their mental health, their ability to make decisions, and the freedom they experience.

They were also asked about how they felt about the life they are currently living, whether they are experiencing loneliness and how often they are experiencing it. They were asked about the quality of sleep they were getting as well.

1.5.1 Subject to Life style or any other chronic illnesses

The state's demographic is increasingly grappling with lifestyle diseases, which are becoming a major public health concern. Lifestyle diseases are conditions that arise from unhealthy lifestyle choices such as physical inactivity, poor diet, and substance abuse. Diabetes, hypertension, cardiovascular diseases, high blood pressure are some of the common lifestyle diseases that Keralites have. 75 per cent of the total respondents in the study said that they are subject to some kind of lifestyle diseases or have some kind of chronic diseases. Among them, 42.5 per cent of the ones with life style diseases were under formal care and 33.3 per cent are under informal care.

Table.7 Presence of illness among the respondents

Presence of illness	Yes		No		Total	
	No.	%	No.	%	No.	%
Informal	40	33.33	20	16.67	60	50
Formal	51	42.5	9	7.5	60	50
Total	90	75	30	25	120	100

Source: Primary data

Only 25 per cent of the total respondents were free of any life style diseases, of which 16.67 per cent lives under informal care and only 7.5 per cent were under formal care.

1.5.2 Level of dependence of the elderly under informal and formal care on others for fulfilling basic activities.

The respondents were asked to rate their level of dependence on others or some other external support to walk, eat, to dress and undress, to carry out chores, and to bath on a five-point scale from very dependent to not at all dependent. Out of the 60 respondents from informal care, 6.65 per cent of them are very dependent on external aid to walk, 6.66 per cent are dependent on external aid to walk, 26.6 per cent of them needs some assistance, 33.3 per cent are rarely dependent on others to walk and 26.6 per cent are not at all dependent on others to walk. When it comes to the respondents in formal care, 5 per cent of them are very dependent to walk, 5 per cent are dependent on others to walk, 35 per cent of them requires some assistance to walk, 38.4 per cent are rarely dependent on others to walk and 16.6 per cent are not at all dependent on others to walk.

In case of eating, 6.66 per cent of the total respondents from informal care are very dependent, 6.66 per cent of them are rarely dependent to eat, and 86.66 per cent are not at all dependent. Among those who lives in formal care, all of them are not at all dependent on any external aid to eat. To dress and undress, 6.66 per cent of the total respondents under informal care are very dependent, some assistance is needed for 6.66 percent, 6.66 per cent are rarely dependent on others and 80 per cent are not at all dependent. Among those under formal care, 1.67 per cent rarely needs assistance, and 98. 33 per cent are not at all dependent. In case of performing house chores like washing their clothes, 20 per cent of those under informal care are very dependent, 26.6 per cent are dependent, 6.6 per cent needs some assistance, 13.33 are rarely dependent, and 33.3 are not at all dependent. Among those under formal care, 63.33 per cent are dependent, 5 per cent needs some assistance, 30 per cent are rarely dependent and 1.66 per cent are not at all dependent.

Among those under informal care, 6.66 per cent are very dependent on others to bath, 6.66 per cent requires some assistance, 13.33 per cent are rarely dependent, and 73.33 per cent are not at all dependent. Among

those under formal care, 16.66 per cent are dependent on others to bath, 26.66 per cent requires some assistance, 6.66 per cent requires assistance rarely and 50 per cent of them are not at all dependent.

Table.8 Level of dependence on others for basic activities

Activities	Type of care	Very dependent	Dependent	Some assistance	Rarely dependent	Not at all dependent	Total %
Walking	Informal	6.66	6.66	26.6	33.33	26.6	100
	Formal	5	5	35	38.4	16.6	100
Eating	Informal	6.66	0	0	6.66	86.66	100
	Formal	0	0	0	0	100	100
Dressing &undressing	Informal	6.66	0	6.66	6.66	80	100
	Formal	0	0	0	1.67	98.33	100
House chores	Informal	20	26.6	6.6	13.33	33.33	100
	Formal	0	63.33	5	30	1.66	100
Bathing	Informal	6.66	0	6.6	13.33	73.33	100
	Formal	0	16.66	26.67	6.66	50	100

Source: primary data

1.5.3 General outlook of their life

Questions enquiring about their general view about their life, loneliness, quality of sleep were recorded from all the respondents. These are factors which can have profound impact on the mental health of the elderly. Poor quality of sleep, loneliness and so on can lead to decline in cognitive functions, mood disturbances, depression, anxiety, increased stress, loss of purpose and so on.

Among those under informal care, 26.6 per cent responded that they always feel loneliness, but in case of those under formal care, only 15 per cent responded that they feel loneliness always. Among those under informal care, 13.3 per cent responded that they usually feel lonely, in case of those under formal care, 15 per cent responded that they usually feel lonely.40 per cent of those under informal care responded that they experience loneliness sometimes. In case of formal care recipients, only 20 per cent responded that they feel loneliness sometimes. 30 per cent of those under formal care were of the opinion that they experience loneliness rarely. Among those under informal care, 20 per cent responded that they never experience loneliness. 20 per cent of those under formal care also responded that they never experience loneliness.

When asked how they feel about the life they are living now, 40 per cent of those under informal care responded that it is good. 23.3 per cent rated their life as acceptable, 20 per cent perceives it to be poor, for 15 per cent their life is good and for 3.3 per cent their life is poor. Whereas for those under formal care, for 45 per cent of them their life is acceptable, 25 per cent responded that their life was poor,15 per cent had the opinion that their life now is very good, for 10 per cent their life is good and for 5 per cent their life is very poor.

When asked about the quality of sleep that they receive, 13.3 per cent of those under informal care responded that their quality of sleep is poor, 26.6 per cent said that it is good, 20 per cent were of the opinion that it is very good and 20 per cent said that it is acceptable, and 20 per cent rated their sleep quality as very good. Among those under formal care, 45 per cent of them responded that they get very

good sleep, 10 per cent responded that they get good sleep, 10 per cent responded that they get acceptable sleep, 20 per cent gets poor sleep and 15 per cent gets very poor sleep.

Table.9 General outlook of life

Variables	Type of care	Always/ very good		Usually/ good		Sometimes/ acceptable		Rarely/ poor		Never/very poor	
Loneliness	Informal	16	26.6	8	13.3	24	40	0	0	12	20
	Formal	9	15	9	15	12	20	18	30	12	20
Feeling about life	Informal	8	13.3	24	40	14	23.3	12	20	2	3.3
	Formal	9	15	6	10	27	45	15	25	3	5
Quality of sleep	Informal	12	20	16	26.6	12	20	8	13.3	12	20
	Formal	27	45	6	10	6	10	12	20	9	15

Source: Primary data

1.6 SOCIAL DIMENSIONS

Social interactions and connections can greatly benefit the elderly by reducing loneliness and isolation, improving mental health, and slowing down cognitive decline. Engaging in social activities can also lead to improved physical health, including lower blood pressure, a healthier and stronger immune system. Moreover, social connections provide a sense of purpose and belonging, which is essential for overall wellbeing. A support network of friends and family can also help with daily tasks, transportation, and emotional support during difficult times.

For the study the respondents were interviewed and were enquired about their means of physical security which refers to the means with which their living environment is physically protected, such as gates, fences, surveillance cameras and so on. They were asked to rate their means of physical security, the safety of their living environment, how often does their relatives contact, how often do they go for family functions, go for social gatherings, the attention and recognition they get from the society, freedom and decision-making capacity.

1.6.1 The level of satisfaction in different factors in social interactions.

When enquired about the means of physical security that the informal care recipients had, 53.3 per cent of them responded that it is very good, 26.6 per cent said that it is good, 6.6 per cent said that it is acceptable, 13.3 per cent responded that it is very poor. 100 per cent of the care recipients in formal care responded that their means of physical security is very good.

When enquired and asked to rate the safety of their living environment, 46.6 per cent of those under informal care responded that it is very good.40 per cent rated it to be good, 13.3 per cent responded it is acceptable. 100 per cent of those in formal care said that the safety of their living environment is very good.

Among those in the informal care, 46.6 per cent has very good contact with their relatives, while only 5 per cent among those in formal care has very good contact with their relatives.

13.3 per cent of those under informal care rated their relatives contacting as good, but only 5 per cent among those under formal care rated it as good. 26.6 per cent of those under informal care rated it as acceptable and 25 per cent of formal care recipients rated it as acceptable. According to 13.3 per cent of those under informal care and 25 per cent of those under formal care rated it as poor. 40 per cent of those under formal care rated that the frequency of their relatives contacting is very poor.

Table.10 Level of satisfaction of respondents in different factors in social interactions.

Variables	Type of care	Very good		Good		acceptable		poor		Very poor	
		No.	%	No.	%	No.	%	No.	%	No.	%
Means of security	Informal	32	53.3	16	26.6	4	6.6	0	0	8	13.3
	Formal	60	100	0	0	0	0	0	0	0	0
Safety of living env.	Informal	28	46.6	24	40	8	13.3	0	0	0	0
	Formal	60	100	0	0	0	0	0	0	0	0
Relatives contacting	Informal	28	46.6	8	13.3	16	26.6	8	13.3	0	0
	Formal	3	5	3	5	15	25	15	25	24	40
Family functions	Informal	16	26.6	12	20	0	0	12	20	20	33.3
	Formal	3	5	0	0	15	25	5	10	36	60
Social gatherings	Informal	12	20	16	26.6	8	13.3	0	0	24	40
	Formal	39	65	6	10	6	10	3	5	6	10
Attention& recognition	Informal	24	40	16	26.6	12	20	8	13.3	0	0
	Formal	21	35	9	15	24	40	3	5	3	5
Freedom	Informal	44	73.3	0	0	12	20	0	0	4	6.6
	Formal	0	0	0	0	3	5	9	15	48	80
Decision making	Informal	40	66.6	4	6.6	12	20	0	0	4	6.6
	Formal	0	0	0	0	3	5	9	15	48	80

Source: Primary Data

26.6 per cent of those under informal care and 5 per cent under formal care rated them attending family functions as very good. 20 per cent of those under informal care rated it as good. 25 per cent of those under formal care rated it as acceptable. 20 per cent of those under informal care and 10 per cent under formal care rated it as poor. 33.3 per cent of those under informal care and 60 per cent of those under formal care rated it to be very poor.

On enquired how often they attend social gatherings other than family functions and to rate it, 20 per cent of those in informal care and 65 per cent of those in formal care responded that it is very good implying that they always try to be a part of such gatherings. 26.6 per cent of those in informal care and 10 per cent of those in formal care rated it as good. 13.3 percent of those in informal care and 10 per cent of those in formal care rated it as acceptable. 5 per cent of those under formal care rated it as poor. 40 per cent of those under informal care and 10 per cent of those under formal care rated it to be very poor.

The respondents were asked to rate the attention and recognition that they receive from the society on a scale of five. 40 per cent of those under informal care and 35 per cent of those under formal care rated it to be very good. 26.6 per cent of those under informal care and 15 per cent of those under formal care rated it as good. 20 per cent of those under informal care and 40 per cent of those under formal care rated it as acceptable. 13.3 per cent of those under informal care and 5 per cent of those under formal care rated it as poor. 5 per cent of those under formal care rated it as very poor.

The respondents were also asked about the freedom and their ability to make decisions in their current living conditions and were asked to rate it in a five-point scale. 73.3 per cent of those under informal care rated their freedom to be very good,20 per cent of them rated it to be acceptable and 6.6 per cent rated it to be very poor. In case of residents in formal care, 5 per cent of them rated it as acceptable, 15 per cent of them rated it as poor and 80 per cent had the opinion that its very poor.

When asked to rate their ability to make decisions, 66.6 per cent of those in informal care rated it as very good, 6.6 percent of them rated it as good, 20 per cent rated it as acceptable and 6.6 per cent of them rated it to be very poor. In case of those under formal care, 5 per cent of them rated it as acceptable, 15 per cent rated it as poor and 80 per cent rated it as very poor.

1.7 ECONOMIC DIMENSION

Economic aspects of prudential retirement planning, savings, and proper spending significantly influence the lives of people in their old age, impacting their financial security, independence, and overall well-being. Adequate savings and investments provide a safety net for unexpected expenses, healthcare needs, and long-term care, reducing anxiety and uncertainty. Proper spending habits during retirement help stretch savings, allowing individuals to pursue hobbies, travel, and social activities, promoting mental and physical stimulation. Moreover, financial independence enables older adults to make choices about their lives, including where to live, how to spend their time, and how to contribute to society. Conversely, inadequate retirement planning can lead to financial strain, forcing individuals to rely on family, friends, or government assistance, potentially compromising their dignity and autonomy. Effective economic planning for retirement empowers individuals to age with confidence, security, and purpose, enabling them to live fulfilling lives in their later years.

1.7.1 Pension and retirement planning of the respondents

Retirement planning and pension play a vital role in enhancing the lives of elderly people by providing financial security, peace of mind, and independence. A well-planned retirement ensures that elderly individuals have a steady income stream to meet their living expenses, healthcare needs, and pursue their interests without financial stress. A pension, in particular, provides a predictable and reliable source of income, allowing elderly people to budget and plan their expenses with confidence. This financial stability enables them to maintain their dignity and independence, making choices about their lives without being burdened by financial worries. Moreover, retirement planning and pension also enable elderly people to leave a legacy for their loved ones, creating a sense of fulfilment and purpose. By ensuring that their financial needs are met, elderly individuals can focus on their physical and mental well- being, engage in social activities, and pursue hobbies and interests that bring them joy and fulfilment. Furthermore, retirement planning and pension also provide a sense of security and protection against unexpected expenses, such as medical emergencies or long-term care needs. This peace of mind allows elderly people to age with confidence, knowing that they have a safety net to fall back on. In essence, retirement planning and pension are essential components of a happy, healthy, and fulfilling life in old age, enabling elderly individuals to live their golden years with dignity, purpose, and financial security.

1.7.2 Pension

The following table shows the opinion of the respondents about their pension

Table .11 Respondents receiving pension

Pension	Receives pension		No pension		Total	
	Number	percentage	Number	Percentage	Number	Percentage
Informal	52	43.33	8	6.67	60	50
Formal	0	0	60	50	60	50
Total	52	43.33	68	56.67	120	100

Source: Primary Data

52 out of the total 60 informal care recipients are beneficiaries of pension, they account for 43.33 per

cent of the total respondents. The remaining 8 respondents do not receive pension and they account for 6.67 per cent of the total 120 respondents. The inmates of formal care institution do not receive pension as per government order.

1.7.3 Retirement planning

The following table shows the opinion of the respondents about their retirement planning.

Table.12 Retirement planning among the respondents

Retirement	Planned		Unplanned		Total	
	Number	percentage	Number	Percentage	Number	Percentage
Informal	32	26.67	28	23.33	60	50
Formal	12	10	48	40	60	50
Total	44	36.67	76	63.33	120	100

Source: Primary data

Among the total respondents 36.67 per cent have planned their retirement, of which 26.67 percent belong to informal care, and 10 per cent belong to formal care. 63.33 per cent of the total respondents did not plan their retirement. Of which, 23.33 per cent is in informal care and 40 per cent of those who did not plan for retirement are in formal care institutions.

1.8 DIGITAL DIMENSION

It is crucial for the elderly to know and use new technology, especially in a digital aspect, as it plays a vital role in enhancing their quality of life, social connections, and independence. In today's digital age, technology has become an essential tool for communication, access to information, and daily tasks. By embracing technology, elderly individuals can stay connected with loved ones through video calls, messaging apps, and social media, reducing feelings of loneliness and isolation. Moreover, the internet provides access to a wealth of information, enabling them to stay informed about news, healthcare, and hobbies. Digital technology also offers various tools and services that can assist with daily tasks, such as online shopping, banking, and bill payments, making life easier and more convenient. Additionally, technology can support health and wellness through telemedicine, fitness apps, and medication reminders. Learning new technology can also help keep the mind active and engaged, potentially delaying cognitive decline. Overall, embracing digital technology can empower elderly individuals to live more independently, stay connected, and enjoy a better quality of life.

To know about their level of awareness regarding the new technologies, they were asked about the phone they possess if any, they were asked if the phone they possess is a smartphone. They were enquired about the internet facilities, they were asked whether they know to use UPI, and use their phones to use entertainment applications.

1.8.1 Possession of smart phones, internet connection and usage of online services such as UPI.

The following table shows the opinion of the respondents about their possession of smart phones, internet connection and online useage.

Table.13 No. of respondents with smartphones, internet and other digital services

Type	Smart phones		Internet		UPI		Entertainment apps.	
Informal	40	33.3	44	36.66	12	10	36	30

Formal	6	5	6	5	3	2.5	6	5
Total	46	38.3	50	41.66	15	12.5	39	35

Source: Primary Data

38.3 per cent of the total respondents knows to use smartphones, of which 33.3 per cent are in informal care and 5 per cent are in formal care. 41.66 per cent of the total respondents had internet connectivity and knows to use it. Of which, 36.66 per cent are in informal care and 5 per cent are in formal care. 12.5 per cent of the total respondents knows how to use UPI, 10 per cent of them are in informal care and 2.5 per cent are in formal care. 35 per cent of the total respondents knows to use entertainment applications on their phone out of which 30 per cent belongs to informal care and 5 per cent belongs to formal care.

1.9 FINDINGS

- The youngest-old and middle old population are the ones who are availing formal care facilities the most. The highest number of respondents were from the age group 71-75 years. the residents in formal care belongs mainly to the age group of 66-70 years and 76-80 years accounting for 12.5 per cent of the total respondents each. Whereas the respondents in informal care mostly belong to the age groups of 66-70 years and 71-75 years.
- The majority of the respondents are women, accounting for 55 per cent of the total respondents. Women are the major recipients of formal care (35 per cent).
- The respondents with higher education qualifications are mostly in informal care and the ones with lower qualifications are under formal care.36.66 per cent of the total respondents have attained high school level education.
- Majority of the respondents under formal care has attained high school level education (20 per cent of the total respondents). In the case of those under informal care, the majority has higher educational qualifications).
- Majority of the respondents are either widows or widowers (37.5 per cent). Majority of the recipients of formal care are widows or widowers (27.5 per cent). Majority of the respondents from informal care are married (33.33 per cent), indicating that most with the absence of a primary care taker are one of the reason for availing care.
- Majority of the respondents of the study are unemployed (36.66 per cent). Among the unemployed respondents, most belong to formal care. Only 10 per cent of the total respondents are currently working, and they belong to informal care.
- The majority of the respondents belong to nuclear families, accounting to 76.66 per cent of total respondents. 40 per cent of them belong to formal care, indicating that, those with nuclear families are the majority consumers of formal care. In case of those belonging to joint family, majority are under informal care, indicating that they are less dependent on formal care.
- 75 percent of the respondents are subject to lifestyle or other chronic diseases. And among those with diseases, majority are under formal care, indicating that having poor health is also a factor in availing formal care. From the interview conducted, those under formal care were given regular health check-ups, regular exercises are incorporated into their lives like Yoga, and are given quality medical attention. In case of those under informal care, the majority of them do not undertake regular check-ups or incorporate exercise into their lives. Through the interviews it is understood that, high blood pressure, diabetes, joint pain, poor eyesight are generally quoted diseases among the respondents.

- Among those in formal care 35 per cent of them need some kind of assistance to walk, while in case of informal care, the number is lesser. This implies that depending on others to walk is one of the factors influencing the demand for care.
- 86.66 per cent of those in informal and 100 per cent of those in formal care are not at all dependent on external aid to eat.
- 80 per cent of those in informal care are not at all dependent on external help to dress and undress, 98.33 per cent of those in formal care are not at all dependent to dress or undress.
- 26.6 per cent of those in informal care are dependent on others to get their house chores done, but in case of those under formal care, 63.33 per cent of them are dependent on others to get their chores done, implying that there is a demand for care.
- 73.33 per cent of those in informal care are not at all dependent on others to bath, but in case of formal care, 50 per cent of them are only not dependent. The rest are dependent on others at some degree.
- 26.6 per cent of those in informal care responded that they always feel lonely, but when it comes to those in formal care it is only 15 per cent. Majority of those in formal care responded that they feel lonely rarely or never. It implies that under the living circumstances, and peers, the formal care inmates experiences lesser loneliness than those in informal care recipients.
- Majority of those in informal care responded that their life is good, which accounts for 40 per cent and majority of those in formal care responded their life is acceptable.
- The recipients of formal care tend to have better quality sleep than those in informal care. 45 per cent of those in formal care has very good quality sleep where as in informal care only 20 per cent has good quality sleep. The good quality of attention, security, and social interactions that the inmates receive in formal care can be the reason behind this.
- In case of the means of physical security, only 53.3 per cent of those in informal care rated it as very good. In case of those in formal care all of them rated their means of physical security to be very good. They are well protected with fences, gates, CCTVs, security and so on.
- Only 46.6 per cent of those in informal care believe that the environment in which they are living in is very good, but in case of those in formal care all of them responds that the environment around them is very safe to reside in.
- Among those in informal care, majority of them, 46.6 per cent, has very good contact with their relatives, in case of those in formal care, majority of them, 40 per cent has absolutely no contact with their relatives. Most of them in formal care has few relatives or no relatives at all, and a significant number of them told the interviewer that most of their relatives cut ties with them once they started living in a care home. This indicates that there are societal stigmas still prevailing in availing care homes.
- When it comes to social gatherings other than family functions, only 20 per cent of those in informal care are indulged in it very frequently, but in case of those in formal care, 65 per cent of them are indulged in such programmes very frequently.
- Majority of those in informal care responded that the attention and recognition that they receive from the society is very good, only 13.3 per cent of them had the opinion that they are given poor attention. While in case of those in formal care, 35 per cent said that they get very good attention. 40 per cent of them said that the attention and recognition that they are getting is acceptable. Through the interview they also added that, they have felt like they are disconnected from the society and they no longer feel

like they are part of the outside world.

- In case of having freedom and the capacity to take decisions of own, informal care recipients are at an advantage. Majority of them responded that they have really good freedom meanwhile those under formal care rates it as very poor.
- In case of decision making, 66.6 per cent of those under informal care rated it as very good and 80 per cent of those in formal care rated it as very poor. Beneficiaries of formal care are definitely subject to a common framework and rules. But at times it may become frustrating for the inmates.
- 52 out of the total 60 informal care recipients are beneficiaries of pension, they account for 43.33 per cent of the total respondents. The remaining 8 respondents do not receive pension and they account for 6.67 per cent of the total 120 respondents. The inmates of formal care institution do not receive pension as per government order.
- Among the total respondents 36.67 per cent have planned their retirement, of which 26.67 percent belong to informal care, and 10 per cent belong to formal care. 63.33 per cent of the total respondents did not plan their retirement. Of which, 23.33 per cent is in informal care and 40 per cent of those who did not plan for retirement are in formal care institutions. This implies how important is it to plan retirement.
- 38.3 per cent of the total respondents knows to use smartphones, of which 33.3 per cent are in informal care and 5 per cent are in formal care. 41.66 per cent of the total respondents had internet connectivity and knows to use it. Of which, 36.66 per cent are in informal care and 5 per cent are in formal care. 12.5 per cent of the total respondents knows how to use UPI, 10 per cent of them are in informal care and 2.5 per cent are in formal care. 35 per cent of the total respondents knows to use entertainment applications on their phone out of which 30 per cent belongs to informal care and 5 per cent belongs to formal care.
- Majority of those in informal care have strongly agreed to the statement that the society is judgemental, but it is not with the case of those in formal care. The stigma associated with using these facilities can be a disadvantage. 50 per cent of the total respondents believe that it is the responsibility of the children to take care of the elderly, meanwhile only 23.33 per cent believed that it is one's own responsibility to plan ahead and save for old age.
- 50 per cent of the respondents belong to emigrant households, i.e. at least one of their children is an emigrant. Most of those in formal care have an emigrant child who is not with them for more than 20 years.
- From the interview held and data collected it is understood that 30 per cent of the respondents reported that they strongly agree that the absence of their child is making their life harder and 30 percent of them agreed to the statement as well, in short a major chunk of those in informal care belonging to emigrant households have expressed that the physical absence of their child is making their life harder in one way or the other.

1.10. CONCLUSION

The emerging issue of Kerala's ageing population is a major consequence. Old age by itself is a challenging period for an individual. During this period people tend to be vulnerable to psychological, social, and health issues. Thus, the institutions for health care and social care should adequately cater to the needs of the elderly population. They deserve long term care such that they are provided with good

care, rights and can live a life of dignity till the end of their lives. Since the process of migration is reducing the role of children and other relatives as primary care givers, alternative provision of care must be ensured for the well-being of the elderly who are prone to chronic diseases, mental illness, and other morbidities in their twilight period of life.

BIBLIOGRAPHY

1. Bookman, A., & Kimbrel, D. (2011). Families and elder care in the twenty-first century. The Future of children, 21(2), 117–140.
2. Baldassar, Loretta. (2007). Baldassar, L. (2007) 'Transnational Families and aged care: the mobility of care and the migrancy of ageing', Journal of Ethnic and Migration Studies, 33 (2):275-297.
3. Bonsang E. (2009). Does informal care from children to their elderly parents substitute for formal care in Europe?. Journal of health economics, 28(1), 143–154.
4. Genet, N., Boerma, W. G., Kringos, D. S., Bouman, A., Francke, A. L., Fagerström, C., Melchiorre, M. G. Greco, C. & Deville W. (2011). Home care in Europe: a systematic literature review. BMC health services research, 11, 207.
5. India Ageing Report. (various years)
6. Krishnan, T. N. (1991). Kerala’s health transition: facts and factors. Center for Population and Development Studies, Harvard University.
7. Kerala Migration Surveys published by the Center for Development Studies, Thiruvananthapuram.
8. Kerala Migration survey 2023 published by Gulati Institute of Finance and Taxation.
9. Longitudinal Ageing Study of India. (various years)
10. Population census, 2011.
11. Qin, M., Punpuing, S., Guest, P., & Prasartkul, P. (2008). Labour migration and change in older people's living arrangements: The case of Kanchanaburi Demographic Surveillance System (KDSS), Thailand. Population, Space and Place, 14(5), 419-432.
12. Sasikumar, s & Hussain, Zakir. Migration, Remittances and Development: Lessons from India.
13. Sparrow, R., Sparrow, L. In the hands of machines? The future of aged care. Minds & Machines 16, 141–161 (2006).
14. Stoddart, H., Whitley, E., Harvey, I., & Sharp, D. (2002). What determines the use of home care services by elderly people? Health & social care in the community, 10(5), 348–360.
15. Sunitha, S. (2023). Demographic trends in Kerala. Kerala’s economic development: COVID-19 pandemic, economic crisis and public policy
16. Zachariah, K.C. & Mathew, E.T. & Sebastian, Irudaya Rajan. (2001). Social, Economic and Demographic Consequences of Migration on Kerala. International Migration. 39. 43 - 71.