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Ageing and Health Programme



AGEING IN INDIA

prepared for WHO

by

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APPENDIX

AGEING IN INDIA

India is a vast country occupying an area of about 2,287,263 square kilometres. The Indian subcontinent is physically and culturally diverse. Though Hindus are the majority, secular India is home to different religions. Sixteen per cent of the world's population lives in the country. Some 826 languages and thousands of dialects are spoken. Different regions of the country – river valleys, plains, deserts, vast stretches of coast, snow covered mountains, present different types of life style and culture. While 72 per cent of the population live in rural areas, there are more than 225 cities with over 100,000 population, and ten cities with over a million people. Different parts of the country are experiencing varying degrees of socio-economic change. Literacy, employment, health and morbidity rates vary from region to region. Urban and rural environments present contrasting pictures with respect to quality of life at any age. Heterogeneity among its populace demands that generalizations about India be made with extreme caution.

India is geographically vast and culturally heterogeneous. Urban and rural environments present contrasts. Hence, generalizations should be made with caution.

It is well known that there are vast differences in both quantity and quality of statistics about the elderly population (Kinsell & Taueber, 1992). In India there is no nation-wide registry of older people. Community based data on morbidity are also not readily available. Absence of reliable and continuous source of data make the task of researchers difficult. Appendix A lists the most common sources of information on older people.

1. DEMOGRAPHIC TRANSITION IN INDIA

Population ageing is the most significant result of the process known as demographic transition. Reduction of fertility leads to a decline in the proportion of the young in the population. Reduction in mortality means a longer life span for individuals. Population ageing involves a shift from high mortality/high fertility to low mortality/low fertility and consequently an increased proportion of older people in the total population. India is undergoing such a demographic transition.

In 1947, when India became independent from British rule, life expectancy was around 32 years. Improvements in public health and medical services have led to substantial control of specific infectious diseases which translated into significant decreases in mortality rates. Life expectancy at birth rose steadily and by 1990 had reached 60 years (60.51 for females and 60.31 for males). Improved sanitation, increased attention to maternal health and better child care facilities greatly reduced infant mortality. Government sponsored family planning measures made some impact, especially in urban areas.

Total fertility rates (i.e. the average number of children a woman will have had by the end of her reproductive life) decreased from 5.97 in 1950 to 3.56 in 1990. It is estimated that by 2000 the crude birth rate may be around 25 and the crude death rate less than 9 per 1,000 population. The shape of the population pyramid will gradually change from a wide base/narrow top, to a barrel-shaped form.

The UN defines a country as 'ageing' where the proportion of people over 60 reaches 7 per cent. By 2000 India will have exceeded that proportion (7.7%) and is expected to reach 12.6% in 2025.

Table 1: Crude Birth Rate (CBR), Crude Death Rate (CDR) and expectations of life at age 60.

Census year	CBR	CDR	Expectation of life at age 60 Males	Expectation of life at age 60 Females
1961	41.7	22.8	11.8	13.0
1971	41.2	19.0	13.6	13.8
1981	33.9	12.5	13.8	14.7
1991	29.7	10.7	14.5	15.5
2001	23.7	8.4	15.2	16.4

Source: Chanana, H.B. & Talwar, P.P. (1987) 'Ageing in India: Its socio-economic and health implications'. Asia-Pacific Population Journal. 2(3), 24.

2. DEFINING AGEING IN INDIA

In ancient India, life span of one hundred years was divided into four stages: life of a student, householder, forest dweller and ascetic. There was a gradual move from personal, social to spiritual preoccupations with age.

In most gerontological literature, people above 60 years of age are considered as 'old' and as constituting the 'elderly' segment of the population. In the traditional Indian culture, a human life span is one hundred years. Manu, the ancient law giver, in his Dharmasastra divided this span of life into four 'ashramas' or life stages. The first, 'brahmacharya' (life of a student) was to be spent at the teacher's (guru) house. This is the life of a celibate, to be spent in education and training. Once education was complete, the boy (grown into adulthood by now) would be ready to enter the 'grihasta' ashram. This was the life of a householder. A man was to marry, have children, shoulder the responsibilities of an average citizen in the society. He was to discharge the debts he owed to the parents (pitru rina) by begetting sons and to the gods (deva rina) by performing Yajnas (rituals). This was the stage when a man would fulfil his basic desires, for love, marriage, for parenthood, for status, wealth, prestige and other such physical and social needs. When a man's head turned grey and wrinkles appeared, he was to give up this life of

householder and turn to 'vanaprastha' which literally means 'moving to the forest'. A mature and ageing man would gradually give up his worldly pursuits, move away from the mundane routine of householder and turn inward in search of spiritual growth. Finally, when he was spiritually ready, he would renounce the world completely and enter the stage of 'samnyasa' or asceticism.

Though this scheme of a man's life did not comment about a woman's life, it was assumed that a wife would follow her husband faithfully in his move through different stages. In ordinary social intercourse, a person would be considered old when his children were married and he had grandchildren, regardless of his chronological age. Marriage of a son and arrival of a daughter-in-law into the joint family often marked a major transition in the life of a woman. She would usually hand over the responsibilities of the household and relinquish her own position as 'mistress' of the house. In some parts of India, married women usually would have the keys of the house tied to the end of their 'pallu' (part of the sari that is drawn up over the upper part of the body or head). When the bride arrived, these keys would be handed over to her symbolizing a transition in the status of the older woman. Menopause and arrival of grandchildren usually marked old age for women. There is a trend for women to consider themselves old at a younger age than men.

Indian culture, like many other Asian cultures, emphasized filial piety. Parents were to be honoured as gods. It was considered the duty of a son to respect and care for his parents. Even today, in India, old parents live with son/s and their families. Living with the eldest son and his family is the most common living arrangement. Indian society is patriarchal and after marriage sons bring their wives to the parental household to live. This tradition assured that old people would have younger in-laws and grandchildren to care for them. Also, caste and kin group exerted pressure on younger members to obey and respect elders.

In modern India, retirement age is fixed at 58 in most Government jobs, and 60 years in the Universities. There is a move to increase the retirement age by another two to five years. For all practical purposes people above 60 are considered to be 'senior citizens'. In academic research, retirement age is often taken as an index of aged status. Chronological age of 58 or 60 is considered as the beginning of old age.

3. CURRENT SCENARIO AND FUTURE PROJECTIONS

The Indian aged population is currently the second largest in the world. The absolute number of the over 60 population in India will increase from 76 million in 2001 to 137 million by 2021. Table 2 shows the gradual rise in the elderly population in India. From 5.4 percent in 1951, the proportion of 60+ people grew to 6.4 per cent in 1981 and is projected to be close to 8.1 per cent in 2001. The decadal percent growth in the elderly population for the period 1991-2001 would be close to 40, more than double the rate of increase for the general population.

Table 2: Growth of elderly population aged 60 and over, by sex, in India 1901-2001

Year	Population 60+ (in millions)		
	Persons	Males	Females
1901	12.06	5.50	6.56
1911	13.17	6.18	6.99
1921	13.48	6.48	7.00
1931	14.21	6.94	7.27
1941	18.04	8.89	9.15
1951	19.61	9.67	9.94
1961	24.71	12.36	12.35
1971	32.70	16.87	15.83
1981	43.98	22.49	21.49
1991	55.30	28.23	27.07
2001	75.93	38.22	37.71

Source: Sharma, S.P. & Peter Xenos. 'Ageing in India: Demographic background and analysis based on census materials' Occasional paper No. 2 of 1992, Office of the Registrar General and Census Commissioner, India, New Delhi, 1992 (4).

Such changes are not without consequences to the living conditions and well-being of this population sub-group. Old age dependency ratio (number of person of 60 and over to the working age group between 15 and 59 years), has consistently increased from 9.8 per cent in 1951 to 11.9 per cent in 1981 and is projected to be 12.6 in the year 2001. While in 1971, there were nearly 14.2 older persons for every 100 children, the ratio will be 24.7:100 by 2001.

Changes in population structure will have several implications for health, economic security, family life and well-being of people.

Demographers have worked out the dependency ratio, which basically takes into account the working versus non working sections in the population and find it rising steadily. This means the burden of a larger group of older people will have to be borne by a relatively smaller younger adult working group (as shown in Table 3).

Table 3 Dependency ratios and indices of ageing, India 1951-2001

Year	Dependency ratio		Total	Index of ageing
	Child	Elderly		
	a	b	c	d
1951	68.49	9.80	78.29	14.31
1961	76.97	10.56	87.53	13.72
1971	80.82	11.47	92.29	14.20
1981	73.64	11.92	85.56	16.18
1991	61.43	11.31	72.75	18.42
2001	50.94	12.59	63.53	24.72

Source as in Table 2

- a) No. of persons aged 0-14 per 100 aged 15-59
- b) No. of persons aged 60+ per 100 aged 15-59
- c) No. of persons aged 0-14 and 60+ per 100 aged 15-59
- No. of persons aged 60+ per 100 persons aged 0-14

Tables 3 and 4 give details of changes that have taken place in the last few decades in the age structure of the population. Projections for the immediate future include further improvement in life expectancy, accelerated pace of growth of old population, gradual tracking of gender ratio in favour of females (especially among the older old), and altered patterns of morbidity, disability and mortality (Kumar, 1997). There will be considerable regional variations in these patterns as different regions are at different phases of demographic transition and its determinants. For example, the model of population growth for the state of Kerala is totally different from the rest of India. Unlike other states, Kerala has already achieved lower birth and death rates, lower infant mortality, higher literacy rate, and higher age at marriage. The expectation of life at birth is higher both for men and women and this is the only state in India at present with sex ratio favourable to women (Krishnakumari & Sudeva, 1996).

Table 4: Percentage of population aged 60 and over to general population by sex, India, 1901-2001

Year	% of population aged 60% to general population		
	Persons	Males	Females
1901	5.06	4.55	5.59
1911	5.22	4.81	5.65
1921	5.37	5.04	5.70
1931	5.09	4.86	5.35
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	6.42	6.35	6.50
1991	6.55	6.45	6.66
2001	7.70	7.55	7.86

Source: same as in Table 2

Table 5 Sex ratio (females per 1,000 males) of elderly population and general population, India, 1961-2001)

Year	All Ages (General Population)	Age 60+	Age Group		
			60-64	65-69	70+
1961	941	1,000	969	962	1,064
1971	930	938	921	922	970
1981	933	956	931	978	970
1991	929	904	904	953	1,024
2001	947	987	969	965	1,022

Source: same as in Table 2

4. PROFILE OF THE AGEING POPULATION

Demographic changes influence health, economic activity and social condition of people. As the age structure of developing countries changes, demands on resources by different segments of population are expected to grow. From the available information, two assumptions could be made. First of all, the prolongation of life span does not necessarily mean that 'life has been added'

to these extended years. Secondly, the state is not likely to have adequate resources to meet the demands on its services created by a larger number of elderly people. India, as one of the largest and most stable democracies in the Asian region, has its share of developmental problems. There are many priorities that may push the interest of the older people into the background.

4.1 Health and Morbidity

The leading cause of death in old age in India is cardiovascular disease (CVD). Earlier in life, infections are still the leading causes of death but among older people most deaths are due to non communicable diseases (Guha Roy, 1994). The Indian Council of Medical Research (ICMR) has attempted to compile data on morbidity from different sources. The total number of blind persons among the older population was around 11 million in 1996, eighty per cent of them due to cataract (Angra et al. 1997). The consequences of blindness are not limited only to physical disability that ensues, but also impinge on economic, social and psychological domains of the affected individual's life. The calculated economic costs for maintenance of the blind is Rs. 432,000 million, and loss productivity is Rs. 86,400 million over a decade. Nearly 60 per cent of older people are said to have hearing impairment in both urban and rural areas. The hearing loss and resultant communication problems adversely affect the well-being of older people (Kacker, 1997).

In 1996 the number of hypertensives among the elderly population was nearly nine million. The prevalence rate of coronary heart disease among the urban population was nearly three times higher than rural population and the estimated number of cases was around nine million in 1996 (Shah & Prabhakar, 1997). An estimated five million were diabetic and the prevalence rates were about 177 for urban and 35 per 1000 for rural elderly people. Crude prevalence rate of strokes is estimated to be about 200 per 100,000 persons. Older persons surviving through peak years of stroke (55-65 years) with varying degrees of disability are already a major medical problem (Dalal, 1997). Population based cancer registries were initiated by ICMR in 1982. The number of older persons with cancer in 1996 was 0.35 million. The reports show that in coming years, as the number of aged increases, the problems associated with cancer in older age will require increased attention and resources.

Age related changes in immune system render people susceptible to a variety of infections and tumours. Though tuberculosis related mortality has declined, it is still not eradicated effectively and the prevalence rate is reported to be higher in the older age group (Dey & Chaudhury, 1997). Adverse reactions and major side effects to anti-tuberculosis therapy have been reported in as much as 40 per cent of the cases. Disabilities arising from ageing assume greater significance as a large segment of this population is below the poverty line. Under-nutrition is also common in this population (Srivastava et al. 1996). Elderly people in low socio-economic groups, in urban slums or among those living alone are at higher risk of poor dietary intake (Wadhawa et al. 1997). The nutrients least adequately supplied in the diet of the aged

Indian are calcium, iron, vitamin A, riboflavin and niacin. Health is a key contribution factor to quality of life and is therefore closely associated to low socio-economic conditions (Bali, 1997).

4.2 Mental Health

Information about mental health of the older people is available from hospital and community based studies. The prevalence rate of mental morbidity among those 60 years and above was estimated at 89 per 1,000 population, about 4 million for the country as a whole. The risk of specific psychiatric illnesses increases with age. The overall prevalence rate rises from 71.5 per cent for those over 60 to 124 for those in 702, to 155 for those over 80 years (Venkoba Rao & Madhavan, 1983). The risk of senile dementia increases with age. As the country moves from being 'young-old' to 'old-old', senile dementia of Alzheimer's type (SDAT) may become a major problem of the next century (Venkoba Rao, 1997). Affective disorders in later age in India, particularly depression, late paraphrenia and dementias form the bulk of total mental morbidity. Neurotic disorders are relatively infrequent (Venkoba Rao, 1997). Psychiatric illness is seldom an isolated event among elderly people. A minimum of two or three other clinical diagnoses is the rule. The number of symptoms vary between 6 and 12. These are often associated with physical illness, disability or handicap.

Mental health of older persons is influenced not just by ageing changes in the body and brain, but by socio-economic and psychological factors.

Older people are at high risk of self destructive behaviour. The suicide rates rise sharply from the young-old to old-old. The rate of suicide in the 50+ group is around 12/100,000, a figure higher than 7/100,000 for general population. Under reporting to the extent of a third of suicides is also noticed. Physical diseases of painful and incurable nature are prominent among the 'causes' of such suicides. Among the other causes, economic factors take the prime place. It is interesting that there are certain inbuilt cultural 'suicide counters'. These are ethical, religious and familial deterrents that may hold back the person from attempting suicide (Venkoba Rao, 1985).

Problems related to health and economic conditions lead to suicides in older people. In India, certain socio-cultural and religious beliefs act as deterrents to suicidal behaviour.

4.3 Economic conditions and social security for older people

The shift in age structure makes issues of social security and economic support for elderly people very crucial. The overriding concern of governments relate to the ability of individual citizens to be economically independent in later years. In industrialized countries, public and/or private

pension systems cover the economic needs of people. In most developing countries economic support still comes from families.

Social security schemes are available in India mainly for those retiring from the organized sector. Ninety per cent of the total work force, however, is employed in the informal sector. National old age pension schemes provide assistance to destitute persons above 65 years.

India, with its predominantly agrarian based economy, has inadequate social security provisions for its older people. The concept of social security implies that the state should make itself responsible for ensuring a minimum standard of material welfare to all its citizens. Although since independence India has been making efforts to achieve the desirable goal of being a welfare state, social security still covers only a small proportion of the population. For government employees, pension scheme and contributory provident fund schemes are the major security provisions. There are several Acts which make provision for labourers in the organized sector. But nearly 90 per cent of the total workforce is employed in the unorganized sector. Among these, only 40 per cent are wage earners. Low wages, job insecurity and lack of legal and governmental provisions to protect their rights, make this group vulnerable to economic hardships.

Life insurance scheme is a public sector undertaking and is a popular security measure. The primary purpose of insurance is to provide protection to the family in case of death of the breadwinner. It also combines elements of saving for old age with family protection. There are several schemes for the self-employed, in addition, the General Insurance Corporation formed by the Government in 1972 has schemes for personal accident insurance, medical insurance, cancer insurance and tax rebate for senior citizens. For the poor, destitute and infirm persons above 65 years of age, the Government provides pensions at the rates ranging from Rs. 50 to Rs. 150 per month under the National Old Age Pension scheme (i.e., at the time of writing this, the equivalent of US\$1-3).

It is obvious that older people have to depend mostly on their own earnings/savings or on their family. Work participation rates among the elderly was about 40 per cent in 1991 and varies from region to region. People employed in agriculture sector continue to work as long as they physically manage the job. Around 60 per cent of male and 65 per cent of female elderly work as agricultural labourers. In urban areas, retired men may take up part time jobs, if available, to supplement their incomes. A vast majority of women are housewives, and as such, 'invisible workers', depend on their families. Women's work is hardly quantified and monetized.

Table 6 Percentage of elderly dependants in India

Degree of dependence	Male		Female	
	Rural	Urban	Rural	Urban
Not dependent	51.06	45.71	8.78	4.84
Partially dependent	16.20	16.90	13.71	9.13
Fully Dependent	32.74	37.39	77.51	86.04

Compiled from 42nd NSSO, 1986/87

Table 6 compiled from the National Sample Survey, shows the extent of dependency of people on others during old age. Rural old and females are more likely to depend totally on family for support.

Nearly 60-75% of all elderly are economically dependent on others, usually their children. Even those with pensions find their economic status lowered after retirement.

An accurate estimate of economic status of older persons is made difficult as agricultural workers do not have any fixed or regular income. Wide disparity exists across and within regions. Different types of public and private pension and saving schemes exist for employees in the organized sector. Nevertheless, there are some indications that aged Indians are less well off economically than the rest of the adult population. Recently the National Sample Survey Organization underscored the fact that nearly one half of the aged persons are fully dependent economically on others. Out of these, three fourths are supported by their own children. Studies put dependency rate at 1:2 and 25.8 per cent of the population as being below the poverty line (Subrahmanya, 1994). Rural aged who are already poor and not supported by any social security schemes are forced into destitution.

Another related aspect to be considered is medical expense. There has been a progressive decline in the allocation of resources for the health sector. Public investment in health care provision has not kept pace with population growth and the demand for basic health care. There is also considerable discrepancy in provision between urban and rural areas in availability and access to health care resources. Rural poor, and those living in tribal areas have little access to modern, high cost, urban based medical care. It is well documented that as people live longer, medical expenses will consume a major share of their savings. When people are already poor, living longer may ultimately mean living with unattended medical problems as health services cannot be readily purchased.

4.4 Families and living arrangements

Living arrangements of older people are influenced by several factors such as gender, health status, presence of disability, socio-economic status and societal traditions. Generations of older Indians have found shelter in the

extended family system during crises, be these social, economical or psychological. However, the traditional family is fast disappearing, even in rural areas. With urbanization, families are becoming nuclear, smaller and are not always capable of caring for older relatives. Yet, in India, older people are still cared for by their families. Living in old age homes is neither popular nor feasible. Allowing parents to live in old age homes draws criticism from the family network and society at large.

There is strong cultural pressure to 'look after' the parents in the family. Old age home neither a popular or feasible option. It is desirable to strengthen this 'familism'.

Currently, in urban areas, women have started working outside the home. Women were the traditional carers for old people. Women's labour force participation has reduced the number of workers available to care for their elderly relatives.

Where people live in their later years will make a significant difference to the quality of their living. Availability of carers in case of illness, disability, emergencies, depend on living arrangements. Living with a married daughter's family is a less preferred alternative. The 1986/87 National Sample Survey (NSS) reported that 8 per cent of urban and 5.9 per cent of rural elderly lived alone. Living alone is usually due to widowhood, childlessness or migration of children. Table 7 gives the figures regarding living arrangements of the older people in India based on the NSS report.

Table 7 Living arrangements of the elderly (%)

	Rural		Urban	
	Male	Female	Male	Female
Institutions	0.65	0.74	0.54	0.20
Alone	11.78	0.69	8.98	0.60
With family	87.19	98.42	90.08	98.77
Non-relatives	0.33	0.16	0.40	0.43

Reported number of Old Age Homes in India was only 354 in 1997. Many of such Homes are run on charity and the inmates are poor and destitute.

In recent years, in large cities relatively well-to-do people are considering living in special condominiums built for older people. In metropolitan cities, senior housing projects with medical and recreational facilities are being promoted by construction companies. Integrated housing schemes where older people can live in their own apartments in a building complex that also houses orphanage, hospital, bank and other services, are also being introduced. The South Indian states of Kerala and Tamil Nadu have together 57% of all old age homes. These states have witnessed emigration of young people in large numbers to Middle Eastern and Gulf countries. People are now more affluent but have no one to care for them.

4.5 Social status of older Indians

Social scientists report that there is a general lowering of social status of elderly people in India. Increasingly, older people may be perceived as burdens due to their disability or dependence. Rapid changes in the family system, even in rural areas, are reducing the availability of kin support. With modernization of the country, older values are being replaced by 'individualism'. The family's capacity to provide quality care to older people is decreasing. The Government had been complacent that the joint family system and traditional values would provide the social security cover in old age. This view is being drastically revised. In non-agrarian societies older persons who are 'economically unproductive' do not have the same authority and prestige that they used to enjoy in extended families where they had greater control over family resources.

The unconditional respect, power and authority that older people used to enjoy in rural extended traditional family is being gradually eroded in India in recent years.

Efforts are being made to revive cultural values and reinforce the traditional practice of interdependence among generations. Families need help in caring for the older persons. Such help may be in economical terms or practical support in care giving. It is neither desirable nor affordable to open a large number of old age homes in a country like India. Thus, reinforcing the existing 'familism' may be the only feasible option.

4.6 Gender and Ageing in India

Gender is a very important variable that influences quality of life at all ages. India is one of the few countries in the world where men outnumber women at all ages till about 70 years. As seen in Table 8, only in the very old age group, 80 and over (Dandekar, 1996) are there more women in the population than men. Most women perceive themselves as 'old' by the time they are 50 years old. This perception of self as old is based on the presence of grandchildren, widowhood, shrinkage of social roles and post menopausal status (Prakash, 1997).

Table 8: Percentage of male and female population at ages 60, 65, 70+

Year	Male			Female		
	60+	65+	70+	60+	65+	70+
1950	5.2	2.9	1.7	6.1	3.8	2.0
1960	5.5	3.3	1.7	5.8	3.5	1.9
1970	5.9	3.6	1.9	6.0	3.7	2.0
1980	6.4	4.0	2.2	6.6	4.1	2.3
1990	7.1	4.5	2.5	7.6	4.8	2.8
2000	8.0	3.5	3.0	8.9	5.9	3.4

Source: United Nations, 1988

Older women are a growing presence in the developing countries. Indian older women face triple jeopardy: that of being old, of being women, and of being poor.

In most of the developed world, women live longer than men by four to eight years. That is not so in India; in 1991, for instance, life expectancy at birth for females was 59.8 compared to 60.1 for males. The reasons for this have to be sought in India's patriarchal social system and the generally low status of women.

One of the main social effects of extension of life in later years is the extended period of widowhood for women. Table 9 shows that the percentage of widows is disproportionately higher than that of widowers due to cultural practice of men marrying younger women and widow remarriage being uncommon. The rate of divorce is negligible in this age group.

Table 9 Marital status of elderly by sex and age (%) in 1981

Age	Currently married		Widowed		Other *	
	Male	Female	Male	Female	Male	Female
60-64	83.44	43.17	14.13	55.98	0.39	0.48
65-69	80.58	40.79	17.06	58.41	0.38	0.41
70+	70.45	21.72	27.12	77.57	0.39	0.30

Source: Compiled by Ministry of Health and Family Welfare, Government of India, 1988

* divorced or separated

In India, marital status of a woman rarely changes after being widowed. According to NSS 42nd round, there were 654 widows and 238 widowers per 1,000 old persons in rural areas. The respective figures were 687 and 200 for urban areas. More than 65 per cent of Indian women live without a spouse as compared to 29 per cent of older men. According to the last census (1991), there were 33 million widows in India.

Widowhood often lowers the socio-economic level of women. Most older women are either illiterate or poorly educated. Only 8 per cent of older women were literate in 1981 and they were unlikely to have had remunerative jobs during adulthood. Their work as home-makers and carers is never monetized. Urban widows sometimes get the pension and life insurance money of their deceased spouse. Rural women rarely have this advantage. Nor are they likely to hold property exclusively in their names. These factors increase the dependency of women on others in old age. All this contributes to women's total dependency on the family for mere survival.

Older women's health is less than satisfactory. The proportion of women physically immobile due to various health problems is higher than for men of the same age. Low social status, discriminatory practices, early marriage, food taboos, multiple pregnancies and poor attention to health are responsible for the poor health of older women. There is an accumulation of disadvantages that make them vulnerable. Older women have more problems with activities of daily living (ADL), but get less help from others.

They are the traditional care givers and are expected to provide care to parents, parents-in-law, and spouse. Women report lower life satisfaction and higher psychological distress (Prakash, 1997). Depression is the most common symptom reported in women.

Older women are likely to be illiterate, poor, widowed, have more health problems and report more psychological distress.

Religious and cultural beliefs that shape women's lives have also helped them to cope with such disadvantages. Only now is attention being paid to older women's issues and at intervention strategies to empower them.

4.7 Urban and Rural differences

India is a country of villages, and nearly three quarters of its population is rural. Urban and rural areas provide striking contrasts in terms of living conditions, availability of resources and facilities. There are regional variations in the condition of villages but in general, most villages have poor sanitary conditions and less access to education and health facilities. Most rural folk work on their own land or as agricultural labourers. There is no income security nor any systematic provision for old age. Children are perceived as old age security. In most surveys, the urban old are found to have better health and better economic security than those in rural areas.

Urban areas in India have benefited disproportionately from improvements in housing, sanitation, education and health care.

Urban males are in the most advantageous position compared to urban females, rural males and rural females. Urban men are better educated, likely to work in the organized sector, to retire with a pension and to be insured. They are also more likely to use health facilities more often and have better health status (Prakash, 1997). Senior citizen clubs are becoming popular in cities. In metropolitan areas, older people organize themselves to fight for better facilities and to pressurize the Government for tax benefits and user-friendly public services.

4.8 Migrants and Refugees

Migration is a most important and worldwide phenomenon with multiple implications. It is estimated that there are 18 million refugees today in the world, and twice that number of individuals displaced within their own country. In India, major cities have grown in size due to the influx of refugee migrants since independence. Industries and developmental projects draw rural migrants to the cities. In India between 40 and 68 per cent of migrants come from rural areas. A large proportion of them is likely to be male, young and unmarried. Two major consequences of uncontrolled migration are unemployment and poverty which are reflected in the sprawling slums that spring up in the periphery of cities. During the British rule there was forced

tribal emigration in different parts of India. Most rural migrants came from lower socio-economic strata and continue to live in poverty in cities.

In colonial India, labourers were recruited to work in plantations and mines in Fiji, South Africa and other countries. There has also been voluntary migration. In urban areas, educated people move to different areas of the country for higher education or better employment opportunities. A large number of Sikhs from rural Punjab migrated to England after the second World War. Large numbers of business people from Gujarat and Punjab are settled in western countries, mostly England (Rao, 1986). In recent years, South Indian states have seen large scale migration of young people to middle-eastern and Gulf countries. There are two important issues to be considered here. One, relates to what happens to migrant people as they grow old in a different culture. Second, what happens to old people who are left behind when young and able bodied people migrate?

The problem of refugees is also quite severe. Refugees from Pakistan, Bangladesh, Sri Lanka and Tibet have been relocated in different parts of India. Illegal migration is a demographic reality, and with the creation of Bangladesh, eight border districts of West Bengal have registered population growth of over 30 per cent in one decade. Between 1971-81, more than 5.5 lakh¹ illegal immigrants entered West Bengal while the number estimated for the state of Assam was around six lakhs (Ghosh, 1998). There are no reported studies of the condition of older refugees.

4.9 Slum dwellers

Slums have become part of the urban landscape in India. The population of slums is usually a mixture of persons from different religions, language groups and occupations. In a study of a well established slum, (Ara, 1996) found 33 per cent of people above 58 years. Most migrants had come from rural areas to escape famine in their native villages. Most of them were illiterate and very poor. In the older group, there were more females than male, and nearly half of them were widowed. Economic necessity forced them to work even in old age. While 41 per cent of the old people were covered by pension schemes, these were not sufficient to meet their needs. Half of the older people had health problems. Impaired vision and hearing problems were common. Most migrants had come with their families in search of a livelihood and tended to live together. This slum was found to be a closely knit group with all the members belonging to the same socio-economic class with very similar needs and problems. Though economically and in terms of health they had disadvantages, they did not report feelings of loneliness or isolation.

4.10 HIV and AIDS

HIV/AIDS has traditionally been viewed as a disease of the younger generation. Health professionals, educators, researchers and service planners have tended to neglect the considerable impact of the AIDS

¹ Editor's note: 1 lakh = 100,000

epidemic on older persons, as people with or at risk of HIV infection, as carers of their adult children who have AIDS and, when those children die, as carers of the orphaned grandchildren. In September 1998, the Tata Institute of Social Sciences, Mumbai, held a conference on HIV/AIDS and elderly people in collaboration with HelpAge India. Figures available indicate that older persons constitute a small but significant proportion of HIV/AIDS cases as a whole. In India the percentage of HIV cases in the group aged over 50 is around 11 per cent.

5. PROMOTING THE WELLBEING OF OLDER PEOPLE

Much progress has been made in the quality and quantity of health care services in India in the last fifty years. However, improvements have been uneven with urban areas getting the best advantage of modern technological advances in medicare. Much of the emphasis of health care delivery system was on mother and child programmes with special emphasis on controlling population. Older people were largely excluded.

While elderly people in India may have reasonable access to family care, they are inadequately covered by economic and health security. The Government, which is already grappling with a number of pressing problems, does not have enough resources. For more than a decade, several individuals and organizations working with older people have been pressing the Government to introduce a National Policy for their welfare. Several draft proposals have already been submitted to the Government.

5.1 Existing Programmes

The Constitution of India encourages the State to shield older people from undeserved want in their old age. An Old Age Pension (OAP) scheme has been introduced to meet the needs of people who have no means to support themselves. But many states accord OAP low priority and the amount given is as low as Rs 50 per month (roughly US\$1). The Ministry of Welfare makes financial assistance available to voluntary agencies to run day care centres. Often called 'activity centre', 'hobby club' or 'golden age centres', these centres are managed by voluntary agencies. In 1993, there were 73 such centres in seven states supported by the Ministry of Welfare (Khan, 1995). There is a need for these centres to expand both quantitatively and qualitatively in order for their impact to be felt. Even in urban areas many older people do not have any idea of the relevance of such centres.

The Constitution of India contains some provisions for the welfare of older people. In 1992 the schemes of giving rebate on the income tax paid by senior citizens were introduced. The Law also helps retired citizens in evicting tenants who occupy their houses and refuse to vacate them. Voluntary organizations are given grant-in-aid to start old age homes, day care centres, day centres and mobile medical units. Although concessions in train and air fares for senior citizens are made by some states, the environment is not as "elder friendly" as in European countries. There is as yet no serious effort to

redesign public transport, public buildings, governmental offices to make their use easier for older people.

5.2 Future Responses to Population Ageing

The practical implications of the population ageing for India are far-reaching. The numbers are increasing, the resources are limited and perceived social priorities lie elsewhere. Hence, the response to such demands has to be well orchestrated, multisectoral and based on systematic planning (Kalache & Sen, 1998). The first step is advocacy, to raise policy makers' awareness of the multiple issues related to ageing in the country. Professionals, politicians, voluntary workers, NGOs and the general public need to be targeted by these awareness-building exercises.

Since economic security is of prime importance, the State is being requested to introduce an Old Age Pension scheme for all needy, especially the rural aged, widows and people in urban slums. The existing pensions need to be enhanced, and steps taken to assure its appropriate disbursement. How soon and effectively this can be achieved is still a question, for the problem of caring for a vast elderly population is complex and there are no immediate and easy answers. The Government is still grappling with controlling life-threatening diseases and preventable maternal and child mortality. Even schemes like the National Social Assistance programme launched in 1995 that cost over Rs 4,000 million, and the Government's monthly financial assistance for those who are destitute do not cover the entire section of people requiring such help. Hence, the emphasis is now on enlisting the co-operation of the NGOs as well as the community.

*Providing necessary care and support
to elderly people within the community
setting is recommended instead of
opening more old age homes*

Schemes to keep elderly people economically active have also been mooted. NGOs have been encouraged to provide income generating activities so that people feel economically independent and also experience an increase in self esteem. Though some suggest that the retirement age in the private and the public sectors should be raised, there are counter arguments that in a country with a vast unemployed young population, this may not be a popular measure.

Tax incentives for families providing long-term care to elderly family members are also recommended. Making payments to carers and providing respite care will help strengthen the family's willingness to provide care. Since there will be a large segment of older people requiring care, efforts are being made to train a large number of paraprofessionals, voluntary workers, community workers and family members. Apart from health professionals, a large number of multipurpose carers is needed at the grass-roots level to give comprehensive coverage for older persons in the community. It is increasingly felt that solutions to the problems of the older segment of

population should be sought outside the health care system and the State, in the society and community (Sathyanarayana & Medappa, 1997).

Geriatric medicine has not yet developed strong roots within Indian medical schools – in only two of them are there academic departments for this specialty.

Advocacy, research, involvement of voluntary agencies, training different levels of gerontological workers, catalysing the community, awareness building, organizing older persons themselves and networking with international agencies are all essential to empower older Indians.

Good planning, policy making and action should be based on accurate information. Hence quality research in ageing issues is urgently needed. At present, nation-wide community-based studies that provide baseline data on health, morbidity, psychological status, socio-economic conditions and living arrangements of the total population are not available. In the early part of 1998, HelpAge India took the initiative of conducting a series of seminars in the four regions – north south, east, west – of the country. From each region, existing regional data were compiled and eventually presented at a National Conference held in New Delhi. This was one of the most serious efforts to document and compile existing nation-wide data.

This Conference recommended that a National Institute on Ageing be established in order to:

- i) undertake, promote and supervise cross regional multidisciplinary research on all basic issues related to ageing;
- ii) issue guidelines for training different levels of gerontological workers;
- iii) evaluate such training programmes;
- iv) monitor the work of old age homes and NGOs involved in gerontological work;
- v) initiate and maintain networking among institutions and individuals involved in gerontological work;
- vi) act as a documentation and dissemination centre.

An examination of culturally relevant strategies for improving the wellbeing of elderly people is strongly recommended. Indian culture has inherently several elder friendly values and practices which need to be reinforced. Importing a western model of care for elderly people is likely to be costly in a country that can ill afford such initiatives. Working in close collaboration with international agencies is one way of learning from models that have been used in other countries and adapting those best suited to the socio-cultural milieu of India.

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Appendix A: Sources of information on older people

1. Decadal census reports from the Office of the Registrar General, Government of India, are a major source of information about population characteristics. The Registrar General's Office has initiated a scheme of medical certification of causes of death based on returns from the district headquarters and teaching hospitals. The sample registration scheme (SRS) collects data on type of medical attention at death. But such information on morbidity and mortality may not have the break-down by age needed to study the older segment of the population separately.
2. National Sample Survey Organization (NSSO) conducts periodic nation-wide surveys on morbidity and utilization of medical services. These surveys also cover socio-economic dimensions to some extent. The 42nd round (July 1986-June 1987), for example, covered 50,000 households spread over a sample of 8,312 villages and 4,546 urban blocks.
3. Institutional studies: The Indian Council for Medical Research (ICMR), the National Council for Applied Economic Research (NCAER) and the Indian Council for Social Science Research (ICSSR) have either conducted surveys/studies (of health and socio-economic conditions) or sponsored individuals or institutions conducting such surveys. ICMR has launched several multi-centre collaborative studies and produced reports on health and morbidity. Data are also available from other sources such as HelpAge India, New Delhi; the Centre for Research on Ageing, Tirupati; Kerala Sastra Sahitya Parishad, Kerala; and the Centre for Development Studies, Trivandrum. All these sources have reported surveys based on certain sections of population. Several University Departments at Bangalore, Baroda, Pune, New Delhi and the Tata Institute of Social Sciences, Mumbai, as well as the All India Institute of Medical Sciences, Delhi are engaged in research on ageing. Findings from such studies cannot be automatically generalized to the whole of the country.
4. International population reports, such as those published by the US Department of Commerce, Economics and Statistics Administration, Bureau of the Census. These contain representative data available from the 1990 round of census, and information from national sample surveys. The reports rely heavily on data available in the International Data Base on Ageing (IDBA). There may be some discrepancies in reported figures when these sources are used. For convenience and simplicity, the term *elderly* is used for those of 65 years and over, *young old* for 65 to 74 year groups, *aged* for 75 and over and *oldest old* for those over 80 years. However, in India those above the age of 60 are designated as elderly.

There are other limitations as well which can be well illustrated using the data on health and morbidity. Such information may have been collected through conventional inquiries by non-medical field investigators, there may be inaccurate diagnosis, lack of precise causal information, ethnologic difference not validated or accounted for in the methodology, cultural and social factors

that affect reporting of sickness and seeking of medical help, absence of standardization in coding illness – to name but a few. In addition, firm data are often lacking on the incidence and prevalence of diseases particular to old age. Information on epidemiological determinants and characteristics of disease episodes in terms of repetition, duration, seasonal manifestations and frequency of hospitalization that would help study the relationship between health and different bio-social characteristics of the aged population, is often missing. Country-wide, community based baseline information about different aspects of older people's lives is not available.

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