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Chapter 19: Perspectives on Old Age in India

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Abstract The elderly population of India is projected to increase to about 300 million by 2050. Families, the traditional source of support for the elderly in India, are getting smaller as result of reduction in fertility and, in rural areas, due to migration. Changing norms and attitudes on intergenerational relations and filial piety have the potential to weaken traditional social and family support structures that the elderly depend on. As institutional and welfare support systems are lacking in India, changes to the family and social support structures will have serious implications for ageing in India. The demographic, economic, family and health perspectives presented in this chapter reveal some of the complexities of the ageing in India. They show that the nature, type and direction of support between the generations depends on the situation and resources of both parents and children, embedded within the wider social and cultural values of support and care, and the expectations and meanings attributed to these values. The perspectives presented also raise important questions about the relationships, roles and responsibilities of individuals, families and the state.

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1. Introduction

About eight per cent of India's population is over the age of 60, a figure similar to that of Indonesia but lower than China's 12.4 per cent. In absolute numbers, however, there are more than 93 million elderly in India and this number is projected to increase to about 296 million by 2050 (United Nations, 2013). This chapter presents important demographic, economic, social, family, health and policy perspectives on ageing in India. Unless stated otherwise, 'elderly' in this chapter refers to those aged 60 and above[2].

2. Demographic Aspects of Ageing

Population ageing is brought about by shifts in the age structure of a population, due to changes in births, deaths and migration. Increasing birth rates make a population younger. However, the effect of mortality on age structure depends on the age groups which experience the decline – decline in mortality at younger ages makes the population younger while decline in mortality at older ages makes the population older.

Demographic transition in India over the last half century has witnessed a steady change in fertility and life expectancy. Fertility began to decline in earnest from the mid-1960s reaching a low of 2.66 by 2011 (Guilmoto and Rajan, 2013). Life expectancy at birth increased rapidly between 1950 and 1975, mainly due to reductions in child mortality rates, followed by a steady but slower rate of increase post-1975 (Saikia, Singh and Ram, 2010). Mortality decline in older ages has not been dramatic. While life expectancy at birth increased from 49.7 to 63.5 between 1970-75 and 2002-6, life expectancy at age 60 increased from 13.8 to 17.9 years and at age 70 increased by less than 3 years during the same period (Government of India, 2011).

The shifts in fertility and mortality and the resulting changes in age structure of the population can be visualized using population pyramids in Figure 1. The pyramids show the proportion of the population in each age group relative to the total population and not the absolute number of people in each age group. The broad base of the pyramid in1950 reflects high fertility rates during the period and the narrow top reflects the small number of elderly in the population. By 2050, declines in fertility will shrink the base (the per cent of population in the younger age groups will decline relative to the total population) and as people from earlier cohorts move up

[2] 60 and above has been used by researchers and the Indian Government as a marker of old age. The National Policy on Senior Citizens 2011 categorically states "All those of 60 years and above are senior citizens." It should, however, be recognized that there is nothing sacrosanct about the age 60 or using chronological age based on number of years lived. Population ageing could also be measured using number of years remaining or prospective age. The words 'senior citizens', 'elderly' and 'aged' are used interchangeably in this chapter.

the pyramid, the middle and top of the pyramid will expand. At this stage, the age structure will have relatively higher proportion of elderly in the population.

The changes in age structure seen in the population pyramids create different levels of dependency over the demographic transition. Figure 2 illustrates the changes in total dependency ratio (ratio of those aged 0-14 and 60+ to those aged 15-59), old age dependency ratio (ratio of those aged 60+ to those aged 15-59) and the proportion of population aged 0-14 and 60+. The trend seen for India follows what Lee and Mason (2010) described as a pattern of increase in dependency ratio during the initial stages of demographic transition (when mortality declines at a faster pace than fertility), decrease in dependency ratio as demographic transition progresses (as fertility continues to decline) and subsequent increase in dependency ratio (as proportion of older people in the population increases). Total dependency ratio in India peaked in the early 1970s due to the large proportion of young in the population, and has been declining since then. Old age dependency ratio has remained constant over the last fifty years, but is projected to increase. By 2050, the increase in old age dependency ratio will lead to an increase in total dependency ratio.

India's spatial variation in demographic indicators means that there is diversity of ageing patterns. States like Kerala and Tamil Nadu which have progressed in the demographic transition have a larger proportion of elderly in the population and this is projected to increase to more than 15 per cent by 2021 (Figure 3). Regional demographic imbalances and economic disparities have intensified the interstate migration of surplus labour from low growth states with large young population such as Bihar to high growth states such as Tamil Nadu (Khandelwal, Sharma and Varma, 2012). Much of labour migration is for work in commercial sectors. There are no signs yet of migrants as care providers for elderly in states such as Tamil Nadu and Kerala.

Migration influences the age structure of the population in both the sending and receiving areas. In urban regions, such as Delhi, an influx of working age adults has kept the population relatively youthful. Many of these young migrants might move out of the city in old age, due to high cost of living in the city, keeping population of cities young over the long term (Desai et al., 2010). Migration is important in understanding the well-being of elderly in rural areas where many elderly are "left behind" in villages as their children migrate to cities.

3. Family, Living Arrangements and Intergenerational Relations

Filial piety, a traditional virtue espoused by religion and culture in India, places the responsibility of support and care for the elderly on children (Bhat and Dhruvarajan, 2001; Croll, 2006). The traditional Indian family structure of elderly living with children was seen as a reflection of filial piety. However, structural, institutional and ideational changes have resulted in changes in employment structure, migration, shifts towards consumerism and changing notions of family.

These may have weakened the support and care received by the elderly and could have brought about changes in the living arrangements of the elderly (Brijnath, 2012; Medora 2007).

Table 1 presents the living arrangements of elderly Indians in 2005-6 based on IHDS[3] data. The number of elderly living alone is low at just 2.4 per cent nationwide, reaching a high of about six per cent for elderly who were not married at the time of the survey. These figures do not include elderly living alone in old age homes or in other institutional settings since IHDS, like most other demographic surveys, does not cover the institutional population. There are no national figures on the number of elderly care institutions or the number of elderly staying in such institutions. Studies from some cities in India suggest that old age homes, while not uncommon, are limited and cater mainly to middle and high income elderly (Kalavar and Jamuna, 2011). Old age homes are market driven, fee based institutions that effectively exclude the poor and destitute elderly (Ansari, 2007). There is not much known about destitute elderly and elderly living in *ashrams* (homes for the elderly run by religious charities) and rural elderly as these groups have been neglected in ageing studies.

In public discourse, elderly living alone or in old age homes is interpreted as a sign of breakdown in traditional Indian values (Lamb, 2011). Elderly cited inability of their families to take care of them as the main reason for living alone. However, a small number of elderly preferred living alone for privacy and to maintain distance from family members (Kalavar and Jamuna, 2011; Liebig, 2003). About 40% of elderly living alone rarely or never communicated with their children despite the availability of communication technology (BKPAI, 2012[4]). While lack of communication with their families might be a reason why they are living alone, it is also possible that living alone further weakens the ties with family members. Elderly approach living alone or in old-age homes with ambivalence. As Lamb (2011: 509) has observed, living alone is not something the elderly in India find "unambiguously easy or natural" but approach it "with critical self-reflection, self-consciousness [and] effort".

A majority of elderly live with at least one other family member. Nearly 22 per cent of them live with their spouse, children or both (Rows 2, 3 and 4 of Table 1). Many elderly reside with their children's family (such households include at least one of the following members: son-in-law or daughter-in-law or grandchildren. Rows 5 and 6). The remaining 17 per cent live in households that have at least one person who is not their spouse, child, son- or daughter-in-law, or grandchild. A majority of the elderly living with children expressed satisfaction with their

[3] Indian Human Development Survey (IHDS), 2005-6, a nationally representative sample survey, interviewed about 40,000 households and collected information on variety of topics including demographic characteristics of all household members (Data available from ICPSR: http://doi.org/10.3886/ICPSR22626.v8).
[4] Building a Knowledge Base on Population Ageing in India (BKPAI), 2011, a survey of elderly in seven states — Himachal Pradesh, Kerala, Maharashtra, Odisha, Punjab, Tamil Nadu and West Bengal —interviewed about 8,329 household and 9,852 elderly residing in these households (BKPAI, 2012).

current living arrangement, and a majority stated that children should support the elderly (BKPAI, 2012).

There are differences in living arrangements by sex and marital status of the elderly. About a third of elderly women lived with children in the absence of spouse as compared to about 12 per cent elderly men in a similar situation. The large number of elderly women with no spouse is attributable to the fact that Indian women marry men older than themselves; as life expectancy of women at older ages is higher than men, there are higher chances of women being widowed. This combined with low rates for remarriage for women, leads to a high proportion of elderly women who are not currently married (Rajan and Kumar, 2003; Chaudhuri and Roy, 2009)[5]. When we look at marital status and living arrangements, there is little difference in the percentage of elderly living with children (about 60 per cent). However, currently married elderly were less likely to stay with non-family members.

The results confirm that majority of elderly live with children or children's family. To further understand the living arrangements of the elderly, data from LASI[6] was analysed. Elderly with children have a choice of living alone or with children. About 80% of elderly with at least one child were residing with their children. Bivariate analysis of the decision to live with children versus living alone reveals a positive gradient by education and household consumption (used as proxy for household economic status), with elderly in the lowest category of these two variables more likely to stay with children. This reflects perhaps the economic needs of the elderly and children in poor households to share and pool resources including housing. Elderly who are not currently married and those living in rural areas were more likely to stay with children. Those with one child were more inclined to stay with the child compared to those with 2 or 3 children.

The decision to stay with a child is dependent upon the sex of the child. Almost 90% of elderly who were living with children were living with sons (based on LASI). This is not surprising as there is strong aversion to staying with daughters. About two-fifth of the elderly said that they did not want their daughters to look after them in old age (BKPAI, 2012). Ethnographic evidence suggests that even though elderly women have stronger ties with daughters, there is strong antipathy towards staying with daughters (Bhat and Dhruvarajan, 2001; Kalavar and Jamuna, 2011). The preference to stay with sons should be understood in the context of the Indian

[5]There are more men aged 60 and above compared to women; but, women aged 60 and above are more likely to be widowed than men. More elderly men than women is in contrast to the pattern of more elderly women seen in most countries. Excess female mortality at younger ages meant that until the 1990s life expectancy at birth for females was lower than males. There also might be underreporting of older women (Rajan, Sarma and Mishra, 2003; Visaria, 2001).

[6] Longitudinal Aging Study in India (LASI), pilot round, 2010, was conducted in four states--Rajasthan, Punjab, Kerala and Karnataka-- and surveyed about 1500 people. The analysis presented here is based on individuals aged 60 and above (N =583).

marriage and kinship system in which daughters are considered as lost to the natal family after marriage, and the responsibility for parents falls squarely on sons (Medora, 2007).

A common narrative in Indian gerontology traces the changes in living arrangements and status of the elderly to the breakdown of the joint family system. Cohen (1992: 124) portrays this narrative as follows:

> (1) Indian families were all once multigenerational "joint" households; (2) in such households, old people had all their needs taken care of, were listened to and respected, and had few complaints - old age was a pleasure; (3) with the advent of the "zations" - Westernization, modernization, industrialization, and urbanization - families begin to break up, and the social support and respect for the elderly declines, along with their quality of life.

Empirical and ethnographic evidence does not mirror this narrative. Elderly in India prefer to and live with children or other family members, and this does not appear to have been deeply eroded by economic, social or other changes. However, demographic shift towards smaller families and subsequent greater investment in children might lead to an inevitable strain in the support and care children can extend to their parents. As Croll (2006) mentions, this shift might lead the older generations to reassess their expectations of the nature of support that their children can provide them.

Living arrangements is one aspect of the complex web of relationships between elderly parents and children. While living arrangement has been shown to be an important determinant for some aspects of elderly life, it should not be taken as a proxy for the care or support received by the elderly or to imply that co-residence is always better (Hermalin, 2002). As Chan (2005: 277) points out, co-residence of older persons with a child “is not evidence in and of itself of a net flow of resources from child to parent, or that co-residence reflects the parent’s needs”. Non-co-residence doesn’t necessarily mean lack of support (Knodel, and Saengtienchai, 1999). As in other Asian settings, a majority of non-co-resident children in India live nearby and they could still potentially help their parents (BKPAI, 2012).

4. Work, Income and Economic Independence in Old Age

As in other countries, elderly in India consume more economic resources than they produce through labour. The relationship between production and consumption of resources across age groups is presented in Figure 4. Production and consumption of resources changes with age, showing a deficit at younger and older ages and a surplus at working ages. The figure shows that labour income declines rapidly past age 60 and plunges below the consumption level leading to a deficit. This deficit at older age can be met through public transfers via government, private transfers in the form of intra-family transfer of resources, and asset- based transfers such as through the use of accumulated savings or income derived from assets.

Asset-based transfers are the main source of support for the elderly in India, except for the very old who rely on public transfers (Lee and Mason, 2011). The contributions of intra-family and public transfers are small and do not cover the deficit in old age in any significant way. Evidence from the National Transfer Accounts (NTA) project in India shows that family resources are used to support the young more than the elderly, and intra-family transfers from children to the parents are not high. In total, elderly contribute more than they receive over their lifetime (Ladusingh, 2012; Narayana and Ladusingh, 2011). Elderly in India use income from productive assets (such as farms or house) and savings accumulated over their productive years to support themselves in old age (Lakshmanasamy 2012; Lee and Mason, 2011).

Public transfers to the elderly through welfare or social security remain low and inadequate in meeting the needs of the aged (Dhillon and Ladusingh, 2013). Net public transfers to elders, after taking into account tax and other contributions of the elderly, covers only five per cent of the deficit in old age (Ladusingh, 2012). Public cash transfers to the elderly is mainly through the Indira Gandhi National Old Age Pension Scheme (IGNOPS) which provides Rs.200/month to elderly living below the poverty line[7] (Kumar, 2003; Pal and Palacios, 2011). IGNOPS is the only nationwide programme to provide cash transfers to the needy elderly. The scheme, funded by the Central Government but administered by the local (state and district) authorities, faces various difficulties: from selecting the beneficiaries based on the laid out criteria without being mediated by personal, political or administrative concerns, to ensuring that funds flow to the intended recipients (Bloom et al. 2010; Vera-Sanso, 2010). Despite these and other challenges, the programme is effective in targeting the elderly with minimal leakage of funds, and for many elderly this is an important source of support (Dutta, Howes and Murgai, 2010).

In countries of South Asia where most workers are in the informal sector without an official retirement age or pensions, more than half of the elderly continue to work past age 60 (Alam and Barrientos, 2010). Indian elderly continue to work as long as possible until they are incapable of doing so, and the age at which they stop work is largely determined by their economic and health conditions (Dharmalingam, 1994; Mathew and Rajan, 2008). As seen in Table 2, nearly 40 per cent of elderly men and 11 per cent of elderly women were working in 2012, with almost all elderly working men putting in more than 4 hours daily. As life expectancy increases, it is estimated that men aged 60 will continue to work for another 10 years on average in 2050, up from 8.7 years currently; as women increasingly participate in the labour force, they are likely to work for 9 years beyond age 60 in 2050 up from the present 3.6 years (Dhillon and Ladusingh, 2013). A majority of men and an overwhelming number of women said they were working

[7] The scheme, formerly known as National Old-Age Pension Scheme (NOAPS), was introduced in 1995, paid Rs.75/month to destitute elderly with no adult son. The scheme was renamed in 2007 and eligibility age raised to 65 and cash increased to Rs.200/month. The scheme was revised again in 2011 with eligibility age lowered to 60 and cash for those above 80 increased to Rs.500/month. Some state governments provide additional money on top of the Rs.200 provided by the Central Government.

because of economic or other compulsions rather than out of choice (Table 2). Changing economic structure and employment opportunities, especially in rural areas which have seen a decline in demand for agricultural labour, has meant that the elderly are increasingly finding it difficult to find work and support themselves (Vera-Sanso, 2007).

Older people might be economically vulnerable because of lack of regular income or financial support from the family or public support. Estimates suggest that there might be as many as 17.7 million elderly living below the poverty line (Srivastava and Mohanty, 2012). More than one in ten elderly men do not own any assets, a quarter of them have no income and nearly a third are financially fully dependent on others (Table 2). These indicators show the extent of dependence and potential financial vulnerabilities of the elderly. But are the elderly more vulnerable than non-elderly in India? Contrary to expectations, studies have consistently shown that elderly households (with at least one elderly member in the household) are not worse off than households without any elderly person (Srivastava and Mohanty, 2012). This could be because the poor are less likely to survive to old age leading to a survival bias in the number of elderly households (Pal and Palacios, 2011). The presence of such bias reflects the cumulative disadvantages of the poor over their life course and calls for caution when looking at poverty in old age.

The economic and financial situation of elderly women is of particular concern. For all the indicators presented in Table 2, elderly women are worse off than men. Some of the disadvantages might stem from the lower level of paid workforce participation of women in both the formal and informal sectors (though they might contribute to the household economy in other ways). Lower work participation of elderly women is in contrast to elderly men who face considerable pressure to find paid work to support the family (Mathew and Rajan, 2008). Ownership and management of assets by elderly women is also low, which further disadvantages them (Bloom et al. 2010; Kodoth and Rajan, 2008). Lack of assets owned by elderly women might partly be a result of the gendered nature of property laws and intergenerational transfers. As Agnes (1999) observes, certain provisions in the Indian law take age of men into account but not age of women; for women only marital status is considered. While Hindu widows and daughters have absolute right to property, the absolute right of men to hold property means that they can sell, gift or will away property which makes the rights of elderly women "illusory" and reduced to claims for maintenance and right of residence (ibid.). Accumulation of disadvantages over the life course means that women enter old age with less financial resources which places them in a vulnerable position in old age (Vera-Sanso, 2010).

The situation of elderly widows is precarious. Social and family control exerted on various aspects of widow's life—from sexuality to asymmetric gender and power relationship—effectively consigns many widows to a lower position (Chen 1997). Widow remarriage is not common because of lack of acceptance and social disapproval. The cumulative disadvantages

over the life course, and lack of independent source of income or support, affect elderly widows more than any other group. Though there are public cash transfers to widows[8], it is essential, as Gopal (2006) has advocated, that women be allowed stronger claims to assets so that their position within the family is strengthened and they are better prepared for old age.

5. Health, Wellbeing and Care in Old Age

Health and wellbeing are important aspects of ageing. This section assess health and wellbeing of the elderly in India using three broad indicators –WHO's Disability Assessment Schedule (WHODASi score), General Health Questionnaire scale (GHQ-12) to measure mental health, and WHO's Quality of Life Assessment (WHOQOL). Details about the indicators are presented in Table 3.

Disability among the older population in India is high. The mean WHODASi score of 71.3 is lower (in this score lower indicates worse health) than any of the five countries (China, Ghana, Mexico, Russia, South Africa) that have similar data (Table 3). Also, nearly 90% of the elderly reported suffering from at least one disability (He, Muenchrath and Kowal, 2012). Disability and poor health in old age in India is because of the double burden of communicable and non-communicable diseases (Johnson, et al. 2011)[9].This is unlike ageing population in developed countries where communicable diseases are not a major risk factor. The burden of disease in old age is further worsened by high rates of smoking and other life style factors (Kowal et al., 2012). As with other aspects of ageing, there are important differences in health status by gender, economic status, dependency level, marital status and living arrangements of the elderly.

Elderly in India report having good mental health and quality of life. Majority of the elderly were below the GHQ-12 threshold for signs of psychological distress or mental health issues (Table 3). Elderly in India ranked higher than four of the other five countries (except Ghana) in WHO's Quality of Life Assessment. This high level of subjective wellbeing is in contrast with high levels of disability seen among the elderly. However, indicators of mental health and wellbeing should be interpreted in the cultural and social context of ageing in India where mental or psychological issues in old age are seen as normal process of ageing, and viewed as not needing medical attention (Brijnath, 2008; Patel and Prince, 2001). Like elderly elsewhere, changes in old age such as loss of authority, increasing dependence, and changing role in the family could affect the mental and psychological wellbeing of the elderly in India (Bhat and Dhruvarajan, 2001), and there is a need for greater awareness of mental health and wellbeing issues in old age.

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[8] Indira Gandhi National Widow Pension Scheme started in 2009 provides widows age 40 to 59 and living below the poverty line Rs.200/month.

[9] Disease profiles of the elderly indicate that about half of the profile is due to communicable diseases, 40 per cent due to non-communicable diseases and the rest due to accidents and injuries (Kowal et al., 2012).

The government's role in treatment and care of the elderly is limited in India. About 24 to 42 per cent of elderly with chronic conditions and about 41 per cent of elderly with acute morbidities sought treatment in public hospitals (BKPAI, 2012). The payment for treatment and hospitalization is overwhelmingly borne by the family, with more than half coming from children (ibid.). Even in public hospitals where treatment is free, indirect cost for transportation, bribes, and payment for medicines make treatment unaffordable for many elderly (Balagopal, 2009). Lack of affordable health care puts considerable pressure on elderly households and many elderly might not have the resources needed to seek treatment and care.

Care for the elderly in India falls on family members. One reason for this is lack of affordable public or private institutional care facilities. Another reason is that seeking institutional care is seen as evading family responsibility and is perceived as bringing shame to the family (Evans, Kiran, and Bhattacharyya, 2011). Caring for the elderly might strain financial, emotional, physical resources of many families, but as Brijnath (2012: 15) observes, families attach "deep meaning to care [of the elderly], viewing it through prisms of love, duty and reciprocity". Thus, families continue to be the main (or sole) provider of care to the elderly.

6. Discussion

The demographic, social, economic and health aspects of population ageing in India presented in this chapter raise important questions about the relationships, roles and responsibilities of individuals, families and the state. In India families remain the main source of support for the elderly. However, the intergenerational relationship is neither unidirectional nor fixed as seen in living arrangements and economic situation of the elderly. The nature, type and direction of support between the generations is determined by the situation and resources of both parents and children, embedded within the wider social and cultural values of support and care, and the expectations and meanings attributed to these values.

The family's role and responsibility in taking care of the elderly is reinforced by the government's approach and policies. National Policy of Senior Citizens, 2011, the guiding framework on ageing, strongly emphasizes that the elderly should continue to live with the family and that the family act as primary caregivers; institutional care is seen as a last resort. This blunt emphasis does not consider circumstances of the family. Neither does it provide any meaningful provisions to help the families support the elderly. The policy does mention that families must be strengthened to support the elderly, but none of the provisions in the "areas of intervention" really strengthen or support the families. Most of the provisions deal with providing support to the elderly in terms of income security in old age, healthcare, housing and welfare needs of the elderly.

The government's emphasis on the family is also evident in legislations such as the *Maintenance and Welfare of Parents and Senior Citizens Act, 2007* which provides redress to the elderly to

seek maintenance from the family, and provides penalties including imprisonment for family members not providing maintenance or care. This approach to elder care as the primary responsibility of the family without providing support to the families puts tremendous pressure on families. As others have argued, there needs to be critical examination of the role of individuals, families, state and non-state actors in providing care and support to the elderly, and to evolve social and public policies that maximize the role of each of these actors to create meaningful ageing in India (see Lamb, 2013; Silverstein and Giarrusso, 2010; Navaneetham and Dharmalingam 2012).

This chapter presented selected perspectives drawing on the empirical and theoretical literature on ageing in India. While there is extensive literature on ageing in India cutting across several social science disciplines, there has been little research on life course analysis and in situating ageing in the context of cumulative (dis)advantages. As elderly in India are a diverse group, research would benefit from paying attention to the diverse life histories across the life course for different groups of elderly. Finally, it is essential to also consider the situation and wellbeing of those caring for the elderly.

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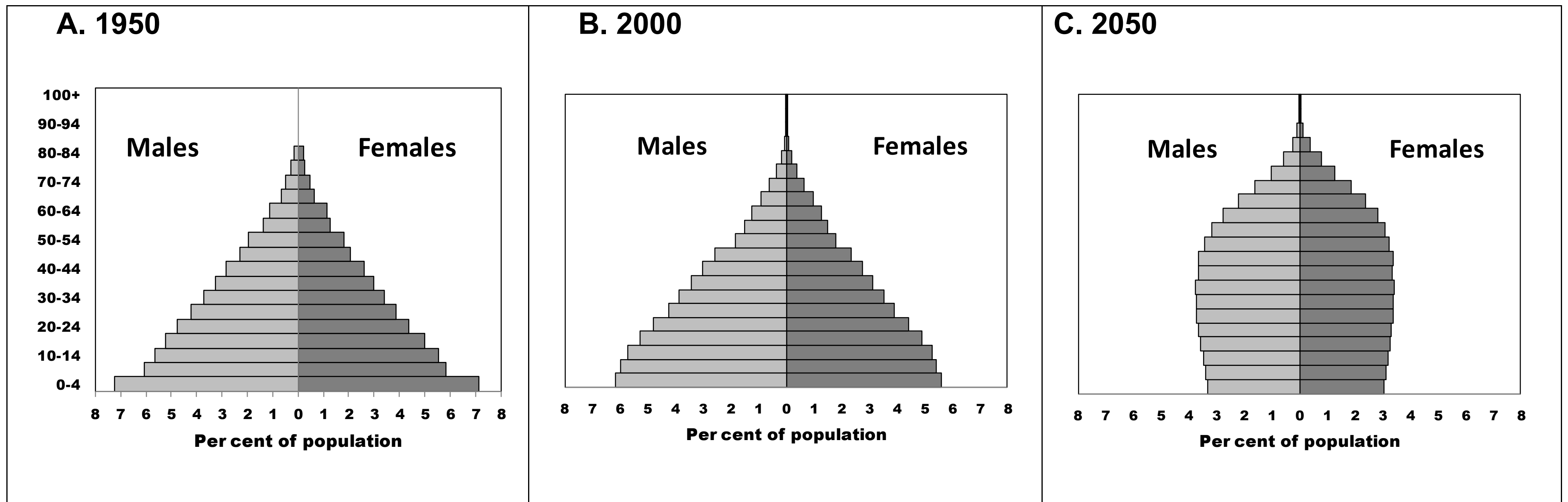
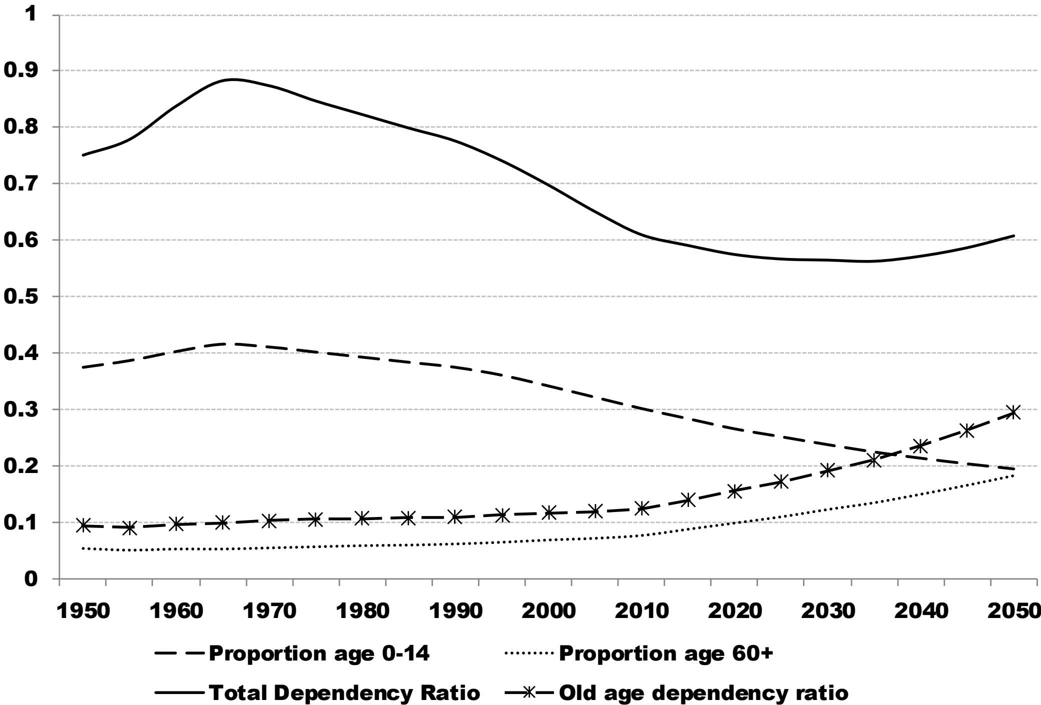
Fig. 1 Population Pyramids, India, 1950, 2000, 2050



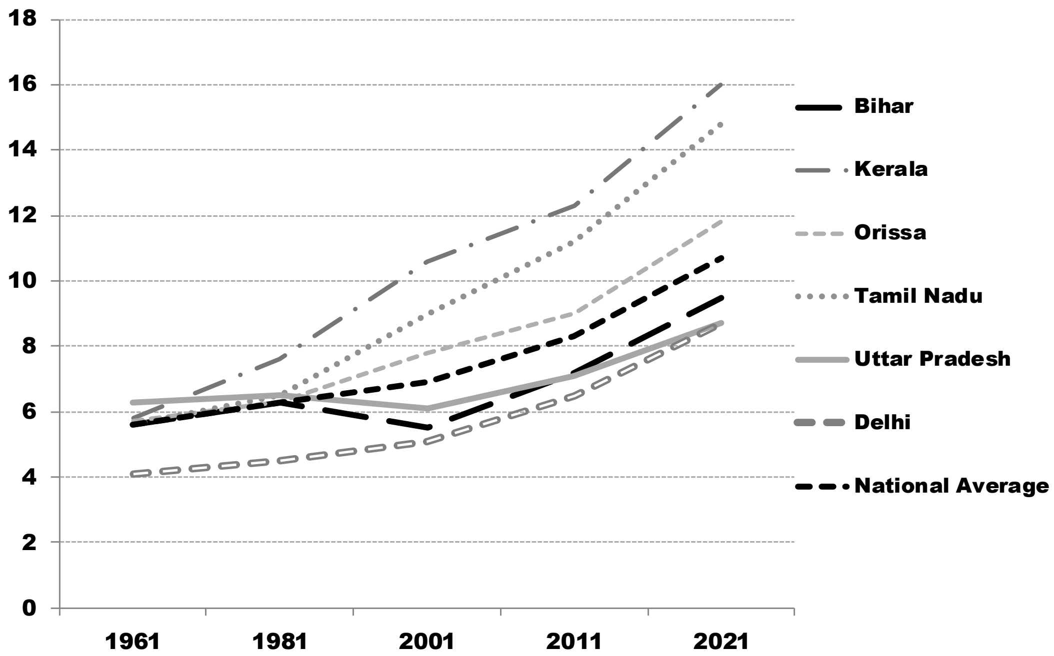
Source: Based on United Nations (2013) World Population Prospects, 2012 Revision

Fig. 2 Dependency Ratios, India, 1950-2050



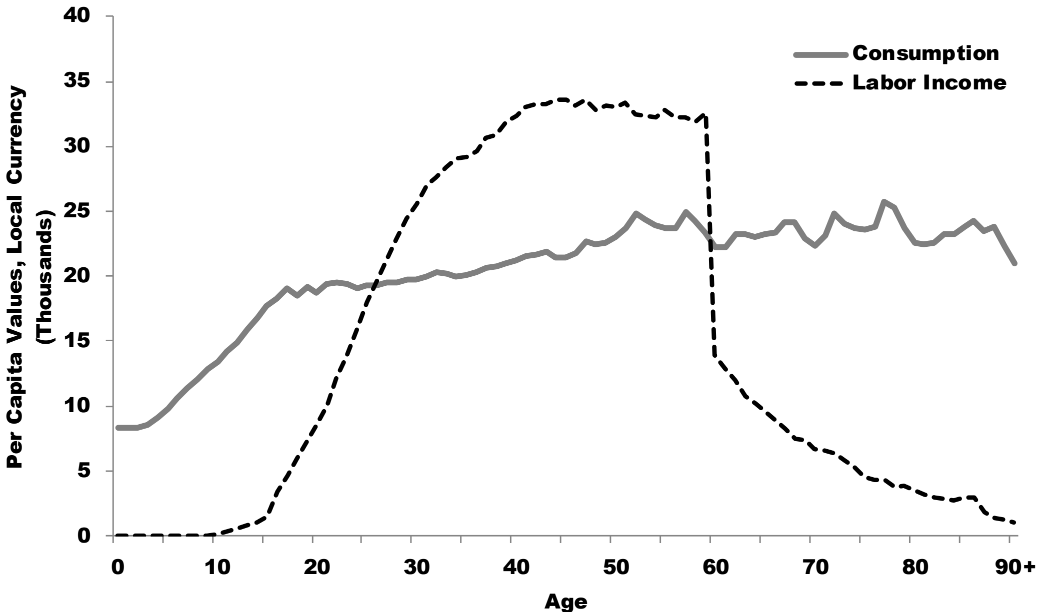
Source: Based on data from United Nations (2013) World Population Prospects, 2012 Revision

Fig. 3 Population 60+, Selected Indian States, 1961-2021, per cent



Source: Based on data from Registrar General & Census Commissioner of India, 2006

Fig. 4 Labour Income and Consumption by Age, India, 2004



Source: NTA database, available: www.ntaccounts.org

Table 1 Living Arrangement of the Elderly, India, 2005-2006, per cent

			Area		**Sex**		**Marital status**	
		Total	**Rural**	**Urban**	**Male**	**Female**	**Not currently married**	**Currently Married**
1	**Alone**	2.4	2.6	1.6	1.1	3.7	6.1	0.2
2	**With spouse only**	9.7	10.0	8.8	12.1	7.2	0.0	16.0
3	**With children only**	2.3	2.5	2.9	1.5	3.6	6.0	0.2
4	**With spouse and children only**	9.8	8.3	11.5	14.3	3.6	0.0	15.0
5	**With children's family in the absence of spouse**	22.6	22.0	25.0	11.6	34.0	61.0	1.5
6	**With children's family and spouse is present**	36.8	37.0	33.0	45.5	27.0	0.0	57.0
7	**Other living arrangements**	17.0	17.0	17.0	13.5	20.5	27.0	10.0

Source: Author's tabulation using IHDS, 2005-6, data

Table 2 Work, Income and Economic Indicators, India, 2011, per cent

	Men	Women	Total
Currently working	38.9	10.9	24.2
Among currently working, working for more than 4 hours a day	95.0	88.6	93.5
Working for economic and other compulsions	67.9	82.2	71.3
No income	26.0	58.7	43.3
Elderly contribution to household expenditure (among those who earn an income)	71.2	35.5	52.4
Financially fully dependent on others	32.6	66.4	50.4
Don't own any asset	11.0	34.1	23.1

Source: BKPAI, 2012. Selected indicators from chapters 3 and 4.

Table 3 Indicators of Health and Wellbeing, India, 2007-2011

		Age		Sex	
	Total*	**50-69**	**70 & older**	**Men**	**Women**
WHO DASI score, mean	71.3	74.6	61.7	75.6	66.9
WHO QOL score, mean	71.6	72.3	69.4	72.6	70.5
GHQ-12 score, mean	13.9	-	-	13.1	14.6
Per cent of elderly below the threshold level of ≤12	51.7	-	-	56.4	47.6

Notes

WHO DASI score: WHODASI is an inverted score for WHODAS with 0=worst health,100=best health. This is based on evaluation of day-to-day functioning in the last 30 days. The six domains are understanding and communicating, getting around, self-care, getting along with people, life activities, and participation in society (SAGE survey).

WHO QOL score: Quality of life score with 0=worst health, 100=best health. This assess quality of life in four domains: physical, psychological, social, and environment. (SAGE survey)

GHQ-12 score: The score ranges from 0-36 with 0 = best mental health and 36= worst mental health. The threshold of 12 or below indicates good mental health. The scale is based on questions on whether respondents had experienced a particular symptom or behaviour recently (BKPAI, 2012).

*WHO's DASI and QOL scores are based on respondents aged 50 and over. GHQ-12 score is based on respondents aged 60 and over.

Sources: SAGE survey indicators from He, Muenchrath and Kowal, 2012.
BKPAI indicators from BKPAI, 2012.