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Original Research Article

Instrumental social support for the rural elderly: study of a rural block of a costal district of Odisha

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ABSTRACT

Background: The objectives of the study were to find out the social support extended to the rural elderly and to find out the trust worthy and long term support providers for them.
Methods: An exploratory descriptive research design was adopted where 1088 subjects were interviewed (517 males and 571 females) with variables of age, sex and standard of living. As per the response to the questionnaires, the quality of social support for the rural elderly, the trustworthy and long term support providers were evaluated.
Results: Out of 1088 elderly people participated in the study only 15% had someone trustworthy care providers where as 84.5% reported to have no trustworthy care providers. 34.4% of respondents had trust on their son as the old age care providers where as 30.4% had trust on their spouse. Similarly 94.4% reported to have long term care giver. 67.3% respondents were confident of receiving indefinite long term care where as 24.9% reported to have "now and then" care and 6.5% have short term care. The study also revealed that the middle aged (60-79 age groups) is less confident in securing instrumental social support than the very old. (80 above age group). It has also been observed that there is shrinkage in the number of long term care providers with increasing age.
Conclusions: Instrumental social support plays a strategic role in the domain of health care, particularly in old age. The study found that rural elderly have less trustworthy care providers in old age. There is variation with regard to age, sex and standard of living. With regard to long term care, it is found that family comes to the centre stage where the core family members like son and spouse engineer the support service. Son is the most trusted care provider and males prefer spouse and females prefer their son as the trusted care provider in long term care. In order to enlarge the support system and raise the quality, support services need to be equipped. Instrumental social support can be both preventive of expansion of morbidity and protective of healthy ageing.

Keywords: Instrumental social support, Old age care, Health care of elderly, Old age support

INTRODUCTION

India witnesses an increasing trend of growth in the number and proportion of elderly population (age 60 and above). The absolute number had reached over 103 million (8.58 percent of the total population) and it is expected to go up to 173 million by the year 2026 and is projected to touch 324 million by the year 2050.[1-3] Odisha also registers a similar pattern of demographic shift in the elderly population. The number of elderly population in the state of Odisha was 2.281 million in 1991 (7.23 percent); 3.04 million (8.26 percent) in 2001 and 3.98 million (9.49 percent) in 2011.[1] As per the Census 2011, a majority of the elderly persons of the state, 3.44 million, constituting 86.33 percent of the total elderly live in the rural Odisha.[1]

The increase in the number and proportion of senior citizens is accompanied with higher old age dependency, higher sense of insecurity, higher disease and disability burden with inadequate public health care facilities. The old age dependency ratio in India has increased from 12.19 percent in 1991 to 13.08 percent in 2001, and finally to 14.23 percent in 2011.[1,2] If one compares the figure of Odisha the percentage are 12.74 (1991), 14.14 (2001) and 15.45 (2011), respectively, which is higher than the national average.[1,2] This has important implications for the quality of life and healthcare of the elderly at the household level.

Social support is the sustainable way to address effective health care for the aged. All social welfare schemes, health schemes and other government and non-government facilities for the senior citizens and elderly people reach the target population through the instrumental support providers. Those with better social support system have a greater chance of resolving problems they face. Social support, from both work-related and private sources play as a protective factor for cardiovascular, endocrine related and immune system, emotional support enhances better physical functioning, social support is identified as a protective factor against functional decline in the elderly people.[4,5]

Social support is commonly divided into two types namely, *instrumental* and *emotional.*[6] Instrumental support relates to assistance in problem solving by tangible help, whereas emotional support relates to communication of caring, empathy, and self-esteem.[7,8] Curtona and Shur distinguish between instrumental and emotional support by commenting the former as 'action-facilitation' and latter as 'nurturant support'.[9] Of course, the distinction is not without its problems. It may so happen that instrumental support carries emotional meaning. Instrumental supportive acts can be perceived as emotionally supportive as well.[10] Semmer et al found that the support behaviour described as instrumental carries an emotional meaning attributed to them by the support recipient.[8] Another study by Schwarzer and Leppin revealed that instrumental support was both predictive of physical health as well as yielding satisfaction with support, which may mean that the value of instrumental support rests upon the emotional meaning associated with it.[11]

The problems and challenges confronted by the aged, particularly in rural settings, prompt us to address the instrumental social support available to, or perceived to be available to the elderly at the time of their need. The literature on instrumental support in rural India, especially in Odisha is scanty and thus deserves special attention.

Aims and objectives

The present study focuses on the availability of instrumental support perceived by the support recipients. The support is instrumental in the sense that the support recipients can rely on the 'action-facilitators' to accomplish the task for daily living including activities of daily living (ADL) and instrumental activities of daily living (IADL) and get appropriate long term care in case of illness and disability. The emotional social support is subsumed under instrumental support availability.

The specific objectives of the study are:

1. To investigate the instrumental support extended to the rural elderly by age, sex and standard of living;
2. To investigate the trustworthy support providers by age, sex and standard of living;
3. To investigate whether the instrumental support provider for long-term care is available to elderly by age, sex and standard of living; and
4. To investigate the persons who provide long term care by age, sex and standard of living.

METHODS

This study was carried out at a rural block of costal district of Odisha between January 2009 to December 2012, where 1080 elderly individuals (age >60) were interviewed with sets of questionnaires regarding instrumental social support. The voluntary nature of the participation and the confidentiality of their data were assured for the participants. Terminally ill individuals, individuals having psychosomatic disorder, dementia, Alzheimer's disease were excluded from the survey sample. Similarly individuals who experienced negative life events within last one month of the interview were also excluded from the study.

Sample

Data for the study was collected from Dharmasala Block of Jajpur District, Odisha. The sample size was originally fixed at 1000 with 500 from either sex. But the target was raised to 1100 to accommodate for 'no response' or for incomplete response data. In all, 1088 cases were available for analysis. Of these 517 (47.5%) were males and 571 (52.5%) were females, over the age of 60 years. A multistage sampling procedure was adopted.

Tools and procedure

The respondents were asked to report self-assessed support providers. The research design was of exploratory-descriptive type. The subjects were interviewed personally with a structured interview schedule. Age, sex and standard of living index were used as variables. The Standard of Living Index (SLI) was computed by adding responses to questions relating to house type, toilet facility, source of domestic lighting, type of fuel used, whether separate kitchen is available, ownership of house, ownership of agricultural land, ownership of irrigated land, ownership of livestock and ownership of household durable goods. The SLI score

ranged between 3 and 52 with a mean and median score of 22.58 and 22.0, respectively that appear to be 'normally distributed'. The persons whose SLI score ranged between 3 and 14 (first quartile) were classified as 'very low SLI'; score between 15 and 22 (second quartile) as 'low SLI'; between 23 and 31 (third quartile) as 'Average SLI'; and those with scores higher than 31 (fourth quartile) were classified as 'High SLI'. Data was analysed using statistical software – SPSS 20.0.

RESULTS

In order to assess the quality of the social support the respondents were asked (i) Do you have someone you can trust and confide upon? The answer to the question had three options: 'Yes', 'No', and 'No response'. Only 163 (15%) stated that they had someone trusted, while 919 (84.5%) did not report anyone trustworthy person as support; 16 (0.6%) did not answer the question. But looking at the variation by age, sex and standard of living it was found that with an increase in age, the percentage of elderly who had someone trustworthy increases. The sex distribution showed a negligible difference between men and women and standard of living did not reflect any relation to availability care giver. Table 1 presents the response by age, sex and standard of living index (SLI).

Table 1: Trusted persons by age, sex and SLI.

Background of the Respondents	Whether can trust someone			
Age	Yes	No	No Answer	Total
60 – 69	71 (11.0)	572 (88.5)	03 (0.5)	646 (100)
70 – 79	54 (16.7)	268 (82.7)	02 (0.6)	324 (100)
80+	38 (32.2)	79 (66.9)	01 (0.8)	118 (100)
Total	163 (15.0)	919 (84.5)	06 (0.6)	1088 (100)
Sex				
Male	76 (14.7)	438 (84.7)	03 (0.6)	517 (100)
Female	87 (15.2)	481 (84.2)	03 (0.5)	571 (100)
Total	163 (15.0)	919 (84.5)	06 (0.6)	1088 (100)
SLI				
Very low	59 (20.7)	223 (78.2)	03 (1.1)	285 (100)
Low	27 (9.9)	245 (89.7)	01 (0.4)	273 (100)
Average	42 (14.9)	238 (84.4)	02 (0.7)	282 (100)
High	35 (14.1)	213 (85.9)	00 (0.0)	248 (100)
Total	163 (15.0)	919 (84.5)	06 (0.6)	1088 (100)

(Source: Fieldwork by the 1st author, (2009) (Note: Figures within bracket show the percentage distribution)

Table 2: Trusted care giving persons by age, sex and SLI.

Characteristics of the respondents	Care givers who could be trusted								
	Spouse	Daughter	Son	Child in law	Siblings	Other relatives	Friends / Neighbors	No response	Total
Age									
60 – 69	234 (38.6)	67 (11.1)	159 (26.2)	4 (0.7)	2 (0.3)	36 (5.9)	70 (11.6)	34 (5.6)	606
70 – 79	58 (19.6)	26 (8.8)	130 (43.9)	4 (1.4)	1 (0.3)	26 (8.8)	25 (8.4)	26 (8.8)	296
80+	11 (11.7)	3 (3.2)	54 (57.4)	5 (5.3)	2 (2.1)	1 (1.1)	3 (3.2)	15 (16)	94
Total	303 (30.4)	96 (9.6)	343 (34.4)	13 (1.3)	5 (0.5)	63 (6.3)	98 (9.8)	75 (7.5)	996
Sex									
Male	186 (39.8)	33 (7.1)	139 (29.8)	5 (1.1)	4 (0.9)	26 (5.6)	46 (9.9)	28 (6)	467
Female	117 (22.1)	63 (11.9)	204 (38.6)	8 (1.5)	1 (0.2)	37 (7)	52 (9.8)	47 (8.9)	529
Total	303 (30.4)	96 (9.6)	343 (34.4)	13 (1.3)	5 (0.5)	63 (6.3)	98 (9.8)	75 (7.5)	996
SLI									
Very low	68 (27.2)	24 (9.6)	76 (30.4)	3 (1.2)	3 (1.2)	19 (7.6)	28 (11.2)	29 (11.6)	250
Low	88 (34.4)	31 (12.1)	85 (33.2)	6 (2.3)	1 (0.4)	13 (5.1)	21 (8.2)	11 (4.3)	256
Average	81 (30.7)	21 (8)	90 (34.1)	2 (2.8)	1 (0.4)	17 (6.4)	29 (11)	23 (8.7)	264
High	66 (29.2)	20 (8.8)	92 (40.7)	2 (0.9)	0 (0.0)	14 (6.2)	20 (8.8)	12 (5.3)	226
Total	303 (30.4)	96 (9.6)	343 (34.4)	13 (1.3)	5 (0.5)	63 (6.3)	98 (9.8)	75 (7.5)	996

Source: Fieldwork by the 1st author, (2009) (Note : Figures within bracket show the percentage distribution)

Table 3: Long term care giver by age, sex and SLI.

Characteristics of the Respondents	Whether any one for long term care giving			
Age	No	Yes	No Response	Total
60 – 69	24 (3.7)	619 (95.8)	03 (0.5)	646 (100)
70 – 79	19 (5.9)	303 (93.5)	02 (0.6)	324 (100)
80+	11 (9.3)	105 (89.0)	02 (1.7)	118 (100)
Total	54 (5.0)	1027 (94.4)	07 (0.6)	1088 (100)
Sex				
Male	27 (5.2)	488 (94.4)	02 (0.4)	517 (100)
Female	27 (4.7)	539 (94.4)	05 (0.9)	571 (100)
Total	54 (5.0)	1027 (94.4)	07 (0.6)	1088 (100)
SLI				
Very low	27 (9.5)	253 (88.8)	05 (1.8)	285 (100)
Low	08 (2.9)	265 (97.1)	00 (0.0)	273 (100)
Average	10 (3.5)	271 (96.1)	01 (0.4)	282 (100)
High	09 (3.6)	238 (96.0)	01 (0.4)	248 (100)
Total	54 (5.0)	1027 (94.4)	07 (0.6)	1088 (100)

Source: Fieldwork by the 1st author, (2009) (Note: Figures within bracket show the percentage distribution)

Table 4: Time period of long term care by age, sex and SLI.

Characteristics of the Respondents	How often long care				
Age	Now and then	Short period	Indefinitely	No answer	Total
60 – 69	139 (22.3)	43 (6.9)	436 (69.6)	06 (1.0)	624 (100)
70 – 79	95 (30.7)	19 (6.1)	189 (61.2)	06 (1.9)	309 (100)
80+	25 (23.6)	06 (5.7)	74 (69.8)	01 (0.9)	116 (100)
Total	259 (24.9)	68 (6.5)	699 (67.3)	13 (1.3)	1039 (100)
Sex					
Male	113 (22.9)	42 (8.5)	332 (67.2)	07 (1.4)	494 (100)
Female	146 (26.8)	26 (4.8)	367 (67.3)	06 (1.1)	545 (100)
Total	259 (24.9)	68 (6.5)	699 (67.3)	13 (1.3)	1039 (100)
SLI					
Very low	73 (28.1)	25 (9.6)	155 (59.6)	07 (2.7)	260 (100)
Low	60 (22.6)	15 (5.6)	189 (71.1)	02 (0.8)	266 (100)
Average	67 (24.4)	21 (7.6)	183 (66.5)	04 (1.5)	275 (100)
High	59 (24.8)	7 (2.9)	172 (72.3)	00 (0.0)	238 (100)
Total	259 (24.9)	68 (6.5)	699 (67.3)	13 (1.3)	1039 (100)

Source: Fieldwork by the 1st author, (2009) (Note: Figures within bracket show the percentage distribution)

The respondents were asked, if they had any one trustworthy support provider and who was that person (relationship with the respondent)? Of the total available respondents 996 only, 343 (34.4%) respondents could place their trust for old age support on their sons, 303(30.4%) on their spouse, 96 (9.6%) on their daughters 98(9.8%) on friends and neighbours, and 63 (6.3%) on 'other' relatives. The majority of the elderly in the sample population believe that son is the most trusted care giver (Table 2). The data also revealed (Table 2) that with the increase in age the trust on spouse, daughter, relatives and friends declines whereas trust on son, son/daughter-in-laws and sibling increases. It is also observed that a higher percentage of males preferred their spouse as trusted care giver, whereas females preferred sons rather than the spouse. The increase in standard of living showed a shift towards the son.

The respondents were asked to state if they had anyone for long term care giving. The data show that 94.4 percent had some one for providing long term care and 5 percent reported none to provide long term care and 0.6 percent did not respond. The result by age showed that with an increase in age the percentage of persons admitting having none for long term care increases. This is indicative of the fact that there is shrinkage in the number of long term care giver with an increase in age. Sex and SLI did not show any relationship. Table-3 presents the data by age, sex and standard of living.

In order to assess the quality of long term care giver, time period of long term care was examined. Long term care could be short, intermediate, and indefinite period. There were three responses on the length of care: 'Now and then' referring to occasional care such as accompanying to a doctor or fixing a lunch etc. 'Short term care' refers to few weeks to six month.

Table 5: Long term care giver by age, sex and living standard.

Characteristics of the respondents	Persons who provide long term care									
	Spouse	Daughter	Son	Child-in-law	Sibling	Other relatives	Relatives/ Friends	Others	No response	Total
Age										
60 – 69	159 (25.5)	45 (7.2)	400 (64.1)	03 (0.5)	02 (0.3)	05 (0.8)	03 (0.5)	01 (0.2)	06 (1.0)	624 (100)
70 – 79	51 (16.5)	20 (6.5)	220 (71.2)	06 (1.9)	01 (0.3)	04 (1.3)	00 (0.0)	00 (0.0)	07 (2.3)	309 (100)
80+	08 (7.5)	05 (4.7)	86 (81.1)	03 (2.8)	01 (0.9)	00 (0.0)	00 (0.0)	02 (1.9)	01 (0.9)	106 (100)
Total	218 (21.0)	70 (6.7)	706 (67.9)	12 (1.2)	04 (0.4)	09 (0.9)	03 (0.3)	03 (0.3)	14 (1.3)	1039 (100)
Sex										
Male	167 (33.8)	24 (4.9)	285 (57.7)	04 (0.8)	03 (0.6)	01 (0.2)	02 (0.4)	01 (0.2)	07 (1.4)	494 (100)
Female	51 (09.4)	46 (8.4)	421 (77.2)	08 (1.5)	01 (0.2)	08 (1.5)	01 (0.2)	02 (0.4)	07 (1.3)	545 (100)
Total	218 (21.0)	70 (6.7)	706 (67.9)	12 (1.2)	04 (0.4)	09 (0.9)	03 (0.3)	03 (0.3)	14 (1.3)	1039 (100)
SLI										
Very low	61 (23.5)	28 (10.8)	142 (54.6)	05 (1.9)	03 (1.2)	07 (2.7)	03 (1.2)	03 (1.2)	08 (3.1)	260 (100)
Low	72 (27.1)	28 (10.5)	160 (60.2)	03 (1.1)	01 (0.4)	00 (0.0)	00 (0.0)	00 (0.0)	02 (0.8)	266 (100)
Average	47 (17.1)	08 (2.9)	216 (78.5)	00 (0.0)	00 (0.0)	00 (0.0)	00 (0.0)	00 (0.0)	04 (1.5)	275 (100)
High	38 (16.0)	06 (2.5)	188 (79.0)	04 (1.7)	00 (0.0)	02 (0.8)	00 (0.0)	00 (0.0)	00 (0.0)	238 (100)
Total	218 (21.0)	70 (6.7)	706 (67.9)	12 (1.2)	04 (0.4)	09 (0.9)	03 (0.3)	03 (0.3)	14 (1.3)	1039 (100)

Source: Fieldwork by the author,(2009), figures within bracket show the percentage distribution

Of the total available of data 1039 only 259 (24.9%) respondents expressed to have 'now and then' care providers available to them; 68 (6.5%) respondents reported to have short term care providers available to them, whereas 699 (67.3%) respondents were confident of receiving indefinite care. Considering the age, it was found that persons above 80 were confident of getting higher percentage long term care for indefinite period compared to other two groups i.e. (60-69) and (70-79) age groups. Table 4 presents the data by age, sex and standard of living.

Two things emerge from this study: (i) First, there is a shrinkage in the number of long term care provider with an increase in age and (ii) second, there is an increasing availability of long term care provider for indefinite period for the very old (80+). Why does this happen? Who are the persons for long term care? In order to assess the persons who provide long term care, the respondents were given nine options from family, neighbours, other relatives, friends and others. Table 5 presents the data by age, sex and standard of living.

The data reveal that 218 (21%) respondents selected their spouse; 70 (6.7%) selected their daughters, 706 (67.9%) selected their sons; 12 (1.2%) selected their son/daughter-in-laws; 4 (0.4%) selected their siblings; 9 (0.9%) selected other relatives, 3 (0.3%) selected their friends; and 3 (0.3%) selected others and 14 (1.3%) did not respond.

The data on age showed that with the increase in age there is an increasing dependence on sons and decreasing dependence on spouses or daughters. The male respondents favoured spouse while female respondents preferred their sons and daughters. This means that the

core family members carry the onus of long term care in the old age. This might be the reason why there is shrinkage in the number of long term care providers as well as increasing availability of long term care providers for indefinite period with an increase in age.

DISCUSSION

The proportion of older adults living in pain and without access to health facilities is growing in India.[12] The older adults in India suffer from both degenerative and infectious diseases. In India informal care used to be the prevalent form of long term care provided by extended family. Khan (2008) identified four pillars of elderly care that are gradually crumbling down. These are: (a) social recognition of older people, (b) role of seniors in decision making in the household, (c) breakdown of traditional family status and (d) family socialization processes.[13] Changes in the family system, structurally (size) and functionally (inter-personal relations) have engendered insecurity of physical space (living space and its quality) and cultural space for elderly care (status within the family). The elderly care is crumbling for three reasons as stated by Khan (2008): (i) Care givers are migrating away from the places where the elderly reside, (ii) values related to elderly care are deteriorating and (iii) the concept of individualism is growing and a sense of community and kinship is declining.[13]

The current study on social support for elderly indicates that a large section of rural elderly (84.5%) do not have trustworthy care providers. This is indicative of the fact that the dearth of qualitative care is a crucial challenge to the wellbeing of elderly in rural areas and this may be due to increasing intergenerational gap in the web of kinship ties, with decreasing degree of intra-family communication. There is wide range of variation of trustworthy care providers for elderly depending upon the religion, casts, community, socioeconomic strata and places like rural and urban areas. Aliyar and Ranjan reported that even though nearly a tenth of India's population comprises of older adults, it is impossible to draw an uniform picture of care providers for the older adults across the country due to the varied and complex nature of the demographic transition in India with Indian States being at surprisingly diverse levels of economic development, cultural norms, and political contexts.[14]

The study also reflects that son (34.4%) is the most preferred trust worthy support provider followed by spouse (30.4%), friends and neighbour (9.8%) and daughter (9.6%). Elderly males prefer their spouses (39.8%) whereas elderly females prefer their son (38.6%) as their trusted care givers. This may be attributed to the cultural practices in India where patriarchy is the dominating milieu for elderly care, and women are treated as the natural care provider. Puri in 2004 opined that home based care with family members as the primary care givers is still the first and often the only option for a majority of the elderly in India.[15] Prakash in 1999 observed that living arrangement for elderly in India is found to be living with married sons and their families who provide the instrumental support in old age.[16]

It is also observed in this study that, though 94.4% of rural elders have someone to provide the instrumental support for them but only 67.3% were reported to get indefinite support, 24.9% get now and then support and 6.5% get short term support. The study also confirms that family members, more specifically, core family members such as sons (67.9%), spouses (21%) and daughters are the long term instrumental care provider for indefinite period. This is indicative of the fact that Indian family system which takes up elderly care as an inbuilt norm is the most suited institution. This comes in line with the observation that respondents preferred co-residence with their spouse and children for physical needs and emotional support; care of the aged is perceived as the responsibility of family members.

The study also finds that the middle-aged (60 to 79) are less confident in securing instrumental support than the very old (80+). In order to enlarge the support system and raise the quality, support services need to be equipped. Instrumental social support can be both preventive of expansion of morbidity and protective of healthy ageing.

CONCLUSION

Although older adults still seem to be part and parcel of their families to a large extent and care provision is still high from the family end, changing living arrangements and family composition in tune with adult child migration for economic and other gains might reduce the availability of care and support to older adults from their families in the near future. It is also evident that the social support for older adults outside their household is still not a widely available and availed component for their care and assistance. Hence, there is need to devise formal strategies to address the care and assistance needs of older adults in India, especially the poorer and marginalized families which are unable to cater to the needs of the older adult.

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