Unhealthy, Insecure, and Dependent Elders

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India faces an exponential growth in the proportion of its elderly in the near future, but there is no specific policy of substance to deal with the many ramifications of this development. What little exists hardly does justice to the country's elderly poor, who are forced to contend with daunting challenges late in life when they have few resources and are partially or entirely dependent on others. More alarmingly, reliable data on the elderly and their situation is lacking. Unless the state acknowledges its responsibility to the elderly, without hoping that the market will come to its aid, today's inexcusable callousness to the aged may seem mild when the crisis that is waiting to happen hits us.

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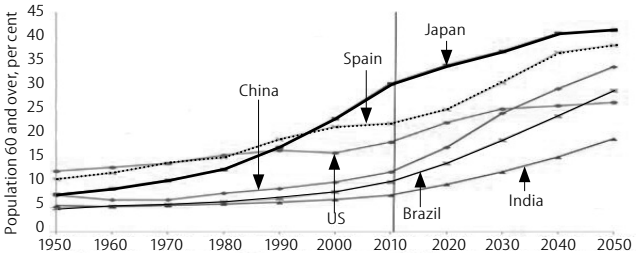
Over the past century, life expectancy has dramatically increased and the world will soon have more older people than children. One of the biggest social transformations of the late 20th and early 21st century is population ageing. More people now survive the challenges of childbirth and childhood, and live longer through adulthood to reach old age. This trend is not restricted to resource-rich countries and has become a global phenomenon. Therefore, healthy ageing is a global concern now. Ageing affects each and everyone – whether young or old, male or female, rich or poor, no matter where we live. The World Health Organisation (WHO) dedicated its World Health Day in 2012 to ageing. The European Union (EU) designated 2012 as the year of "Active Ageing and Solidarity between Generations". The United Nations (UN) General Assembly held a high-level meeting in September 2011 on preventing and controlling non-communicable diseases (NCDs), which is a threat to human health and the global economy that is strongly associated with ageing. These activities were built around the framework of "Active Ageing" established by the WHO in 2002.[1] The WHO framework defines the multiple determinants of active ageing, from access to health and social services to behavioural, personal, physical and social environments, and economic determinants cutting across all categories.

1 Introduction

A major reason why population ageing is attracting so much attention and debate is the rapid ageing of humanity, perhaps the most salient and dynamic aspect of modern demography. The world experienced only a modest increase in the share of people aged 60 and above in the past six decades, from 8% to 10%. But in the next four decades, this group is expected to rise to 22% of the total population – a jump from 800 million to 2 billion people. While this ageing trend began in the developed world, it is now a global phenomenon, and is accelerating, especially in low- and middle-income countries (Figure 1, p 218). In industrial countries, the share of 60-plus has risen from 12% of the population in 1950 to 22% today. It is expected to reach 32% (418 million) by 2050. In developing countries, the share of those 60-plus has risen from 6% of the population in 1950 to 9% today. It is expected to reach 20% (1.6 billion) by 2050. The pace of this change means that developing countries will have much briefer periods to adjust and establish the infrastructure and policies necessary to meet the needs of their rapidly shifting demographics. It also means that unlike developed countries, they will need to cope with getting old before they get rich (William and Krakauer 2012). India is one of the developing countries which will start converging with developed

Figure 1: Aged Population Growth in India and Other Major Countries



Source: Beard et al (2012: 6).

ones by 2050 in terms of growth of its aged population (Figure 1). That the developed world reached this stage well before India gives us the advantage of learning lessons from it.

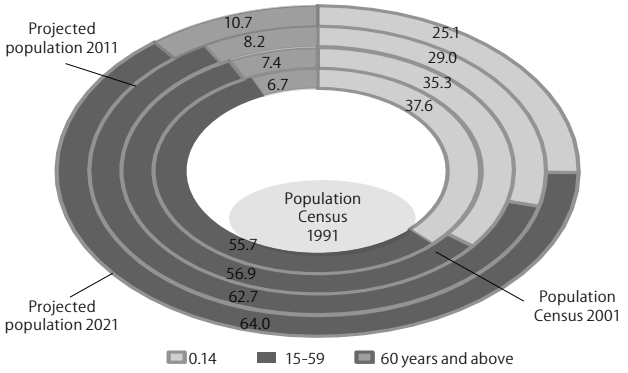
Greater longevity means that people have both more productive years and more years suffering from NCDs, representing both economic contribution and economic cost. By 2030, while many elders will remain healthy and vital, nearly half will have at least one NCD, such as heart disease, pulmonary disease, hypertension, stroke, diabetes or malignancies. NCDs are by far the leading cause of mortality in the world, responsible for 60% of all deaths. The death rate from NCDs is already pronounced in some low- and middle-income countries (Williams and Krakauer 2012).

Over time, the major risks to health shift from traditional risks (associated with poverty) to modern risks (for example, obesity). World Bank data for 2009 indicate that total health spending per capita for 129 low- and middle-income countries averaged $365, with average public spending per capita on health about 55% of that figure ($202). Among these countries, both total health spending and public spending on health increased on a per capita basis on people aged 60 and above (holding constant 2009 income per capita). If these relationships hold in the years ahead, the UN Population Division's 2050 projections of population shares of those aged 60 and above will translate into a 27% increase in average total health spending per capita for these countries, and a 29% increase in average public spending on health per capita (Bloom, Mahal and Rosenberg 2012). Therefore ageing as such and the health of the aged is becoming an important policy issue in developing countries as well.

The above-mentioned figures highlight that ageing is throwing up many questions and issues that have not been understood clearly so far, especially in developing countries. Serious discussion of these issues has yet to start in developing countries. Demographers have worked on ageing trends, structures, and projections. But how this shift is going to affect national economies; what the determinants of successful ageing are; the role of public health policy in addressing the change in disease burden; and healthcare coverage and health expenditure of the elderly are important issues that have missed the attention of policymakers and researchers. Although some sporadic attempts have been made in some developing countries, this work outlines some important issues that have a bearing on the health of the elderly in India. This is important for two reasons. One, the proportion of aged is rising very rapidly in the country, which is very soon going to be in the league of countries with a high percentage of aged persons. Second, India's public health policy is focused on reproductive and child health (RCH), and there is no attention paid to the impending pressure on the public health system. The public health system has to be geared to meet this challenge as a large percentage of elderly persons have to rely on public resources because of the lack of any other social security system, a declining joint family system, migration (children going out for jobs and the elderly returning to their native places after retirement), and so on. In India, an estimated 189 million people will be at least 60 years of age by 2025, triple the number in 2004. This growing elderly population will place an enormous burden on the healthcare infrastructure (Pricewaterhouse 2007).

The proportion of the population aged 60 or above was about 5% in India in 1901. This marginally increased to 5.4% in 1951, and rose to 7.4% by 2001 (GOI 2011). The size of the elderly population rose from 12.1 million in 1901 to approximately 77 million in 2001. According to official population projections, the number of elderly persons will rise to approximately 140 million by 2021 (Figure 2). Nearly 71% of the increase in the number of the aged between 1951 and 1991 could be attributed to population growth, while the remaining 29% was due to ageing of the population or an increase in the percentage of the aged in the population (Visaria 2001).

Figure 2: Age Distribution of Population in India over Decades



Source: GOI (2011: 4).

This highlights that changing demographics in India will bring forth issues to do with providing basic amenities, nutrition and food security, social security, livelihoods, and employment and income security in general, and public healthcare in particular.

This paper is based on secondary sources and it is organised as follows. Section 1 sets the background of the study. Section 2 links income security and economic independence of the aged with their health outcomes. Section 3 examines the physical dependence of the aged, and Section 4 investigates disease patterns in elders in India. Section 5 examines the role of public health policy, and Section 6 concludes the discussion.

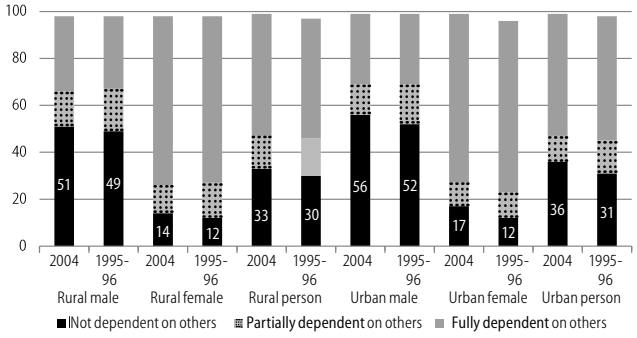
2 Income Security and Economic Independence

Although the Indian economy has grown faster in recent times and there has been an improvement in per capita income, this has mainly benefited new entrants to the labour market.

Elders are those who have withdrawn from the labour market, voluntarily or involuntarily, implying falling income and depreciation of assets, combined with rising health expenditure. "In India where over 90% of the total workforce is employed in the informal sector, social security offered by pension schemes is only available to the 10% retiring from the organised sector" (Kumar and Anand 2006: 19). Consequently, their chances of being dependent on others rise with age. There is a sudden fall in income once a person retires or withdraws from the labour force. Formal retirement is associated with the organised sector in India. But even in the unorganised sector, which is growing phenomenally, there is a withdrawal for various reasons, morbidity being the most important one. Ideally, aged persons should have income security either based on insurance or a state-mediated mechanism. Unfortunately, there is no such thing for the majority of the aged in India.

The dependency ratio has shown an ever-increasing trend, climbing from 10.9% in 1961 to 13.1% in 2001 for the country as a whole. The female old-age dependency ratio as well as the gap between the female and male old-age dependency ratio are increasing and the two were 13.8% and 12.5%, respectively, in 2001 (GOI 2011). This is a matter of grave concern. The rising dependency ratio means that a larger percentage of the aged is dependent on others for their consumption needs. A National Sample Survey Office (NSSO) report (GOI 2004) on morbidity and the aged revealed that 65% of the aged had to depend on others for their day-to-day needs. The situation was worse for elderly females, with about only 14% to 17% of them being economically independent in rural and urban areas, respectively, while the remaining were dependent on others, either partially or fully (Figure 3).

Figure 3: Percentage of Elderly Persons by State of Economic Independence



Source: GOI (2011: 12).

Economic dependence and lack of income security have important implications on the health outcomes of the aged. Various studies have shown a strong correlation between income support and health outcomes of the aged (Alwan et al 2007). A study by Kochar (1999) on familial support for the elderly in rural Pakistan revealed that medical expenditure on the elderly reflected their individual wage rate. Alam and Mukherjee (2003) indicated a very high prevalence of activities of daily living (ADL) impairments among the aged, with the major risk factors involving frailties, diseases, a sedentary lifestyle, and their link with poor economic standing. They also showed that women were likely to suffer more. Alam and Karim (2006) suggested that with no or negligible old-age healthcare infrastructure in rural areas, deceleration in productive employment, and growing casualisation of the rural labour market (GOI 2004), familial transfers may not suffice in many cases. Alam (2008) showed a high support burden on working age people (15-59) and also that socially backward communities such as the scheduled castes (SCs) and scheduled tribes (STs) were burdened more heavily. Alam (2004) and Rajan (2007) suggested that aged people need multi-pillared income security, failing which a large percentage of them may face serious financial difficulties late in life. Even in state-supported schemes, such as the National Social Assistance Scheme, there is an imminent risk of destitute elders being left out. Likewise, a large majority of the aged from the unorganised sector remains without a safety net. Kumar and Anand (2006) showed that nearly 90% of the total workforce is employed in the unorganised sector where no social and financial security is available after retirement. The work participation rate among the elderly is around 40%. And most of the 60-plus elderly are from rural areas and work in agriculture.

From the above, the issue of the affordability of healthcare services for the elderly becomes a matter of grave concern. Affordability of health services refers to being able to financially access services, or an individual's ability to pay the cost of healthcare. This is all the more important in India where the insurance system is not that developed and the larger part of the economy is unorganised. Table 1 provides an idea of the gravity of the issue of affordability of health services for the aged.

Table 1: General Statistics about the Elderly in India

Population aged 60 +	77 million
60 + as a percentage of 15-59	13%
Percentage of females among the 60 +	52%
Percentage of females among the 80 +	55%
Number of elderly poor	23 million
Entirely economically dependent	Rural male 45%, rural female 58% Urban male 46%, urban female 64%
Disease profile (deaths) (70 +)	Cardiovascular diseases (25.7%)
Private expenditure on health	83%

Source: Compiled from 2001 Census; Kumar and Anand (2006); *Report on Causes of Death, 2001-03*; Brooks (2008).

The table shows the gravity of the situation – a high prevalence of diseases, 54% of the elderly entirely economically dependent, and private expenditure on health being as high as 83%. With 23 million older poor persons, the healthcare system is clearly unaffordable to a large number of elders. Within such a health system, a whopping 77 million elderly are marginalised as they all suffer from one disease or the other.

Intuitively, there appears to be a close link between income security and economic independence and health outcomes of the aged, as the latter is always a function of the former. However, there seems to be a dearth of literature on these linkages in India. Therefore it needs to be understood how far economic independence and income security are linked with health outcomes of the elderly. Is a smoothening of income possible in a way that it remains sufficiently high later in life by transferring a large percentage of income at the higher income stage to

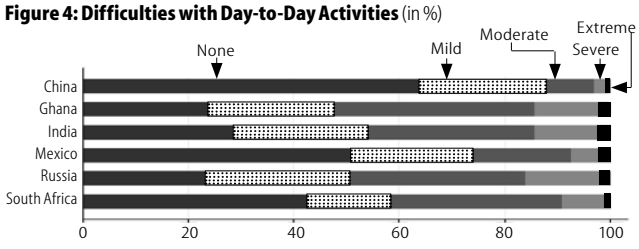
the lower income stage? What makes it important is that in the latter part of life, income falls and a large percentage of it goes to meet health needs. How do we reconcile these two opposing trends? Health insurance at an early age has been put forward as a solution. But again there are problems. The US offers some insights into the functioning and effectiveness of health insurance. The role of insurance has been hotly debated in the US and many other developed countries, and it is now being advocated for India as the state is withdrawing from providing social security cover. It becomes all the more important when the health sector is being privatised and the cost of services is mounting. What could be other possible suggestions to ensure that the people of India age without undue suffering?

Working on such issues of the elderly in India is difficult due to the paucity of data and discrepancies in what exists. We only have two data sources on health outcomes of the population. One is the National Family Health Survey (NFHS), which mainly deals with adult men and women and family health issues. The other comprises the 42nd, 52nd and 60th rounds of the NSS. This data throws some light on morbidity and health status of the aged, but it is not very meticulously worked out. The biggest problem with this data set is that it is outdated, even the latest in the series is dated by 10 years. There is a complete dearth of data on health institutions and health personnel and their functioning in India. Only of late has there been an international intervention to collect in-depth data about the elderly, with the WHO's Study on Global Ageing and Adult Health (SAGE), which has completed two rounds. These data sets are gold mines, but their utilisation has been very limited in the Indian context.

3 Physical Mobility and Level of Dependence

A kind of dependence comes through the physical inability of the aged to perform day-to-day activities. It is clearly a reflection of their "life course experiences" and health status. Better access to health can be a modifying factor in this regard. India is one of the countries where a large percentage of the aged experience severe difficulties in their day-to-day activities (Figure 4).

Figure 4: Difficulties with Day-to-Day Activities (in %)



Source: Chatterji (undated).

Dandekar (1996) revealed that about 5% of old persons in rural and urban India were physically immobile. Women had more physical health problems, which was an offshoot of their generally low access to opportunity and poor reproductive health, combined with episodes of pregnancy. Dandekar presented statistics from the NSS on physical immobility, which are summarised in Table 2.

Table 2: Physically Immobile Persons in Different Age Groups in Rural and Urban India

Age	Urban		Rural	
	Male	Female	Male	Female
60-64	2.24	3.30	2.40	3.25
65-69	4.12	4.73	3.32	4.87
70 and above	8.10	11.66	8.33	13.46

Source: Dandekar (1996: 80).

Nearly 60% of those who were immobile were 70 plus. In about 92% of the cases, households provided the necessary care – characteristically, the female members. Chronic illness increased with age. The percentage of those who were chronically ill rose from 39% in the age group 60-64 to 45% in the age group 65-69, and further to 55% in the age group 70 and above. A community-based study of health and functional competence (ability to carry on activities of living in spite of old age) on the rural and urban elderly reported long-term illness in nearly 60% of those aged 65 plus (Prakash 1998). Mobility and vision are two important factors affecting independence in the elderly. Nearly 55% of men and 50% of women in rural areas had problems with their eyesight. Their visual impairment was aggravated because they did not have access to corrective surgery or prosthetic aids. About 45% of the rural elderly complained of problems with walking (Prakash 2013). The proportion of physically mobile elderly men and women in the age group 60-64 years declined from about 94% to about 72% for 80-plus men and 63% for 80-plus women. The proportion of elders physically fit to move was invariably higher in urban areas than rural areas and higher among men than women in various age groups (GOI 2011).

Prakash (1998) in his study used ADL measures to construct an index of functional competence and concluded that rural women had more problems, indicating the need for help in self-care. A disturbing finding was that while 26% of rural women required help with ADL, only 4% were getting it. Urban men managed to get help from multiple sources. Problems with ADL were closely related to subjective well-being, gender, and social support, apart from economic variables and age (Prakash 2013).

4 Disease Pattern and Its Burden

The nature of diseases in the aged is different from other age groups. As can be seen from Table 3, they are mainly lifestyle diseases and chronic in nature, which need continuous medical treatment and monitoring. One of the major determinants of the change in disease burden over the next two decades in

Table 3: Percentage of Disability Adjusted Life Years as a Proportion of Total Population Burden by Sex, Age, and Cause (2004 and 2030)

Sex/Age	2004				2030			
	Group I	Group II	Group III	All Causes	Group I	Group II	Group III	All Causes
Males								
45-59	1.24	5.44	0.76	7.44	0.78	11.04	1.37	13.19
60-69	0.53	3.15	0.17	3.85	0.36	5.96	0.31	6.63
70-79	0.29	1.48	0.08	1.84	0.24	2.61	0.16	3.02
80 +	0.07	0.34	0.02	0.43	0.09	0.81	0.06	0.96
Females								
45-59	0.8	4.47	0.49	5.75	0.41	8.01	0.87	9.3
60-69	0.47	3	0.16	3.64	0.29	6.16	0.42	6.87
70-79	0.3	1.7	0.09	2.09	0.28	3.97	0.24	4.49
80 +	0.8	0.39	0.02	0.48	0.09	1.15	0.07	1.31
Total	3.77	19.96	1.79	25.52	2.55	39.71	3.5	45.76

Group I: communicable, maternal, prenatal, and nutritional conditions;
Group II: non-communicable diseases; Group III: injuries and violence.
Source: Chatterji et al (2008).

India is going to be its rapidly ageing population. It is projected that about 45% of the total disease burden in India will be shared by elders by 2030 (Table 3).

By 2030, elders will bear nearly half of the total disease burden in India (Chatterji et al 2008). Nandal, Khatri and Kadian (1987) found a majority of the elderly suffering from diseases such as cough (including tuberculosis of the lungs, bronchitis, asthma, and whooping cough), poor eyesight, anaemia, and dental problems. The proportion of the sick and the bedridden among the elderly increases with age. Their major physical disabilities are blindness and deafness (Darshan, Sharma and Singh 1987). Shah (1993) in his study of urban elders in Gujarat found deteriorating physical conditions among two-thirds of the elderly, such as poor vision, impairment of hearing, arthritis, and loss of memory. Besides physical ailments, psychiatric morbidity was also present among a large proportion of the elderly. An enquiry in this direction by Gupta and Vohra (1987) provided evidence of this. This study also draws a distinction between functional and organic disorders in old age. It is found that functional disorders precede organic disorders, which become frequent after 70 years of age. It is only a matter of time before India is soon going to house one of the largest numbers of sick elders.

Chatterji et al (2008) have presented a very alarming picture of India and China. According to them, China and India are home to two of the world's largest populations, both of which are ageing rapidly. The Ministry of Statistics and Programme Implementation's "Situation Analysis of the Elderly in India" (GoI 2011) presents the disease burden and its pattern across states and rural and urban locations. Visaria (2001) has compared two rounds of the NSS (42nd and 52nd) to assess changes in the incidence of chronic disease and economic dependence in aged persons in India, highlighting the enhanced need of the aged for healthcare as well as the mechanisms available to meet those needs.

5 Public Policy and Elders in India

Public policy in India seems quite oblivious to the looming crisis, and there is little realisation of the health needs of elders. By default, elders are those who are no longer in the labour force, and they have lower or stagnant incomes. The question is whether health is to be considered a commodity to be supplied by the market and bought by these elders, or whether the state has some responsibility in meeting the health needs of these elders. It appears that the former route has been accepted by public policy. This is evident from the sharply rising out-of-pocket expenditure of households on health in India (Tripathi 2010). Privatisation and mismatched expenditure in the health sector has led to mounting costs of treatment. The out-of-pocket spending of households is not only alarmingly high, but also rapidly rising. This has serious repercussions when households have to make huge payments (Wagstaff and Doorslaer 2003; Xu et al 2005; Doorslaer et al 2006). Moreover, public healthcare facilities, which used to offer services free of cost, now force patients to obtain drugs and receive diagnostic services from private service providers.

Garg and Karan (2009) and O'Donnel et al (2005) have shown that approximately 11% of households in India spent more than 10% of their total expenditure during 1999-2000 on medical needs. In consequence, an additional 37 million people (3.7% of the total population) were impoverished in 1999 because of health shocks, increasing poverty headcounts by 12% (Meeta and Rajivlochan 2010; Garg and Karan 2009; Doorslaer et al 2006; Berman et al 2010). The main reason for not seeking care is cost, especially in the case of the poor (Gupta and Trivedi 2005). Elders find it difficult to meet their health needs from their own resources. An alternative could have been the state providing healthcare for elders. But, so far the health system has been preoccupied with RCH. Of course, the state has created a healthcare system, but it suffers from several shortcomings (Tripathi and Mishra 2014). Thus, the rising cost of treatment and a widening shortfall in health infrastructure means that there is a competition to grab whatever little public resources are available. In this competition, the resource-poor and physically unfit are definitely losers. Elders fall into this category. The situation may have been ameliorated if there had been specific provisions for elders, as has been done for certain socio-economic groups. But the near absence of a specific policy on elders essentially means that the state has left its elderly population to meet their health needs on their own.

There is also little realisation of the determinants and causes of bad health among elders. For instance, public policy has not taken into account the living arrangements of elders, which is an important determinant of their health status. Widowhood is a major factor contributing to the vulnerability of elderly women. According to the 2001 Census, more than half the number of elderly females in India (51%) were widowed, divorced, or separated, compared to only 15% of elderly males. Further, the dependency status, as reported by the elderly themselves, varies between men and women. The 2001 Census showed that there were 6,31,000 elderly beggars (0.8% of the elderly population) in India. It may be noted that only 0.2% of the elderly were reported to be beggars by the NSS in 1999-2000. The burden of having to care for the elderly is not equally distributed among households. For instance, nearly 60% of the households in India had no elderly persons to care for while about 31% had one elderly member each, 11% had two elderly members each, and about 1% had three or more elderly each (Rajan and Kumar 2003). Any policy on social assistance should, therefore, take into account the living arrangements of the elderly.

The NSSO reports some other relevant characteristics of the elderly in the country. According to a 2004 report, every 1,000 people in the working age had to provide support, physically or otherwise, to 125 aged persons (old age dependency ratio). It was 103 elders in urban areas. Of the elderly, 4% to 5% were living alone, while 65% depended on others for their day-to-day maintenance. About 8% of the aged were either confined to home or bed. The proportion of confinement increased with age, with it being as high as 27% for those aged 80 or more. It was observed in the same survey that as high as 55% to 63% of

the aged with diseases felt that they were not in good health (GoI 2004). These aspects should be adequately considered when designing a support scheme for India's elderly population. It is also important for another reason – it will have an immediate effect on the health status of elders. The determinants of the health of the aged are not the same as those for other age groups. Rather, they are much more diffuse and intricately linked with many other aspects of their life. There seems to be a lack of clarity on this issue.

In view of the increasing need for intervention in old age welfare, the ministry of social justice and empowerment adopted a National Policy for Older Persons in January 1999. It provides broad guidelines to state governments for taking action for the welfare of older persons by devising their own policies and plans of action. The policy defines a "senior citizen" as a person who is 60 years old or above. It provides a comprehensive list of various facilities and covers many areas such as financial security, healthcare, shelter, education, welfare, protection of life and property, and so on. The Ministry of Health and Family Welfare has done little to care for the elderly. Its interventions have been mainly cosmetic in nature, such as separate queues for older persons in government hospitals, two national institutes on ageing in Delhi and Chennai, and setting up geriatric departments in 25 medical colleges.

A review of various legislations on social security schemes for the aged since Independence is available in Rajan, Mishra and Sarma (1995); Rajan (2002); and Rajan, Perera and Begum (2005). Generally, the schemes for elders in India are welfarist in nature – either in the form of income support (direct cash transfers or subsidising certain consumption items) or protection against injustice and violence. The most important programme for elders is the National Old Age Pension Scheme (NOAPS), a centrally-sponsored programme managed by the Ministry of Rural Development. This is essentially an income support programme in the form of a pension. According to it, a person who is 65 plus and below the poverty line will get Rs 150 per month from a central fund. There is a ceiling on the number of people who can get the old-age pension, which means that if the number of the elderly poor exceeds the ceiling, some of them will have to wait until those registered earlier die. Apart from the amount being meagre, the modus operandi is in itself faulty. More than 30 programmes are being run by the central government on various dimensions of health, but surprisingly only one caters for the needs of the elderly. And the size of this programme is so small that it can hardly make any impact on the health of elders.

Table 4 summarises perceived requirements and the problems in the few programmes and schemes that exist for elders in India. It shows that public policy has not recognised the problem of elders as such and there is no significant public health programme for the aged. Elders are more exposed to NCDs and chronic diseases, especially to cardiovascular disease, chronic pulmonary disease, diabetes and cancer. But there is no priority for the aged in this area. Moreover, various studies on public health expenditure have documented that the bulk of the money and resources is targeted at RCH and family welfare, and the remaining goes to various disease-specific programmes such as malaria, TB, dengue, and HIV/AIDS, leaving little for general health intervention.

Table 4: Requirements, Institutions, Policies, and Problems

Requirements of Elderly	Institutions and Policies in Place	Problems
Income security and economic independence	Old Age Pension Scheme for BPL elderly >60 at Rs 150 per month	Amount too small and leakages
Employment/ post-retirement activity	No policy in place	
Physical disability/ immobility	No institution and policy are in place	Primary health centres and sub-centres are too far away
Shelter and unsuitable housing	Old age homes	Coverage, condition, and quality are questionable
Nutrition and food security	Annapurna Yojana	For BPL elderly only
Treatment of non-communicable diseases and chronic diseases such as arthritis, sugar, blood pressure, cancer, poor vision, impairment of hearing, loss of memory	No disease-specific scheme is in place; 25 geriatric health centres were proposed in 1999.	Too few for the entire country; issues of functionality a question
Psychiatric morbidity – stress and strain.	No institution and policy in place	
Elderly-friendly hospitals	Nothing in place; no policy, no infrastructure	

6 Conclusions: Marginalisation of the Elderly

India now appears to be celebrating a "youth bulge" and "demographic dividend". In the euphoria, it is not recognised that a crisis is waiting. India is going to house the largest number of elders in the near future and their share in the population is already rising. This process is going to accelerate, and the country needs to prepare itself for this.

The elders in the country are deprived in many ways – falling income, growing economic and physical dependence, and bad health outcomes. The disease pattern of elders is different from others, and it is established that NCDs and chronic diseases take a larger toll of their lives. Somehow, there is little recognition of this changing disease pattern in India. Public health policy is still obsessed with RCH and does not recognise the specific health needs of elders. It has to be recognised that the privatisation of the health sector has dealt a severe blow to the health-seeking behaviour of elders. The moment health becomes a commodity to be bought from the market, low income and physical inability prevent elders from seeking medical help. So far, there is no evidence to suggest that private initiative can be a solution. Health insurance for elders has largely been a non-starter. Moreover, one is not sure about the financial viability of health insurance for the elderly.

The National Policy for Older Persons of 1999 provides guidelines and stresses the need for elderly-friendly healthcare intervention. However, in the 15 years that have passed, there has been no discernible evidence of progress in public institutions and basic

amenities. Geriatric healthcare does not figure on the agendas of policymakers, healthcare professionals, and medical schools. In sum, the state needs to admit it owes a responsibility to the country's elders. They are likely to be very vulnerable if left to market forces and no society can afford to treat its elders as callously as has been done by public policy in India. It is only thanks to some traditional values and norms that elders still have some space in this country.

NOTE

1 Active ageing is the process of optimising opportunities for health, participation, and security to enhance the quality of life as people age.

REFERENCES

Alam, M (2004): "Ageing, Old Age Income Security and Reforms: An Exploration of Indian Situation", *Economic & Political Weekly*, 14 August.

– (2008): "Ageing, Socio-Economic Disparities and Health Outcomes: Some Evidences from Rural India", Working Paper Series No E/290/2008, Institute of Economic Growth, New Delhi.

Alam, M and M Karim (2006): "Changing Demographics, Emerging Risks of Economic-Demographic Mismatch and Vulnerabilities Faced by Older Persons in South Asia: Situation Review in India and Pakistan", *Asia-Pacific Population Journal*, Vol 21 (3), pp 63-92.

Alam, M and M Mukherjee (2003): "Ageing, ADL Disabilities and Need for Public Health Initiatives", Discussion Paper Series Number: 78/2003, Institute of Economic Growth, New Delhi.

Alwan, N, M Wilkinson, D Birks and J Wright (2007): "Do Standard Measures of Deprivation Reflect Health Inequalities in Older People?", *Journal of Public Health Policy*, Vol 28, No 3, pp 356-62.

Beard, J R, Simon Biggs, David E Bloom, P Linda Fried, Paul Hogan, Alexandre Kalache and S Jay Olshansky (2012): "Introduction" in *Global Population Ageing: Peril or Promise?* Global Agenda Council on Ageing Society, World Economic Forum, Geneva.

Berman, Peter, Rajeev Ahuja and Laveesh Bhandari (2010): "The Impoverishing Effect of Healthcare Payments in India: New Methodology and Findings", *Economic & Political Weekly*, Vol 45, No 16.

Bloom, E D, A Mahal and L Rosenberg (2012): "Design and Operation of Health Systems in Developing Countries" in *Global Population Ageing: Peril or Promise?* (Geneva: World Economic Forum).

Brooks, Alton Dodge (2008): "Primary Health Care for Older People: A Participatory Study in Five Asian Countries", HelpAge International, East Asia Pacific Regional Development Centre.

Chatterji, S (undated): "Ageing in Developing Countries: Building Bridges for an Integrated Research Agendas", Study on Global Ageing and Adult Health (SAGE), WHO, Geneva, at http://www.who.int/healthinfo/07_SAGE_Chatterji.pdf

Chatterji, S, Paul Kowal, Colin Mathers, Nirmala Naidoo, Emese Verdes, James P Smith and Richard Suzman (2008): "The Health of Aging Populations in China and India", *Health Affairs*, 27, No 4, pp 1052-63, at ontent.healthaffairs.org/content/27/4/1052.short

Dandekar, K (1996): *The Elderly in India* (New Delhi: Sage).

Darshan, S, M L Sharma and S P Singh (1987): "Health Needs of Senior Citizens" in M L Sharma and T M Dak (ed.), *Aging in India* (New Delhi: Ajanta Publications).

Doorslaer E V, C Masseria and X Koolman (2006): "Inequalities in Access to Medical Care by Income in Developed Countries", *Canadian Medical Association Journal*, 174, pp 187-88.

Government of India (2004): "Morbidity Health Care and Condition of the Aged", NSS 60th Round, Report No 506, National Sample Survey Office, Ministry of Statistics and Programme Implementation, New Delhi.

– (2006): Census of India 2001, Office of the Registrar General and Census Commissioner, India.

– (2011): "Situation Analysis of the Elderly in India", Ministry of Statistics and Programme Implementation, New Delhi.

Garg, Charu and Anup Karan (2009): "Reducing Out of Pocket Expenditures to Reduce Poverty: A Disaggregated Analysis at Rural and Urban and State Level in India", *Health Policy and Planning*, 24, pp 116-28.

Gupta, P and A K Vohra (1987): "Pattern of Psychiatric Morbidity in the Aged" in M L Sharma and T M Dak (ed.), *Aging in India* (New Delhi: Ajanta Publications), pp 214-21.

Gupta, Indrani and Mayur Trivedi (2005): "Social Health Insurance Redefined: Health for All through Coverage for All", *Economic & Political Weekly*, Vol 40, No 38.

Kumar, Anand and Navneet Anand (2006): "Poverty Target Programs for the Elderly in India: With Special Reference to National Old Age Pension Scheme", Background Paper for the Chronic Poverty Report 2008-09, Chronic Poverty Research Centre.

Kochar, A (1999): "Evaluating Familial Support for the Elderly: The Intra-household Allocation of Medical Expenditures in Rural Pakistan", *Economic Development and Cultural Change*, Vol 47, No 3, pp 621-56.

Meeta and Rajivlochan (2010): "Inequalities in Health, Agrarian Distress and a Policy of Avoidance", *Economic & Political Weekly*, Vol 45, No 43.

Nandal, D S, R S Khatri and R S Kadian (1987): "Aging Problems in the Structural Context" in M L Sharma and T M Dak (ed.), *Aging in India* (New Delhi: Ajanta Publications).

O'Donnell, O, E van Doorslaer, R Ravi, A Somanathan, C C Garg, P Hanvoravongchai, M N Huq, A Karan, G M Leung, K Tin and C Vasavid (2005): "Explaining the Incidence of Catastrophic Expenditures on Healthcare: Comparative Evidence from Asia", Equitap Working Paper 5, at http://www.equitap.org/publications/docs/EquitapWP5.pdf

Office of the Registrar General (2001-03): "Report on Causes of Death in India 2001-03", Ministry of Home Affairs, New Delhi.

Prakash, I J (1998): "Maintenance of Competence in Daily Living and Well-Being of the Elderly", *Research and Development Journal*, 4 (2-3), pp 26-34.

– (2013): "Aging, Disability and Disabled Older People in India" in Phoebe S Liebig and S Irudaya Rajan (ed.), *An Aging India: Perspectives, Prospects, and Policies*, Routledge.

Pricewaterhouse Coopers (2007): *Emerging Market Report: Health in India 2007*, Pricewaterhouse Coopers.

Rajan, S I (2002): "Social Security for the Unorganized Sector in South Asia", *International Social Security Review*, Vol 55, No 4, pp 143-56.

– (2007): "Population Aging, Health and Social Security in India", Centre for Development Studies, Discussion Paper No 3, at http://www.econ.osaka-cu.ac.jp/CREI/index.html

Rajan, S I, M Perera and S Begum (2005): "The Economics of Pensions and Social Security in South Asia" in Mohsin Khan (ed.), *Economic Development in South Asia* (New Delhi: Tata McGraw Hill).

Rajan, S I and S Kumar (2003): "Living Arrangements among Indian Elderly: Evidence from National Family Health Survey", *Economic & Political Weekly*, Vol 38 , No 1, pp 75-80.

Rajan, S I, U S Mishra and P S Sarma (1995): "Living Arrangements among the Indian Elderly", *Hongkong Journal of Gerontology*, Vol 9, No 2, pp 20-28.

Shah, V P (1993): "The Elderly in Gujarat", Mimeograph, Department of Sociology, Gujarat University, Ahmedabad.

Tripathi, Tulika (2010): "Public Health Care in Uttar Pradesh", unpublished PhD thesis (Varanasi: Banaras Hindu University).

Tripathi, Tulika and N K Mishra (2014): "Access to Public Health Services: A Disaggregated Analysis of Uttar Pradesh", forthcoming.

Visaria, P (2001): "Demographics of Ageing in India", *Economic & Political Weekly*, 2 June.

Wagstaff, A and E van Doorslaer (2003): "Catastrophe and Impoverishment in Paying for Healthcare: With Application to Vietnam 1993-98", *Health Economics*, 12 (11), pp 921-34.

Williams, R and R Krakauer (2012): "The Challenge of Non-Communicable Diseases and Geriatric Conditions" in *Global Population Ageing: Peril or Promise?* World Economic Forum, Geneva.

Xu, K, D Evans, G Carrian and A M Aguilar-Rivera (2005): "Designing Health Financing System to Reduce Catastrophic Health Expenditure", No 2, Technical Brief for Policy Makers, WHO.

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