Care of the Elderly

About the authors

HelpAge

HelpAge India is a national level voluntary organization working for the cause and care of disadvantaged elderly in India for the past 26 years. HelpAge has been implementing projects that provide health, economic and emotional security to the elderly besides direct intervention to provide relief to the elderly. It also undertakes Research and Strategic Department work to mainstream issues concerning ageing and aged in India. For this purpose HelpAge organizes seminars, discussions, interactive sessions with all the stakeholders; contributes articles to various academic and other journals/magazines; publishes a journal and reader friendly booklets. It also compiles information on old age homes and on the benefits and privileges given to elderly in the country.

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Independent Commission on Development and Health in India

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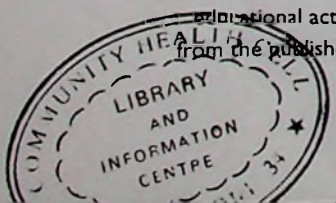

Independent Commission on Development and Health in India

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Foreword

Voluntary Health Association of India facilitated setting up of the Independent Commission on Health in India in 1995, renamed as the Independent Commission on Development and Health in India, as a people's initiative to assess the current health and development status and facilitate the process of need based and people-centric, sustainable development and health. Through analysis of existing data and in-depth study the Commission, consisting of distinguished persons from the health and development sectors, identifies the maladies affecting the present health care system and development programmes and provides clear recommendations for future action.

The first Report of the Commission was released in 1998 by the Prime Minister and was also presented to the President of India. The Report was widely distributed, discussed and debated in different fora, including the Parliament, the Health and Family Welfare Ministry and the Planning Commission. In many ways the report has influenced current thinking on various issues of public health including the National Health Policy and the National Population Policy.

The first Report was a summarized version of voluminous reports prepared by the Commission over two long years of painstaking but rewarding process. Some of the significant chapters were published as separate monographs.

The second Report of the Commission particularly addresses the issues of Poverty Alleviation and Governance of Social Sector. This is particularly keeping in mind the poor performance of the Nation in both these areas. Besides these core areas ICDHI will also research on following areas of current concern:

1. Revamping and Re-energizing of Primary Health Care.
2. Private Sector in Health Care and Medical Ethics.
3. Human Resource Development in Health Care..
4. Health Sector reforms and external assistance for health.
5. Role of Indian Systems of Medicine in strengthening health care practices.
6. HIV/AIDS and Reproductive and Child Health.

This monograph focuses on the need to care for and support the elderly, given the fact that the elderly population in India in 2001 was a whopping 71 million and is projected to be 114 million by 2016. It is time we take stock of the health and economic security provided to the senior citizens of the country. The monograph poignantly brings out the change in status of the elderly in terms of their economic and emotional dependence on the younger lot. The health concerns of the elderly need to be adequately addressed and services provided for the same. Although there are various schemes for the elderly, somehow the benefits do not reach the targets, either due to lack of awareness or apathy of the service providers. The

monograph gives a well-laid out set of recommendations for the income, health and emotional security of the elderly.

Alok Mukhopadhyay

Content

1.0 Introduction

Ageing is an inevitable process in the life of every human being; however, the pace may vary from individual to individual. Most people tend to view ageing as a problem, but these people lose sight of the fact that elderly represent a vast reservoir of experience and maturity and could be used to the advantage of the family, community and country. So, there is an urgent need to take a hard look at how, the elderly themselves, and the society perceive them. However, all said and done, one cannot deny the fact that like every other stage in life, old age also presents its own peculiar challenges to human beings.

In old age, the need for economic, health and emotional wellbeing assume special significance because of gradual reduction in abilities. Traditionally, family provided these comforts for its ageing members, as it was based on the principle of reciprocity among generations. These ties were reinforced by the economic relations and social conventions. In contemporary world, these bases of family have weakened due to lessening of dependence on family assets for economic sustenance; prevalence of values of individualism and other such developments. Despite these changes, family is still considered the mainstay of social support for the elderly in India. Though the Indian state was never unmindful of the welfare of elderly and this is reflected in the Constitution of India wherein, under article 41, "the State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in case of unemployment, OLD AGE, sickness and disablement and in other cases of undeserved want". This promise has been fulfilled to the extent that the later governments were committed to labour welfare and made several provisions for social security. But, the real challenge is to provide economic security to the workers in the unorganized sector that constitute almost 90% of the workforce and also those who live below poverty line.

The problem of economic security has not only compounded over the years for following reasons, increasing longevity, increase in absolute number of elderly and adoption of lop sided policies to pamper the governmental sector and making the post retirement benefits almost unsustainable. Average life expectancy at the age of 60 years has increased from 12.4 years in 1950 *(Source: Sharma, S.P. & Xenos, P.; Ageing in India: Demographic Background and Analysis based on Census Material: Occasional paper No.2 1992; RGI, New Delhi.)* to 17 years in the year 2002 and expected to be 20.8 in the year 2050 *(Source: World Population Ageing: 1950-2050. Dept of Economic and Social Affairs Population Division, United Nations. New York: 2002.)* The number of elderly has also increased from 19.61 million in 1950 to 81.09 million in 2002 and expected to increase to 323.82 million by the year 2050. The solutions to these problems should be found in the changed

context of shrinking family and government support to the elderly and increased role to the market forces.

The other related issue is that of health security of elderly. Here also the scenario is more or less similar to that of income security. The government employees have been provided health services under the CGHS scheme and ESI, but this covers only a miniscule minority of elderly. Those at the bottom of the rung i.e. the people below poverty line, just above it and those in the not so poor category, petty bourgeoisies are all beyond the purview of any organized system of health care delivery. They are at the mercy of private practitioners and the PHCs, CHCs and government hospitals. Besides the pertinent questions of availability and accessibility; there are the questions of affordability. This last question assumes significance in the changed context of privatisation and liberalisation. Private sector has entered health care delivery and insurance as a major player. These facilities may not be affordable to most of the elderly people as their resources shrink with age. Insurance coverage is restricted by age and other stipulations. So, there is the need to plan for future keeping these factors in mind.

2.0 Demographic Trends

Due to preoccupation with increasing population in India, most of us have not paid attention to another silent demographic revolution the country, whose implications will become pronounced in the next fifty years. Depending on the decline in the fertility and mortality rate and increase in the expectation of life, this will lead to increasing in the proportion of the elderly after a time lag.

According to the official projections of the Registrar General, India, in the year 2001 the elderly population is estimated to be 71 million, and 114 million by the year 2016(the year for which the ultimate projections were made).

Table 1: Percentage share of person 60 years and above in the total population by sex, India 1901-1991

Year	Total	Males	Females
1901	5.06	4.55	5.58
1911	5.22	4.81	5.70
1921	5.37	5.04	5.70
1931	5.09	4.85	5.34
1941	5.66	5.43	5.91
1951	5.43	5.21	5.66
1961	5.63	5.46	5.80
1971	5.97	5.94	5.99
1981	6.32	6.23	6.41
1991	6.70	6.69	6.71

(Source: Census Data 1991).

Table 1 reveals that the proportion of the old age in the population of India increased from 5.1% in 1901 to 6.7% in 1991. Proportion of Elderly males increased from 4.55% to 6.69% as compared to 5.58% in 1901 to 6.71% elderly females in the same period.

Table 2 shows that the percentage of people above 60+ years of age in 1991 is highest in Kerala (8.8%) and lowest in Assam (5.2%) In seven states, the percentage is higher than the percentage of 60+ age group population in India i.e. more than 60 percent. The Technical Group on Population projection estimated the percentage of population of India and some of the major Indian State, for the years 2001, 2011, and 2016. These figures reveal that the percentage of 60+ years of Population will gradually increase, except in Assam where it will come down from 5.2 percent to 4.0 percent in 2016. Kerala and Tamil Nadu will have more than 13% of their population in the age group of 60+ years by 2016.

Table 2: State wise Distribution of Percentage of the Elderly Population				
India / states	**1991**	**2001**	**2011**	**2016**
India	6.7	6.7	7.6	8.3
Andhra Pradesh	6.7	7.4	9.3	10.5
Assam	5.2	4.6	4.0	4.0
Bihar	6.2	6.1	6.7	7.4
Gujarat	6.4	6.2	6.9	7.7
Haryana	7.7	7.0	6.8	7.5
Karnataka	6.9	7.1	8.6	9.8
Kerala	8.8	9.7	11.6	13.1
Madhya Pradesh	6.6	6.5	6.9	7.2
Maharastra	6.9	7.1	8.0	8.8
Orissa	7.1	7.3	8.3	9.0
Punjab	7.8	7.2	7.0	7.5
Rajasthan	6.1	6.4	7.2	7.6
Tamil Nadu	7.4	8.4	11.5	13.1
Uttar Pradesh	6.8	6.6	6.8	7.1
West Bengal	6.0	6.6	8.3	9.3

Source: Report of the Technical Group on Population Projection, August 1996; Ashish Bose, Population Profile of the Elderly (60+ yrs.) in India, (under publication)

In order to devise effective policies and programmes for the elderly in the country following facts should never be lost sight of:

(i) 78% of the aged population lives in rural areas and the rest 22% in the urban areas.(National Sample Survey Organisation (NSSO) data).

(ii) Feminisation of aged population:
(1991) 27.32 million 60+ women (48.2% of elderly) the UN estimate says 42.46 million in 2002 (52.36%).

(iii) Percentage of elderly women in rural and urban areas:
77.77 % of elderly women were living in rural areas according to 1991 census 22.23 % of elderly women were living in urban areas.

(iv) Percentage of literacy level (literates and illiterates):
In 1991 only 27.15% of elderly were literate (40.62% of males and 12.68% of females).

(v) Percentage of widows:
According to NSS 52nd Round of 1995-96, 58% of the elderly women were widows.

3.0 Economic Status of Elderly in India

According to the Census 1991, there were 22.2 million elderly (60+) workers in India comprising of 17.8 million males and 4.4 millions females. This implies that 39.1% of the total 60+ population were workers. The male work force participation rate was 60.5% while it was 16.1% for the females.

There were more than a million in each of the following states: U.P. (4.3 million), Bihar (2.3 million), Maharastra (2.2 million), M.P. (2.0 million), Andhra Pradesh (1.9 million), Tamil Nadu (1.7 million), West Bengal (1.3 million) Karnataka (1.2 million) and Rajasthan (1.0 million). The elderly work force participation in some of these states are as follows: U.P. (45.5%), Bihar (42.4%), Tamil Nadu (39.9%), West Bengal (30.8%), Karnataka (37.3%) and Rajasthan (36.4%). Andra Pradesh has the highest female work force participation rate (24.2%) among the elderly and West Bengal, the lowest (6.5%).

The National sample survey (52nd Round, 1995-96) collected data on economic dependence of the elderly. The all India picture is as follows: among the elderly rural males, 48.5% claimed that they are not dependent on others, 18% were partially dependent and 31.3% were fully dependent on others. In the case of elderly rural females, 70.6 % were fully dependent on the others, 14.6% were partially dependent and 12.1% said that they were not dependent on others at all.

The urban scenario has been slightly different from the rural scenario. Here, 51.5% of the males claims that they were not dependent on others, 29.7% were fully dependent 16.9% were partially dependent. In the case of urban females, 75.75% were fully dependent on others. In West Bengal, which tops the list of dependency of elderly in India, over 88% of the rural females and 85% of the urban females were fully dependent on others. The economic dependency ratio among the females is the lowest in rural areas of Himachal Pradesh were 48.7% of the women are fully dependent on others. Himachal has the highest ratio of economic independence (23.6%) among females in rural areas. The NSS data provides the details about the category of persons who support the economically dependent elderly. In India as a whole, children support 73.2% of the rural males, and 76.5% of the urban males and grand-children support 4.8% of the rural males and 5.2% of the urban males. In the case of elderly female, children support 69.9% of the rural females and 67.9% of the urban females. The share of grand-children is 5.2% and 5.5%, respectively.

3.1 Change in the Status: Economic and Emotional Dependence

As age advances, dependence on "others" be it adult, children, grandchildren

or relatives, increases and this is accompanied by compromise with dignity, independence and participation. As is clear from the data quoted above, most Indian elderly work, well after the age of 60 years, but need less to emphasis the obvious that their contribution to family declines as compared to their adult children. This, at times, result in decline in status in the family.

This loss of status is more pronounced in middle class families, where the elderly have been in the organized sector and retire at the mandatory age of 60. This abrupt departure from the active and productive work creates a void in their life, unless he/she had diverse interests and activities in the field of art, literature science, sports, religion etc. The individual's life style is also likely to be adversely affected, owing to reduction in income and loss of the 'position'. The pinch of these changes is felt more by people who have good health and feel they can contribute more to the society because of their expertise and knowledge. These people, in most cases are unable to find employment due to what is termed as 'ageism' and are unable to contribute meaningfully to the domestic responsibilities. Despite awareness at all levels to harness the potential of the elderly population not much has been done to explore this possibility.

Structure of the family and relationships have also undergone tremendous change in most parts of the country. Inter-country and intra-country migration of the young adult, lack of adjustment in multi-generation households has increased the vulnerability of the aged. However, intergenerational bonding though weakened has not been severed. This, at times, help in bridging the gap, if any, between the parent's and grand parent's.

4.0 Provisions for Economic Security of Older Persons

In India, economic security in old age is considered of prime importance; it is believed that if one is economically secure in the twilight years of ones life, then other problems can be tackled with ease. This coupled with the labour welfare policies of the government has resulted in many programmes and schemes to ensure income security in old age. Some of which are listed below:

(a) **Civil Services scheme of the Central and the State government:** In 1998, there were 7.3 million civil services pensioners in India (IMF, 2001). In 1998, the average pension to average wage for the civil service was 45.1 percent, and the pension outlays accounted for about a third of the wage bill at the Central and 22% at the State Level (IMF, 2001) even though not mandated. The main social security for the Civil Servants are non-contributory, unfounded DB pension which is indexed for both prices and wages, and has fairly generous commutation provisions(up to 40% of the pension benefit can be taken in a lump-sum) and survivors' benefits (called family pensions). The DB pension schemes provide a maximum replacement rate of the 50 % of the average salary during the last 10 months of the service.

(b) **Public sector enterprise:**
This includes insurance companies, Reserve Bank of India, Public sector banks, electricity boards, oil companies such as ONGC ,industrial entities etc. which have their own pension.

(c) **Voluntary Tax advantaged saving schemes:**
These comprises of the Post Office Saving Bank schemes (constituting 10% of GDP), Public Provident Fund (PPF) and the group annuities of Life Insurance companies (these are currently regulated by the IRDA).

(Quoted from: Reforming India's Social Security by Mukul G. Asher, Professor, Public Policy Programme).

4.1 Government Schemes for Poor Elderly

(a) **Targeted Public distribution:** a scheme of distribution of tier system to house holds below poverty line (BPL) and above poverty line food grains at high subsidized rate entitled to 10kgs of food grains schemes covers about 600 lakhs families. *(Source: U.K. Singh Ministry of Finance Delhi).*

(b) **Annapurna:** Under this scheme 10 kg of food grains per person per month free of cost will be provided to indigent senior citizens. Initially this benefit was admissible to those persons who were eligible for old age pension but were not presently receiving the pension.

(c) **Subsidized Insurance Schemes:** The Govt. of India as well as several state governments have launched a variety of subsidized Insurance scheme for the benefit of the weaker section of the of the people through the Life

Insurance Corporation of India and General Insurance Corporation of India. One such scheme introduced is a pension scheme administered through the LIC called Jeevan Suraksha. Another such scheme introduced through GIC is Jeevan Arogya. In August 2000, many of these schemes were discontinued and replaced by a new scheme called Janshree. Under this scheme insurance benefit has been raised to Rs.20000 for the natural death and Rs.25000 for the partial disability.

(d) Government of India has also introduced another Insurance scheme for the benefit of agricultural worker called **Khetihar Mazdoor Bima Yojna** on 18th May 2001. The following benefit are provided under this scheme:

i. Lump sum payment of Rs.20000 on natural death.
ii. Lum sum payment of Rs.50000 in case of death due to accident.
iii. Lump sum payment of Rs.50000 in case of permanent disability or Rs.25000 in case of partial disability due to accident.
iv. Rs.100 to Rs.1900 per month will be entitled for pension to the agricultural worker.
v. On death after commencement of pension the family will be paid a lump sum amount ranging from Rs.13000 to Rs.250000 depending on the entry to the scheme.
vi. The insured person has to pay a premium of Re.1 per day or 365 per annum.

(Source: HelpAge India, Research and Development Journal, Special Issue, vol. 8 No. 1 January 2002)

(e) Varistha Pension Bima Yojna: It is a Government's subsidised pension scheme announced for senior citizen aged 55 years and above, in the Union Budget 2003-2004. The scheme is being launched to provide an annual return of 9% per annum.

(f) Dada–Dadi bond: Central Government announced new Dada- Dadi Bond from April 1, 2004, which will be a new saving instrument for senior citizens. Persons above the age of 60 will be eligible to subscribe to this bond, which will carry a return higher than the market rate of interest. The income from interest of this bond is exempted from income tax.

(Source www.niaci.com/news-unihealth.html)

5.0 Health and Medical Problems

In a developing country like India, the elderly people suffer from the dual medical problems of both communicable as well as degenerative disease. The elderly are highly vulnerable to infectious disease because of their decline in their immune functions and atrophic change in various organs. The psychological changes in the old age lead to impairment cough reflex, impairment circulation and tissue perfusion. There is a deficient collagen synthesis and poor wound healing. Further incidence of infection remains high because of poor nutrition and high intake of immune suppressive drugs.

Joint pain and cough are the most common health problem among elderly. Other remote diseases include blood pressure, heart disease, urinary problem and diabetes. A major killer among elderly was discovered to be respiratory disorder in the rural areas and disorder in the circulatory system in urban areas. Lack of adequate nutrition was one of the contributory factors for the ill health of the elderly. Moreover the diet taken by them was deficient in micro nutrients, like iron, vitamin A, roboflavin calcium etc, deficiency of Vitamin A leads to poor vision, dry skin, and weakened immunity. Antacids (containing aluminum) are avoided because their interface with calcium may cause Alzheimer's disease and other type of senility. Low socio economic status has been found to be the cause of deficiency.

Among infectious diseases, pneumonia is 50 times more common in the elderly than in adolescents and it accounts for half the deaths cause due to respiratory diseases, excluding cancer. Asymptomatic bacteriuria affects 30% of the elderly women and 7% of the elderly men. The common cause of urinary tract infection in the elderly is the insertion of catheter and other instruments.

(Source www.india-seminar.com)

Table 3A Distribution of Old age death by system (60+) in rural India, 1993 (Top 5 causes)	
Disorders of the respiratory system	33.7%
Disorders of circulatory system	21.6%
Other clear symptoms	18.1%
Disorders of central nervous system	9.6%
Fevers	6.6%

Table 3B Distribution of Old age deaths by the disease (60+) in rural India 1993	
Bronchitis-Asthma	25.8%
Heart Attack	13.2%
Paralysis	8.4%
Cancer	7.1%
Tuberculosis of lungs	5.8%

(Source: Data-Office of the Registar General 1997, reference book Active Ageing in New Millenium by Abha Choudhary)

The main cause of death among the elderly population is Cardiovascular disorder accounting for 1/3 mortality followed by the respiratory disorder (10%) and the infectious disease forming 10%, Neoplasm 6% and the balance for others diseases. The distribution of the moralities, sex wise in urban areas is given below:

Table 4

	65-69years		70+	
Cause of Death	**Male**	**Female**	**Male**	**Female**
Infectious and parasitic disease	13.2	9.6	9.3	6.5
Neoplasms	5.3	6.9	4.1	3.8
Endocrine nutritional and metabolic diseases and immunity disorder	4.9	6.5	4.1	4.5
Disease of blood and blood forming organ	1.5	1.8	1.4	1.9
Mental disorder	0.2	0.1	0.1	0.1
Disease of the nervous system and sense organs	1.9	2.3	1.9	1.9
Disease of the circulatory system	38.3	36.3	36.9	36.9
Disease of the respiratory system	8.2	7.1	9.7	10.2
Disease of the digestive system	5.1	3.5	3.2	2.4
Disease of genitourinary system	1.8	1.7	1.7	1.2
Disease of the skin and subcutaneous tissues	0.2	0.3	0.2	0.2
System, signs and ill defined conditions	15.7	19.5	24.1	27.3
Injury and poisoning	3.5	3.3	2.9	2.6
Others causes	0.1	0.5	0.3	0.4
All causes	100.0	100.0	100.0	1...0

(Source: Health Information of India(1996) Directorate General of Health Services MoH&FW, Govt. of India, Delhi.)

Table 5: Percentage Distribution of Major Diseases of Older Persons In Rural Areas 1991 –1994

Year	Bronchitis & Asthma	Heart attack	Paralysis	Cancer	T. B of Lungs	Anemia	Diabetes	Malaria	Typhoid
1991	25.9	12.8	9.7	6.0	7.1	4.7	1.9	2.1	1.3
1992	11.8	11.8	9.9	6.0	7.3	4.2	1.6	-	1.6
1993	12.5	12.5	9.8	5.8	7.0	4.4	1.8	-	-
1994	13.7	13.7	10.4	7.6	6.1	4.0	2.2	2.3	-

(Source: Survey of Causes of Death (Rural) Registrar General of India, 1991)

These trends have been confirmed by some micro studies as well and two of which are quoted below. The prevalence of TB is higher among the elderly than

younger individuals. A study of 100 elderly people in Himachal Pradesh found that most of the patients came from rural background. They were also smokers and alcoholics. Endocarditis thus is the major factor in the elderly mortality. Besides these common infections, the elderly also susceptible to gastrointestinal infections, pressure sores, septic arthritis, septic anemia and meningitis, which calls for special immunization programs. *(Source www. india- seminar.com)*

Prevalence of Physical Problem among the institutionalized elderly were studied in rural and urban setting, covering both the sexes. *(study conducted by Dr.V.S. Natrajan at Chennai).* Though the eye problem were high among the rural and urban area and in all age groups, joint pain and dizziness was higher in rural areas. The proportion of the older persons with headache, asthma, indigestion and shivering were same in the institutionalized and non-institutionalised elderly in both the sexes. Restlessness and weight loss were more in urban areas. Another fact that came to light in this study has been that health disorders in older person were found to have some difference as far as institutionalized and those living with the families were concerned. Cardiovascular problem were more in institutionalized females as compared to non institutionalized female while it was reverse in the case of males. More institutionalized females reported mental problems than males.

Table 6

	Institutionalized		Non Institutionalized	
System	**Male**	**Female**	**Male**	**Female**
Cardio-vascular system	16.39	22.31	26.09	18.52
Respiratory system	32.78	33.10	34.78	25.92
Central nervous system	14.76	17.27	15.21	5.56
Endocrine	11.47	10.79	15.22	3.70
Genito-urinary	19.67	10.79	10.86	9.25
Nutritional	24.59	23.74	26.09	33.34
Locomotor	26.24	36.69	36.95	50.00
Gastro-intestinal Track	24.60	34.54	19.57	38.88
Psychiatry	18.03	17.27	21.74	29.63

Another concern that has yet not been researched in India pertaining to the elderly is the implication of HIV/AIDS. This dreaded disease is expected to hit the elderly directly and indirectly. In other words, there could be many elderly infected with HIV and many more whose adult children will be inflicted with HIV/AIDS. Some of them may even die leaving their young children in the care of the elderly parents. The trauma resulting from the loss of family members and the stigma of being effected by HIV /AIDS can result in high level of exclusion, for older people. Besides, in advanced age they will be expected to take care of their young grand children. Such cases have come to light in large numbers in Africa. *(See website of HelpAge International for more details).*

6.0 Mental Health

Mental Health of the elderly is another important area in understanding their overall health situation. Mental health concerns of the elderly include depression, delirium, psychosis and dementia. Over 10% of India's elderly suffers from depression and 40-50% of elderly requires psychiatric or psychological intervention at some point in their twilight years. The principal mental disorders of old age are depression and dementia. Schizophrenia is another disorder found in the old age eg. paranoid psychoses which begin in later life; substance abuse specially alcohol abuse and abuse of prescribed medication; anxiety disorders - specially those that begin as a result of loss of confidence or as a result of physical illness such as hip fractured. Delirium is usually the result of infections, in the older people who are not properly nourished and who have other physical disorder, or early cognitive impairment in older people in the developing world.

Another dimension of mental health that has been neglected so far has been the gender dimension. Following points will highlight the need to focus on this area:

(i) Alzheimer's is a disease of longevity and women outlive men and are more likely to be the victims of dementia.

(ii) Delirium is also common in women as they are extremely sensitive to things like anaesthesia, drug toxicity and infections.

(iii) Depression is a common condition among women: life time risk of depression in women is 25% as compared to 7-12% for men; 1/3 of the cases of depression in women go untreated.

Magnitude of Health Problems

To appreciate the magnitude of health problems faced by the aged, following points should be considered:

1. The National Sample Survey (NSS) findings on the aspects of physical mobility as well as chronic disease indicates that 44%-47% elderly males were physically immobile as compared to 67%-68% females.

Table 7: Percentage Distribution Of Physically Immobile Elderly By Age, Gender And Residence

	Rural			Urban		
Age	Male	Female	Total	Male	Female	Total
60-64	22.71	19.93	21.30	19.10	18.07	18.59
65-69	20.88	19.88	20.37	24.66	19.83	22.34
70+	56.41	60.19	58.13	56.24	62.10	59.17

Source: National Sample Survey, 1991

Table 8: Percentage Distribution of Type of Chronic Diseases among the Indian Elderly by the age and Residence

(A) Rural

Age	Cough	Piles pain	Joints	Blood Pressure	Heart disease	Urinary problem	Diabetes
60-64	35.6	3.37	46.07	6.47	3.26	3.20	2.04
65-69	33.8	2.98	48.50	6.22	3.53	3.21	1.78
60+	34.37	3.25	46.96	6.42	3.74	3.53	1.73
70+	33.69	33.35	46.65	6.52	4.33	4.05	1.41

(B) Urban

Age	Cough	Piles pain	Joints	Blood Pressure	Heart disease	Urinary problem	Diabetes
60-64	24.16	3.65	38.37	18.53	6.44	3.20	5.65
65-69	24.25	3.80	38.70	17.65	6.88	3.10	5.62
70+	24.95	3.58	39.16	16.60	5.93	5.23	4.76
60+	24.52	3.58	38.79	17.48	6.34	4.02	5.27

(Source: National Sample Survey, 1991)

As can be seen from the table, the proportion of the aged persons with chronic disease varied from 44.3% to 45.5%. This proportion holds true for almost all states. With regard to the prevalence of the chronic disease among the elderly in general, the problems of the joints (46.96%) followed by coughs and related complaints (34.37%) were found to be prominent. However, there have been some differences between rural and urban areas.

The ageing survey 1993 points out three major impairments amongst the elderly viz, vision, hearing and walking.

Table 9: Percentage Distribution of Elderly According to Impairments

Age	Vision	Hearing	Walking
60-64	28.9	7.8	11.9
65-69	32.8	8.9	15.7
70-74	35.6	12.0	19.9
75-79	45.3	19.8	29.7
80-84	54.5	31.2	44.2
85-90	66.7	33.3	43.3
90+	60.0	66.7	73.3

Source: Ageing Survey 1993, reference books Active Ageing in New Millenium by Abha Choudhary)

7.0 Health Care Provisions

Health security is one of the basic pre-requisites for an enjoyable life in old age. There are many aspects of health security that need to be taken into account to ensure health. First and foremost is the concern of healthy ageing. This most important fact about ageing has been neglected by all concerned to their peril. Quality of life in old age depends on many things, particularly, on ones life style. If throughout life an individual has been sedentary, negligent about food and nutrition then one cannot expect to be healthy when ageing. *"Tomorrow's elderly are today's adults, and yesterday's children."* That is why WHO emphasis a life- span approach for the elderly. Here, health promotion at all ages comes before geriatric care.

The other aspects of health security are availability of geriatric health care and resources to foot the medical bills. These aspects are widely debated by experts and policy makers and many steps have been taken to implement schemes and programmes for this. Many hospitals are running regular geriatric clinics for the elderly. Many NGOs are running Mobile Medicare Units for them, besides these specialised efforts elderly can avail medical facilities general hospitals etc.

To cover the medical expenses of the elderly there are some schemes run by government and some by public sector and private sector insurance schemes. Some of which are given below:

1. Central or State Government based system includes Central Government Health Schemes (CGHS) and Employees State Government scheme (ESIS), which is estimated to cover 20 to 30 million population;
2. The community based Universal Health Insurance Scheme was announced in the union budget 2003-2004.
3. The New India Assurance Company Ltd. is implementing this scheme. The scheme offers health protection and easy access to good health services to the disadvantaged sections. Under this scheme, a premium of Rs. 1per day for an individual, Rs. 1.50 per day for a family of five (including the first three children) and Rs. 2 per day for a family of seven (including the first 3 children and dependent parents) will entitle eligibility to get re-imbursement of medical expenses up to Rs.30,000 towards hospitalisation, an accident cover upto Rs.25,000 and compensation due to loss of earning at the rate of Rs. 50 per day up to maximum of 15 days after a waiting period of 3 days. For below poverty line (BPL) families, the government will contribute Rs. 100 per years towards their annual premium.
4. The scheme run by the member based NGO cover about 5% of the population. It is estimated that 20 million employees may be covered by such reimbursement arrangements. Under the Insurance of GIC, LIC, UTI covers 3.4 million.

Policies of Life Insurance Companies

(a) Nav Prabhat

It is close-ended scheme for Senior Citizens between 50 and 70 years of age. Disability benefits include partial disability and disability due to sickness. Sum assured is Rs 15,000 to 20,000. Life Insurance Corporation has other policies includes Asha Deep and Jeevan Asha. Asha Deep, includes cancer, paralytic stroke, renal failure, and coronary artery disease. In Jeevan Asha includes respiratory system, lymphatic system etc. in 2% of sum insured is also available.

(b) UTI's Senior Citizen Plan.

This policy is akin to Bhavishya Arogya Policy. The insured gets life long cover after a pre-determined retirement period. There is no pre-exiting exclusion and there is no provision for the return of the amount on withdrawal from the scheme.

(c) Jan Arogya

This policy was introduced primarily to meet the needs of poor people both urban and rural. The policy is essentially a medi-claim policy with the reduced sum of Rs 5000 only.

(Source: HelpAge Journal + Internet site. www.niaci.com/news-unihealth.html)

8.0 Recommendations

The above account highlights the urgent concerns of aged in India. In order to address the issues of immediate concerns of elderly of today and make effective plans for elderly of tomorrow following steps are highly recommended:

8.1 Income Security

1. Reforms in Non-Contributory Pension System: It is estimated that 30% of the elderly in India are living below poverty line and the same percentage just above it. This segment of social needs care and support. To provide them with a safety net it is essential that there be maximum coverage of this segment of elderly under old age pension scheme; preferably universal coverage of elderly women, tribal and dalits. A drive to enroll the physically disabled or people over 80 years of age should be launched. There should be a system of identification of the elderly which automatically enrolls all those over 60 years of age in the list and also periodically identifies all those who will be included in it each year.
2. The young-old should be given opportunities to take advantage of rural credit schemes to open small ventures to support themselves and their families. Encouragement should be given to them to form SHGs. In this case also preference should be given to women, tribal and dalits.
3. In this liberalized and globalised economy where everything has become market-driven, government should ensure some basic minimum return on savings and ensure effective regulatory regime for the private pension fund managers.
4. Facilities of redeployment to the elderly should be provided through special training for the skill development. The reemployment should be either part time or flexi time, with the view to keep the older person busy, economically independent, avoiding unnecessarily straining their physical capacity.

8.2 Health Security

1. Plan health care facilities for elderly based on the need as highlighted by various national level surveys and provide appropriate services in the tertiary health care system. Make special provision for geriatric clinics with the help of private sector and NGOs that can supplement government efforts.
2. Geriatrics should be included in the curriculum of medical and paramedical students as a compulsory subject. Sensitisation of existing staff through refresher courses etc. especially the PHC and CHC staff as they are the first point of contact for any patient.
3. Special attention should be paid to health of elderly women particularly their mental health. Not only facilities should be provided for them in terms of

clinics etc but awareness should be raised with the help of NGOs for the urgent need to consult medical specialist and not to trivialize the issue.

4. Medical facilities should be accessible to the elderly, so improvement in infrastructure is required urgently. The ideal situation would be geriatric wing in each district level hospital in the country.
5. Given the fact of privatization of medical facilities especially the tertiary health care system, government should regulate the practitioners to provide special concessions to the senior citizens not only for hospitalization but also for treatment and pathological tests.
6. Younger people should be encouraged to take up medical insurance for the entire family including their elderly parents, so that they have some cover. Insurance companies should also be urged to spread awareness about usefulness of these policies and also redesign their policies to give maximum benefit.
7. The most important issue of healthy ageing that can save money by preventive care should be made part of the curriculum in school and colleges; so as to reiterate its importance in life.
8. Over the years, WHO has been taking action to improve the health care of the elderly. The principal focus of WHO's action has been on community participation and family care. Promotion of traditional family ties has, therefore, been emphasized instead of institutional care. In collaboration with its Members State, the WHO Regional Office for South- East Asia has been concentrating its efforts in several areas of elderly care. These include:
   - Identification of the special needs of the elderly.
   - Creation of awareness among policy makers and people.
   - Supporting the formulation of appropriate National policies, strategies and programs.
   - Establishment of institutions or centres of excellence for health care of the elderly.

8.3 Emotional Security

1. Changes in the structure and function of the family in the modern socio-economic context are inevitable. The fact of the matter is that family may not be able to take the strain of taking care of elderly, so support should be provided by the community to take care of the elderly. Efforts should be made to develop better home care services, with workers/volunteers specially trained to take care of elderly people.
2. To reduce conflict in families especially the urban middle class, family counselling centres should be opened to help members of the family reconcile their differences.
3. Special care should be taken while framing the laws that concern the family

relationships that interests of elderly are reconciled with that of the younger members of the family.

4. Special programmes should be devised for school and college students to promote inter-generational bonding.
5. Sensitization of enforcement agencies, medical staff to spot cases of elder abuse and treat them appropriately. Law needs to be in place to deal with cases of elder abuse just as the law on domestic violence.
6. Loneliness and isolation from family and other loved ones are common for the elderly. Death of spouse may leave the remaining partner without the enthusiasm or capability to care for him or herself. Encouraging and supporting these folks to attend the group or community meals, and find new friends can make a big difference.
7. Connecting our elderly people with the support or care of young children. Young children and elderly people often seem to have a special magic together.
8. The capacities and skills of the elderly should be used for village development activities eg. social workers, health educationists etc. The elderly people services should be utilized in various activities of the community such as manning child care centres, cultural clubs, vocational training etc. for which they must be paid remuneration.
9. Counseling is needed to mentally prepare the elderly people to gracefully accept the old age.
10. There should be priority for allotment of houses for the retiring employees at subsidised costs, where were necessary.

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The Independent Commission on Development and Health in India

The Independent Commission on Development and Health in India (ICDHI), formerly known as The Independent Commission on Health in India (ICHI), was formed in 1995, facilitated by Voluntary Health Association of India. The commission, comprising of distinguished people from the development and health sectors, aims at assessing the development and health situation of the country through policy research and analysis, in-depth surveys, focus group discussions, public hearings, round table conferences with developmental workers, policy makers and people, particularly disadvantaged community at large. By means of participatory process, the Commission seeks to identify the maladies impending the development and progress of the country and come out with clearly defined solution to the problems identified. The Commission works closely with the Prime Minister's Office, Ministry of Health & Family Welfare and Planning Commission within the government, and reputed Research organizations, Non-government organizations, Panchayati Raj Institutions at the grassroots as well as other relevant forums . The first report of the Commission was released by the Prime Minister and was presented to the President. The report was discussed in the Parliamentary forum. ICDHI's constant endeavour has been to facilitate the process of need based and people-centric sustainable development.

The Independent Commission on Development & Health in India

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