

The old and the ignored

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With the population of elderly people rising, their health care has become a matter of concern especially since the family support system is crumbling and there is no comprehensive geriatric care system.

THE rising life expectancy at birth is one of the major achievements of the 20th century. But instead of rejoicing over the favourable demographic indicator, the world is caught in an "age-quake". For, the proportion of people aged 60 plus is rising and is expected to accelerate in the next 50 years. This "demographic time bomb" is nearing explosion in developed nations, and Asia, including India, is not far behind.

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Two-thirds of the world's elderly live in developing countries.

The rise in the proportion of the ageing population represents one of the most significant demographic shifts in history. In 1950, there were 205 million people who were over 60; in 2000, there were 606 million; and by 2050, there will be two billion. The number of the elderly trebled over the last 50 years and an encore is expected in the next 50 years. As a proportion of the total world population, the number of the elderly will double in the next 50 years. This demographic change is fast turning the hair of policy-makers prematurely grey throughout the world, especially in developing countries, where the growth of the aged population is happening at a more rapid pace.

Though developed countries have a relatively high proportion of the elderly, the older population is concentrated in the developing world and growing at a much faster rate. Two-thirds of the elderly live in developing countries. Women comprise a greater number and proportion of the elderly in almost all societies. This disparity rises as people grow older - women comprise 55 per cent of the 60-plus population; in the 80-plus set, they are 65 per cent; and in the 100-plus, 77 per cent.

The last century saw rapid industrialisation and urbanisation the world over. In India, these developments brought about major changes in the social structure. The centuries-old joint-family system disintegrated, and with it collapsed the safety net of parents and grandparents. Since the welfare of the elderly has been a low priority with the state, they have nowhere to turn, and are left disillusioned, shattered and lonely.

In India, the elderly population has grown manifold. While only 19 million people were 60-plus in 1947, today the figure has risen to nearly 80 million, an increase of 285 per cent in the last five decades. The figure is expected to double in the next 25 years. Nearly 90 per cent of the elderly have no form of official social security, and over 40 per cent live below the poverty line. Close to 75 per cent are from the rural areas and over 73 per cent are illiterate. Some 55 per cent of the women over 60 years (over 20 million) are widows.

If achieving longevity was the triumph of the 20th century, care of the elderly will be the challenge of the 21st century. While research on ageing is well-developed and documented in developed countries, it hardly happens in countries such as India. According to Dhar Chakraborti (*The Greying of India*, Sage Publications, 2004), this is primarily because of the belief that the family support system is and will continue to be an adequate insurance against all problems related to old age.

No doubt family has so far been the most effective provider of old-age support in India in the absence of institutional support. But with social and economic developments undermining traditional values, and with the number of the elderly growing rapidly vis-a-vis those expected to provide them support, it is becoming a major problem.

Experts argue that the increasing proportion of the elderly will make the latter's own conditions pitiable as they would draw heavily from the limited resources of most families. They would take away large shares of the national income, burdening future generations of taxpayers, and savings and investments would decline. Simultaneously, national productivity will also fall with a rise in the median age of workers.

The problem of the rising proportion of the aged has been compounded, in most populations, by a steady decline in the proportion of children, with a decline in fertility - mortality transition always

precedes fertility transition. From 34 per cent in 1950, the proportion of children below 15 declined to 30 per cent in 2000 and is projected to fall to 21 per cent by 2050. At around this time the proportion of the elderly population will equal the population below 15 years. The dependency ratio (the number of over-65 dependent on every person in the 15-64 age group) would zoom to 23; it had risen from eight in 1950 to 10 in 2000. This would mean that every parent would have fewer children to take care of them during old age. With the cost of parent care rising per child, and in the face of the continuing financial crisis, most children do not have adequate resources to take care of their elderly parents. Where resources are not scarce, psychological barriers against caring for parents have emerged. Pressured by high unemployment levels and job insecurity, youth migrate in search of work. This also puts tremendous strain on the elderly.

THE elderly require special care. Most hospitals in the country do not have a special geriatric facility and if there is one, it is prohibitively expensive. Yet, on an average, 10-15 per cent of hospital beds are occupied by the elderly. According to the principles of health economics, the elderly requiring treatment for longer periods are best kept at home for better resource utilisation. But with increasing female participation in the labour force, caring of the elderly at home has come down sharply. Housing shortages and the consequent reduction in space are increasingly eroding the rights of the elderly to privacy.

The elderly are the major casualties of the break-up of the joint family system. Studies conducted recently among old people show that over 35 per cent of the elderly in urban areas and 32 per cent in rural areas live alone. There is nobody to look after them - and financial constraints and lack of security add to their troubles. Thus dependence - mental and physical - becomes unavoidable. An increasing number of the elderly are now looking for employment, mostly for low wages, and under insecure and unhealthy working conditions. Among the poorest and the most vulnerable are the elderly living in rural areas.

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At an old age home on October 1, 2003, International Elders' Day. In India, there has been a 285 per cent increase in the population of the aged in the past 50 years.

There are significant socio-economic differences between the urban and rural elderly. More than 80 per cent of those over 60 years live in rural areas. The rural elderly are older than the urban elderly, but have little access to tertiary care. In rural areas over 6 per cent of the women are elderly, while in

urban areas it is 5.1 per cent. While over 78 per cent of the elderly men have the support of their spouses, 64 per cent of elderly women are widowed, most of them dependent on someone else for their care. A large workforce among the elderly exists in the rural informal sector - over 70 per cent of the rural elderly men work, as against 48 per cent of the urban elderly men. Health care services also differ significantly in rural and urban areas, with emphasis on primary health care in the rural areas and tertiary care in the urban areas.

Recent Indian Council of Medical Research (ICMR) studies in Chennai, Lucknow, Delhi and Mumbai have revealed that out of the surveyed older population, 52 per cent did not have any income. The studies show that it is the women who suffer most and in greater numbers as they live longer than their spouses. Widows form a large number of the elderly, particularly with Indian women married to men 10-15 years older than they are, and who, therefore, have to endure longer periods of widowhood. Their conditions are worse as they, more often than not, cannot fend for themselves after the death of their husbands. Studies also show that they are abused severely - verbally, psychologically and physically.

According to Dr. Shilu Srinivasan, Editor of *Dignity Dialogue*, average life expectancy in India, which was 42 years in 1947, has increased to 65 years today. But geriatric care continues to be one of the most neglected sectors in hospitals. According to the ICMR, the special problems of the elderly are best dealt with within a geriatric unit with trained geriatricians and nursing staff, putting special emphasis on early rehabilitation, remedial exercise and occupational and psychiatric therapy.

In India, hospitals merely provide outpatient geriatric service. According to Dr. C.A.K. Yesudian, Professor and Head of the Department of Health Services Studies, Tata Institute of Social Sciences, Mumbai, private hospitals do not like venturing into geriatric care as hospital stay of these patients is longer. These patients do not require intensive care, owing to which the infrastructure is poorly utilised.

Geriatric care is also capital intensive, but non-profitable. According to Dr. D.M. Gamadia, medical adviser, Masina Hospital, Mumbai, to have a separate geriatric unit would be ideal, but no one wants to invest in a full-fledged geriatric unit as the returns are poor. (Masina Hospital has a geriatric home, which is open only for the Parsi community.)

Though government hospitals provide geriatric care, it is not a speciality, says Neha Dalal, a social worker with Dignity Foundation. Most doctors in India have not specialised in geriatrics. There is only one hospital in Chennai that gives post-graduate (M.D.) education in geriatric medicine. Yesudian suggests having geriatric departments in teaching hospitals.

Medically, early diagnosis is difficult in elderly people. They mostly ignore the symptoms, considering them as part of the ageing process. This means it is often too late when a disease is diagnosed. In some cases they suffer in silence, in some others the family ignores their complaints. Youngsters are hesitant to spend money and time for the aged. Communication barriers also contribute to the problems. Thus, when the examination of the patient becomes difficult, only a "specially trained" medical practitioner (geriatrician) can diagnose the silent atypical symptoms of the aged patient.

THE medical problems of the elderly are mainly chronic. Coronary heart disease is the leading cause of death in the elderly. Visual impairment and locomotive disabilities are widely reported. In a recent rural survey by the ICMR, only 20 per cent of those interviewed said they had no major medical problems. Many reported five or six symptoms and were presented with two or three diagnoses. The problems reported related to vision (65 per cent), movement (36 per cent), respiration (10 per cent), skin (8.5 per cent), the central nervous system (7.4 per cent), cardiovascular ailments (6.3 per cent), and hearing (5.8 per cent).

According to the ICMR study, geriatric clinics can be set up successfully at the rural primary health centres with the existing infrastructure. The paramedical staff can be trained to recognise major physical illnesses and find appropriate medical, community or social interventions. The study showed that sleeplessness, vague body pain and backache responded well to intervention by health workers, while other symptoms such as a visual handicap, giddiness and pain in the joints showed marginal improvement. Counselling proved very useful in cases where lack of family and social integration led to depression, which was the most common problem. Such patients responded well to intervention. Among those living with their families, many reported lack of integration.

Screening and referrals greatly decrease the load on tertiary care services for the elderly. Some hospitals do have geriatric outpatient services, but very few have in-patient facilities, especially for the aged. This may be because the elderly are mostly in the "young elderly" group (60-75 years), in which case there is little demand for long-term health care.

A recent study on those attending a geriatric clinic in a rural primary health centre found that 58 per cent required referrals for medical care, 5.3 per cent for psychiatric help, and only 2.3 per cent for in-patient admission. In a recent countrywide survey by the National Sample Survey Organisation (NSSO), only 5.4 per cent of those above 60 years reported being immobile.

General hospitals and departments of medicine continue to cater to terminally ill patients. Several forums have discussed the need for more emphasis on geriatric medicine and management in India. The public health system needs more centres and specialists in this field.

The elderly are not easily moved to seek hospital care. According to the ICMR, on an average the time between needing institutionalisation and accepting it is 9.8 years. Health insurance and other support measures for the terminally ill are available only for some 10 per cent of the elderly, who have worked in the organised sector.

In the latest Census, 65 per cent of the country's elderly men and 14 per cent of elderly women are listed as workers. Thus, a large proportion of the elderly remain economically active. Of the non-working elderly, only 23 per cent of the men are retired pensioners; 69.4 per cent of the men and 52 per cent of the women are dependents.

In India, the position and the status of the elderly and the care and protection they traditionally enjoyed have been undermined by several factors - urbanisation, migration, break-up of the joint family system, growing individualism, change in the role of women from being full-time carers to earners, and increased dependency status of the elderly. There is also a generation gap in terms of education, aspirations and values, and the allocation of resources to different members of the family.

Often the family is unable to meet the financial, social, psychological, medical and welfare needs of the elderly, and seeks help from supporting services.

The government, instead of dealing with the problem of the elderly by itself, is implementing schemes to assist voluntary organisations to help senior citizens. These organisations are provided financial assistance - grants up to 90 per cent of the project expenditure - to set up day-care centres, old-age homes and mobile medicare units for the elderly. There are 186 old-age homes, 223 day-care centres and 28 mobile medicare units under these projects. The Centre's direct contribution for the elderly comes in the form of tax rebates and travel concessions.

The responsibility of the state for its senior citizens is enshrined in Article 41 of the Constitution. While the welfare of the aged is a State subject, the nodal responsibility for the aged is vested with the Centre. The public policies of old-age income support takes three forms: retirement benefits for those in the formal sector, voluntary insurance schemes encouraged through tax exemptions, and direct government programmes to help the needy elderly. The eligibility rules are often complicated and the pension amount varies across States - from Rs.55 to Rs.300 a month. The National Old Age Pension scheme offers a mere Rs.75 a month for those over 65. And even these inadequate schemes together cover only 10 per cent of the elderly. An NSS survey (52 Round, 1995-96) shows that 79 per cent of the elderly in the rural areas (who were engaged in wage/salaried jobs or were casual labourers) and 35 per cent in the urban areas did not receive any benefit after retirement.

With such a rapid increase in the proportion of the elderly, this is hardly the way for the government to respond. It should, as Dr. Koshy Eapen, a researcher on geriatric care in the University of London, points out, put in place a comprehensive geriatric care system.

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