

# COUNTRY PROFILE - INDIA

## CONTENTS

<b>S.No.</b>	<b>Title</b>	<b>Page No.</b>
1.	<b>Historical background</b>	<b>1</b>
2.	<b>Socio-economic background</b>	<b>1</b>
3.	<b>Demographic trends</b>	<b>3</b>
3.1.	Mortality	3
3.2.	Fertility	3
3.3.	Population structure	3
4.	<b>Fifty Plus Population</b>	<b>5</b>
4.1.	Distribution, Evolution & projection (by sex and by age groups)	5
4.2.	Source of income of the elderly and their poverty level, their working status	6
4.3.	Housing and living arrangements of the elderly	7
4.4.	Health of the elderly	7
5	<b>Health system : principles, evolution and economics</b>	<b>8</b>
5.1.	Health financing	8
5.2.	Health policy	8
5.3.	Health providers	8
5.4.	Age care services	11
5.5.	NGO initiatives and programmes for care of older persons	12
6.	<b>Health Security, chronic diseases and causes of death</b>	<b>13</b>
6.1.	Life expectancy of the elderly	13
6.2.	Functional capacity	14
6.3.	Morbidity rates of the elderly	15
6.4.	Dependency	15
7.	<b>Social security system and the work status</b>	<b>16</b>
7.1.	Constitutional & legislative Provisions	17
7.2.	Retirement Benefits for Organized Sector	17
7.3.	Income Security for Unorganized Sector	17
7.4.	National Policy for Older Persons	18
8.	<b>Current scenario and future projections</b>	<b>19</b>
9.	<b>Concluding remarks</b>	<b>20</b>
	<b>References</b>	<b>20</b>

## COUNTRY PROFILE - INDIA

India, the local short form being Bharat, is located in Southern Asia, bordering the Arabian Sea and the Bay of Bengal, between Burma and Pakistan. It is a vast country, different parts of the nation 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.

### 1. Historical background

The Indus Valley civilization, one of the oldest in the world, goes back at least 5,000 years. The Indian subcontinent is the site of this civilization, as ancient as any in the world. City states arose in North India, along the Indus River, at about the same time as the early civilizations of the Tigris-Euphrates at Sumer and other locations. Over the centuries, India was invaded by many different peoples, all of whom left their imprint.

After India got independence in 1947, the subcontinent was divided into the larger secular state of India and the smaller state of Pakistan. A third war between the two countries in 1971 resulted in East Pakistan becoming the separate nation of Bangladesh. Fundamental concerns in India include the ongoing dispute with Pakistan over Kashmir, massive overpopulation, environmental degradation, poverty, and ethnic strife, all this despite impressive gains in economic investment and output. Multiplicity remains a major feature of Hinduism, as it is of Indian culture in general, with a multiplicity of ethnic groups-- languages -- a multiplicity of castes within each community-- and the worship of a multiplicity of gods that vary according to locality, caste, and personal preference.

India at a glance - Administrative Divisions : (Including J & K)	
No. of States	25
No. of Union Territories	7
No. of Districts	466
No. of Tahsils / Talukas	3,987
No. of CD Blocks	5,886
No. of Statutory Towns	2,987
No. of Census Towns	1,702
No. of Inhabited Villages	587,226
No. of Uninhabited Villages	47,095

Source : Census of India, 1991

### 2. Socio-economic background

In India, gender and generation tend to dominate the power structure within most families, thus restricting autonomy and physical mobility on women. The following tables would give an overview of the socio-economic situation in the country.

**SELECT SOCIO ECONOMIC INDICATORS OF INDIA**

<b>Economic Indicators</b>	<b>India</b>
Area ('000' Sq.Kms) (2001 Census)	3287
Population ( in Million) (2001 Census)	1029
Rural	742.7
Urban	286.1
Projected	
2006	1094.1
2011	1178.9
2016	1263.5
Density (Population per Sq.Kms)	325
Sex Ratio ( Females per 1000 Males) (2001 Census)	933
Urban Population Percentage (2001 (P))	27.78
Scheduled Caste Population as Percentage of Total Population 2001	16.2
Scheduled Tribe Population as Percentage of Total Population 2001	8.2
Birth Rate 2002	25.0
Death rate 2002	8.1
Infant Mortality Rate 2002	64
Literacy Rate - 2001 Persons	64.8
Male	75.3
Female	53.7
Literacy Rate - 2000 (P) Rural	60
Urban	81

### **3. DEMOGRAPHIC TRENDS**

#### **3.1 *Mortality***

Infant and child mortality rates are highest among illiterate women, minority households, and women who receive no antenatal care or delivery care. They are also higher in the states of Bihar, Orissa, Rajasthan, Uttar Pradesh and Madhya Pradesh. The major causes remain malnutrition, ARI, and diarrhoea due to lack of safe water and sanitation. The primary reasons for this are lack of access and poor awareness among families.

Once the reproductive age group is crossed, the mortality rates among women are lower as women outlive and outnumber men in the age group 65 and above.

Improved control of diseases has resulted in lower death rates. The death rate per thousand population has decreased from 26.6 in 1955 to 9 in 2000. In the past ten years, the infant mortality rate (per thousand births) has decreased from 96 in 1989 to 72 in 2000, comparable to the average of 74 for South Central Asia.

#### **3.2. *Fertility***

The Government of India has set the goal of reaching replacement level fertility (a fertility rate of 2.1, or a two-child family norm) between 2011 to 2016. Achieving this goal will allow the long-term population size to stabilize by the year 2056. Even a small delay will have a significant impact on future population growth. If fertility of 2.1 is reached by 2016, the population size will continue to grow for the following forty years but will stabilize at 1.45 billion by the year 2056 before beginning to decline. With a ten year delay, if replacement level fertility is reached by 2026, the population size will stabilize in the year 2066 at 1.55 billion, 100 million more people. Unwanted fertility (20 percent) and high wanted fertility (19 percent) due to high infant mortality rates and son preference contribute further to population growth.

#### **3.3. *Population structure***

The total population of India as at 0:00 hours on 1st March 2001 stood at 1,027,015,247 persons. With this, India became only the second country in the world after China to cross the one billion mark. The population of the country rose by 21.34 % between 1991 - 2001.

<u>Population</u>	<u>Decadal Growth 1991 - 2001</u>
Persons 1,027,015,247	Persons : (+) 21.34 %
Males 531,277,078	Males : (+) 20.93 %
Females 495,738,169	Females : (+) 21.79 %
Sex Ratio: 933	
<u>Population (0 - 6 years):</u>	<u>Percentage of Population (0-6)</u>
Persons 157,863,145 Males	<u>to Total Population:</u>
81,911,041	Persons : 15.42 %
Females 75,952,104	Males : 15.47 %
	Females : 15.36 %
<u>Sex Ratio:</u>	
927 - (0 - 6 years)	
<u>Number of Literates:</u>	<u>Percentage of Literates to Total</u>
	<u>population:</u>
Persons 566,714,995	Persons : 65.38 %
Males 339,969,048	Males : 75.85 %
Females 226,745,947	Females : 54.16 %

The four large Northern states of Uttar Pradesh, Rajasthan, Madhya Pradesh and Bihar, sharing relatively backward social and economic characteristics, together contribute 40 percent of India's total population. Since Indian Independence in 1947, the population of the country has almost increased three-fold. The reason for increase in the population growth rate was primarily due to a decrease in mortality, a result of improved health infrastructure, and not increase in fertility.

One in six people in the world lives in India. India is second only to China in population and is expected to surpass China's population with 1.5 billion people by 2040. The population density of India is one of the highest in the world at 789 persons per square mile, ten times the density of the United States. The basic underlying determinant of the high population growth in India is the low status of women in the economy and the Indian society. Another concern is the poor health, particularly reproductive health, of women related to their low status.

## 4. FIFTY PLUS POPULATION

### 4.1. *Distribution, Evolution & projection (by sex and by age groups)*

Ageing is an issue of global concern, a significant product of demographic transition. Globally, one out of every co-person was aged 60 in 2000. By 2020, the ratio will be about one in eight. By 2050, number of elders will exceed number of younger persons for the first time in the history. The reasons are improved life expectancy, public health programmes, medical advances, health services, improved living and lifestyle circumstances.

In India, the population of the elderly is growing rapidly and is emerging as a serious area of concern for the government and the policy planners, i.e., there is an increase in the proportion of the aged vis-à-vis a decrease in the proportion of the young. India now has the second largest aged population in the world. The small-family norm means that fewer working, younger individuals are called upon to care for an increasing number of economically unproductive, elderly persons.

The census has been the only source of information on the age structure of the population. The process of enumeration of a large population of diverse culture and religion spread over a large country has always been a tedious process and therefore far from accurate. Despite its limitation, the census from 1901 to 2001 has provided valuable evidence of population ageing. The growth of elderly population in the previous century is shown in table.

*Growth of population aged 60 years or more in India*

Year	Total population (In millions)	Males	Females
1901	12.06	5.50	6.56
1911	13.17	6.19	6.98
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	43.17	22.02	21.15
1991	56.68	29.36	27.32
2001	75.93	38.22	37.71

The distribution of elderly in broad age groups shows that in 1991 census 62.8% of older people were between 60 and 69 years, 25.9% between 70 and 79 years, 9.1% between 80 and 89 years, 1.92% between 90 and 99 years, and 0.27% were centenarians which in absolute number was 151,646. The data presented below depicts the drift in the increased growth of the Indian elderly.

*Aging scenario in the country*

<b>Year</b>	<b>Total population (million)</b>	<b>Population of 60+ (million)</b>	<b>Percent aged 60+</b>
1950	357.56	20.10	5.60
1975	620.70	38.48	6.20
2000	1008.94	76.84	7.60
2025	1351.80	168.50	12.50
2050	1572.05	324.31	20.60

The above table indicates a rapid increase in the proportion of the aged, the consequences of which manifest themselves in various forms. The collapse of joint family system, emotional alienation, migration of youth to cities and spiralling costs of health care are a few of the aggravating problems of the aged in India. The unconditional respect, power and authority that older people used to enjoy in rural extended traditional families is gradually eroding in India in recent years. Indian older women face triple jeopardy : that of being old, of being women, and of being poor. Globally the older the population, the greater the proportion of women. Women live longer than men with more disabilities, as a result of demanding workloads, repeated child births, inadequate nutrition and access to healthcare. Care-giving functions are largely assigned to older women. Women's greater longevity does not translate into healthier lives. They are more prone to chronic disabilities - Osteoporosis, diabetes, hypertension, arthritis and alzheimer's disease than men.

#### **4.2. Source of income of the elderly, their poverty level and their working status**

Inadequate financial resources is one of the major problems of the Indian elderly. If you consider work participation among the elderly as an index of poverty (if you work when you are old, you only do so because you need to), then in India approximately 60 per cent continue to work beyond 60 years whereas in some developed nations only 2 per cent over 65 are part of the labour force. In India, even in the above-80 group, about 20 per cent are forced to work.

It is not that the elders who do not participate in the workforce do not contribute to the economy - only it is not taken into account. They contribute by bringing up grandchildren, doing voluntary service, caring for the sick, and often counsel and resolve conflict by virtue of their position. In many cases they are also repositories of knowledge, experience, culture and religious heritage.

#### **Percentage of elderly dependants in India**

<b>Degree of dependence</b>	<b>Male</b>		<b>Female</b>	
	<b>Rural</b>	<b>Urban</b>	<b>Rural</b>	<b>Urban</b>
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 42<sup>nd</sup> NSSO, 1986/87

Demographic data suggests that majority of the working elderly population are found in the rural areas. However, their work participation rates are gradually declining from 1961 to 1991 (census

1991). Further, having an agrarian economy, among the main workers in the 60 plus age group, 78 percent of males and 84 percent of females are in agriculture sector, and 2 percent of males and 3 percent of females are engaged in the household industry. The Census 1991 reveals that around 60 percent of the elderly widowed work in rural areas and with growing difficulties to maintain their livelihoods, elderly in India continue to work even after 60 years of age.

Further analysis indicates that elderly men are predominant in cultivator's category (76.5 percent) whereas elderly women are predominant in agriculture labour category (51.1 percent). Further elderly women's participation in household duties is much higher (37.9 percent) than that of the elderly men (3.03 percent) and this is more so in rural India.

#### **4.3. *Housing and living arrangements of the elderly***

Under the social security, housing is given highest priority in Scandinavian countries, but in India this is the most neglected issue under the government welfare schemes. Some of the agencies like Railway Employees Welfare Association, LIC, HUDCO have floated housing schemes for the retirees, which is confined to a few who can invest their savings in such schemes.

Suitable housing is more important to the elderly, since their abodes are often the Centre of all their activities, however, both in rural and urban areas, many elderly residents live in low quality housing and majority of them cannot afford even to upgrade or maintain their homes.

Sufficient housing units are lacking both in rural and urban areas. This stands out in urban areas with surplus population from villages making a switch from their villages in search of employment. It is estimated that at the turn of the century, India will be short of 41 million houses. In this case, the targets for urban housing will prove to be more difficult to achieve due to a shortage of land and the consequent development of interest groups.

According to the 1991 Census, a majority of the elderly of the country, i.e. 78 percent, live in rural areas. Proportionately, more elderly males than females reside in the rural areas, in contrast to adult males. The latter phenomenon is due to migration of young adults to the urban areas and the return migration of the older males back to their native areas in the rural settings (Dandekar, 1996). Further, the proportion of the elderly men who live in rural areas tends to increase with age. The opposite is the case with respect to the elderly females who are more concentrated in the urban areas.

#### **4.4. *Health of the elderly***

In the next twenty years, over 3/4<sup>th</sup> of the deaths in the developing world will be due to noncommunicable diseases, surpassing communicable diseases and injuries (WHO). This remarkable transformation in the profile of ill health requires the provision of costly services for the disabling noncommunicable diseases while continuing investment in the prevention of communicable diseases.

The elderly depend on community health services for most of their health problems. Even among the reasonably healthy older persons, there is a constant need for regular health care supervision,

monitoring of blood pressure, early detection and treatment of chronic illnesses, monitoring of the effectiveness and side effects of routine medication, assessment of nutritional status and instruction in healthy lifestyles.

In the case of NCDs burden, the major factors that contribute to the high prevalence of cardiovascular diseases as well as neuro-psychiatric disorders include the increase in life expectancy, changes in lifestyles, stressful living and working conditions and general lack of support systems that enable better coping mechanisms.

## **5. HEALTH SYSTEM : PRINCIPLES, EVOLUTION AND ECONOMICS**

India's position in the healthcare sector (manpower and infrastructure) can be summarized as follows: At the time of independence when the situation was very dismal, people had little or no access to health care services. Since then with improvements in the health manpower and infrastructure facilities, the people of India have access to health services – even if it is more of a curative nature. Awareness of the availability of services has also increased and with it the utilization of the same to some extent. However even after 50 years of independence the lacunae evidenced in the facilities, have resulted in the provision of less than optimal services both in quantitative and qualitative terms, in certain parts of the country.

### **5.1. Health financing**

The health investment profile of India across the Five-Year Plan periods clearly suggests that investment levels have hovered around 5–6% of the total GDP. Though planners and policy makers have recognized for a long time the importance of providing optimal health as a means to optimal productivity, such awareness has not found expression in increased health financing or adequate budget allocations in the health sector. Further, curative care continues to receive higher budgetary allocations over the years followed by family welfare and disease programmes compared to preventive health care giving rise to wide inter and intrasectoral disparities in health financing and budget allocation policies and practices. This low figure is self explanatory in that the private sector shoulders the lion share of health expenditure in the country. Moreover with the cost of health and medical care escalating by leaps and bounds, a vast majority of people in need of health care will be unable to utilize it due to poverty, high cost of health and medical care and poor access to the services and/ or care provided by the government sector.

### **5.2. Health policy**

Although a National Health Policy was formulated only in 1983 in India, several committees, provided useful and timely guidelines for planning and implementation of health services in the country starting with the Bhore Committee and its famous report in 1946 to the Shrivastava Committee in 1974–1975. These policies provided the basic framework for health and medical services infrastructure development as well as medical and paramedical manpower planning and management.

### **5.3. Health providers**

In India, Primary Health Centres (PHCs) are the cornerstone of rural healthcare; a first port of call for the sick and an effective referral system; in addition to being the main focus of social and economic development of the community. It forms the first level of contact and a link between individuals and the national health system; bringing healthcare delivery as close as possible to where people live and work.

Covering almost all the parts of the country, it has more than 20,000 PHCs and 140,000 Sub-centres spread in more than 400 districts. This system consumes large amount of resources and is the system which provides the services for primary care including preventive programmes. The system is mainly managed by doctors, some of whom have brief public health training. a *three-tier health infrastructure* that consists of primary health care centres, first referral hospitals, and tertiary health care facilities. According to the present norm, a population of 5000 is covered by a sub-centre, 30,000 by a PHC and 100,000 by a community health facility with first referral capacity.

### **Government Health Infrastructure in India**

<b>Level of health facility</b>	<b>Number of institutions</b>
Medical college hospitals	150
District hospitals	400
Community Health Centres (CHC)	3,000
Primary Health Centres (PHC)	20,000
Sub-centres (SC)	130,000

Note: The numbers shown in the table above are approximate figures and are presented to give a rough understanding of the scale of health infrastructure in India.

It offers a wide range of services such as health education, promotion of nutrition, basic sanitation, the provision of mother and child family welfare services, immunisation, disease control and appropriate treatment for illness and injury. The PHCs are hubs for 5-6 sub-centres that cover 3-4 villages and are operated by an Auxiliary Nurse Midwife (ANM). These facilities are a part of the three tier healthcare system; the PHCs act as referral centers for the Community Health Centres (CHCs), 30-bed hospitals and higher order public hospitals at the taluk and district levels.

Primary healthcare services substantially affects the general health of a population, however many factors undermine the quality and efficiency of primary healthcare services in developing countries. In India, although there are many reasons for poor PHC performance, almost all of them stem from weak stewardship of the sector, which produces a poor incentive framework.

The current PHC structure is rigid, making it unable to respond effectively to local realities and needs. For instance, the number of village health nurses per PHC is the same throughout the country despite the fact that some states have twice the fertility level of others.. Government health departments are focused on implementing government norms, paying salaries, ensuring the minimum facilities are available rather than measuring health system performance or health outcomes. Further, the public health system is managed and overseen by District Health Officers. Although they are qualified doctors, they have inadequate training in public health management

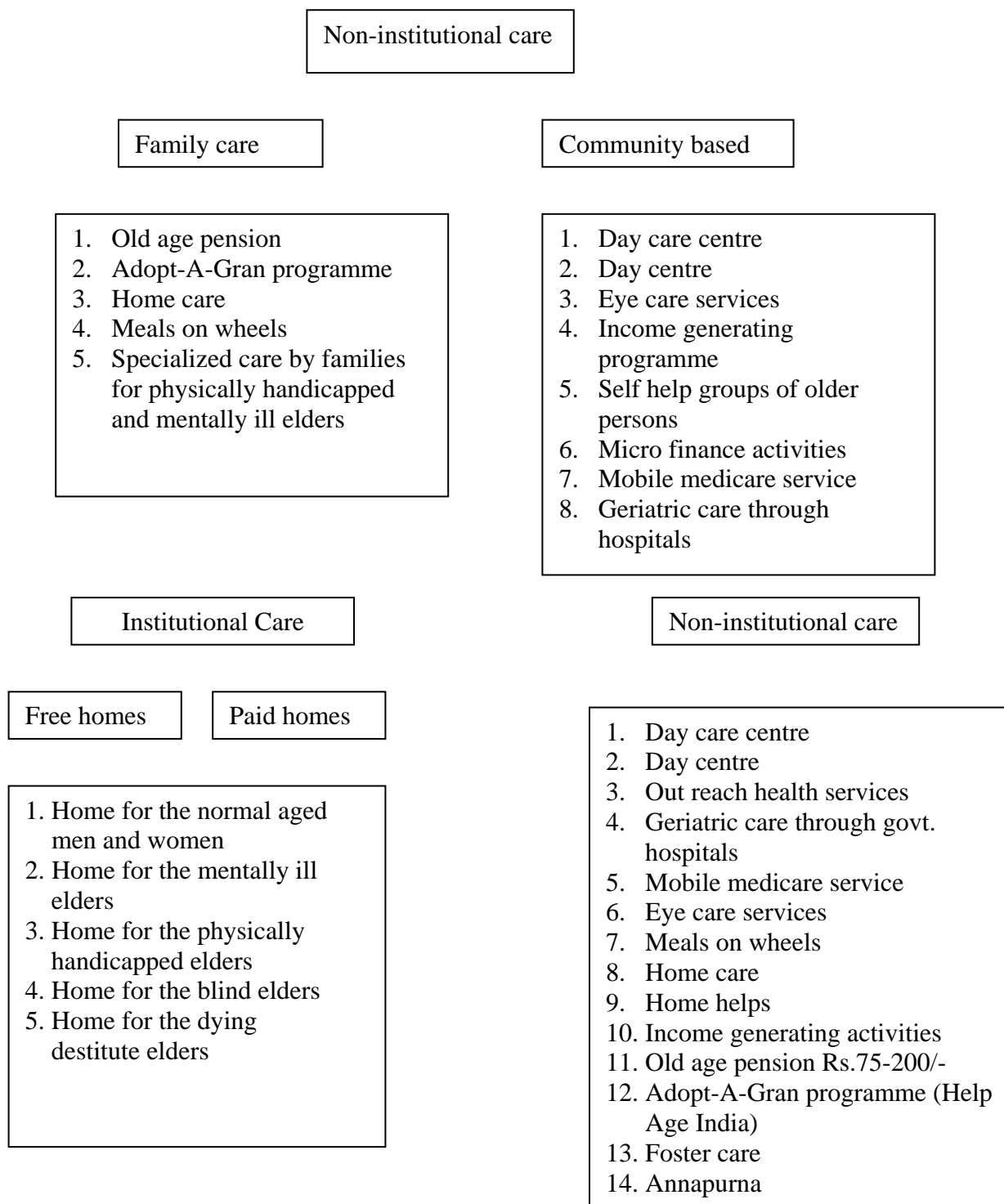
and strengthening the capacity for public health management at the district and taluk level is crucial to improving public sector performance.

The lack of accountability stems from the fact that there is no formal feedback mechanism and incentive to treat citizens as clients. The lack of accountability leads to absentee doctors, as it is difficult to attract qualified doctors to rural areas, unresponsive village health nurses, inconvenient opening times and little or no community participation.

The lack of resources, which is acute in some states, is certainly a contributing factor to the poor performance of the primary health care system. In poor states, spending levels are low while expectations for coverage remain high. The incongruence between resources and targets result in lack of medicines; the current budget for essential drugs is insufficient to cater to large number of patients. At the same time, patients usually do not visit PHCs in the early stages of their diseases, while healthcare providers are forced to focus only on seriously ill patients due to the volume of cases.

As per the norms prescribed by the Government of India, one Primary Health centre is to be set up for every 30,000 population in the plains and for every 20,000 population in the hill areas.

#### 5.4. Age care services



### 5.5. *NGO initiatives and programmes for care of older persons*

The non-governmental/voluntary organisations substantially contribute towards the welfare of the Indian elderly.

- ◆ HelpAge India, a leading NGO working for the cause and care of the elderly operates 56 Mobile Medicare Units across the country, reaching out to as many elderly destitutes as possible and addressing community healthcare issues at a local level. This programme serves as a lifeline providing up to 1.5 million treatments every year making it the only Medicare programme of such magnitude in Asia. The Mobile Medicare Unit in a van, visits identified sites with a doctor and a pharmacist. They provide primary medical care to those who cannot approach regular doctors due to age & poverty. The Social worker associated with the MMU facilitates involvement of the local community rendering social sanction to the project, thus ensuring greater success.
- ◆ The Elders helpline initiated by Help Age India is functioning in the Central control room of City Police Commissioner's office at Chennai. The Chennai City Police deal with the cases of elders' abuses, crime against elders, theft in elders' houses, etc.

The Adopt A Gran programme by Help Age India provides for adoption of elderly women and provide direct financial support.

- ◆ Agewell Foundation has set up a helpline for older persons in Delhi. The volunteers are constantly available to attend to matters of medical or emotional nature, as well as legal and financial advice.
- ◆ Dignity Foundation is India's premier organisation committed to enriching the lives of senior citizens, and enabling them to live independently. Dignity helpline is exclusively dedicated for the help and rescue of older persons. Distress calls from elders seeking assistance are handled by a qualified social worker. The Dignity Enrichment Centre provides a new facility for day long care, recreation and community togetherness for Senior Citizens of South Mumbai. Dignity Second Careers was started as a separate division of the Foundation with the objective of enabling people over 50 years of age to seek a productive occupation of their choice that would enrich their lives before and after retirement. The Dignity Companionship service is extends a social support system to the senior citizens. The caller most often calls with reports of boredom, loneliness, depression, etc. for reasons such as the client is living alone, children are away at work, not in the same city etc.
- ◆ The Center for Old in Need (COIN) is a non-profit, non-racial, non-political and non-religious organization dedicated to ameliorate the immense sufferings of old people who need care.
- ◆ Age Care India is yet another Premier Organisation for the welfare of the aged in the country which helps them lead a healthy, happy and dignified post retirement life in reasonable comfort and peace.

## 6. HEALTH SECURITY, CHRONIC DISEASES AND CAUSES OF DEATH

45% of older Indians have chronic diseases and disabilities. The number increases to 95% among those who seek health screening. Information on acute health problems and service requirements is not available.

The common diseases among the ambulatory elderly are cataract, osteoarthritis, hypertension, chronic obstructive pulmonary disease, ischaemic heart disease, diabetes, benign prostatic hypertrophy, dyspepsia, irritable bowel syndrome and depression, which account for 85% of the burden of ill health. Among the very old patients, stroke, dementia, osteoporosis, heart failure and frailty and physical dependence are the usual problems. The commonest causes of death in the Indian elderly are bronchitis and pneumonia, ischaemic heart disease, stroke, cancer and tuberculosis.

A common myth in the society about the health of the elderly is that they are frail, chronically ill and quite often disabled and hence, much priority is not given to the health care of the elderly. We have special policies to protect women's health, children and so on but not for elderly people. Surveys conducted by NSSO and NAS concluded that 45 percent of the elderly in urban and rural areas are suffering from chronic diseases and about 5.4 percent are found to be physically immobile. Studies on health say that majority of the deaths among the elderly are due to heart problems, cancer and stroke Alzheimer's disease is probably the fourth leading cause of death. Apart from these death causing diseases, about 45 percent of the elderly are suffering from Arthritis and Parkinson's disease (Shah 1996, Habibulla 1996, Vinod Kumar 1995). Depression is another important and common problem of majority of the elderly.

### 6.1. *Life expectancy of the elderly*

The age pyramid of India is typical of a population just entering demographic transition from high to low fertility, with a large number of children and relatively small numbers of the elderly. Expectation of life at birth for India has increased from 48.9 for males and 49.3 for females in 1971, to 61.6 for males and 62.2 for females, respectively in 1996. For those above the age of 60, it has increased from 13.80 for males and 14.75 for females in 1971, to 15.01 for males and 16.23 for females in 1991 (Irudaya Rajan; Misra and Sankara Sarma, 1999). As for gender, the Census indicated that the 60 + category favored the males, but in the 70+ age group, the ratio of females was higher than males, which is explained by the higher life expectancy at age 60+ for females in comparison to males.

Over a period of 25 years, the expectancy of life at 60 and 70 years has also shown a significant increase from 13.8 and 8.9 years respectively to 16.2 and 10.6 years. This trend is likely to persist in the coming years, and in next 50 years the expectancy of life at birth may well surpass 80 years in most countries of the world, including India.

The projections of expectations of life in the years 2011 and 2021 for older Indians at 60 and 70 are shown in table. The implications of these projections are that there will be a large elderly population with substantial length of life in old age.

### *Expectation of life for older Indians at 60 and 70*

Year	Male 60+	Male 70+	Female 60+	Female 70+
1991	15.01	9.27	16.23	9.97
2001	15.74	9.70	17.05	10.45
2011	16.29	10.03	17.75	10.87
2021	16.75	10.32	18.18	11.14

***Projected number of older persons, their percentage in population, sex ratio and old age dependency in India : 2001-2051 [populations in millions and %]***

	2001	2011	2021	2031	2041	2051
Age						
60+	70.78 (7.1)	96.30 (8.2)	133.2 (9.9)	178.59 (11.9)	236.01 (14.5)	300.96 (17.3)
70+	27.02 (2.7)	35.90 (3.1)	50.55 (3.8)	73.13 (4.8)	97.90 (6.0)	133.31 (7.6)
80+	5.37 (0.5)	7.88 (0.7)	10.75 (0.8)	15.69 (1.0)	23.17 (1.4)	31.98 (1.8)
Dependency	11.9	13.4	16.0	19.0	23.2	28.2
Sex ratio x 1000						
Age 60+	1036	1034	1004	964	1008	1007
Age 80+	998	884	866	843	774	732

**6.2. Functional capacity**

***Percentage distribution of physically immobile aged persons by age and sex***

Age group	Rural			Urban		
	Total	Males	Females	Total	Males	Females
60-64	2.7	2.4	3.2	2.6	2.2	3.3
65-69	3.9	3.3	4.4	4.3	4.1	4.7
70 & above	10.4	8.3	13.4	9.6	8.1	11.6
60 & above	5.4	4.5	6.8	5.5	4.6	6.6

*Percentage distribution of physically immobile aged persons and having chronic illnesses by age and sex*

Age group	Rural			Urban		
	Total	Males	Females	Total	Males	Females
60-64	38.7	38.3	39.4	38.0	36.8	39.7
65-69	44.7	44.8	44.5	43.4	43.9	42.8
70 & above	54.4	54.9	52.6	53.8	54.0	53.6
60 & above	45.0	45.1	44.8	44.8	44.3	45.5

**6.3. Morbidity rates of the elderly**

*Percentage prevalence of specific morbidities in persons aged 60 and above*

Morbidity	Rural			Urban		
	Total	Males	Females	Total	Males	Females
Visual	17.2	13.4	22.3	14.5	9.8	19.2
Hearing	59.6	NE	NE	61.3	NE	NE
Mental	2.0	2.0	2.0	NE	NE	NE
Diabetes	5.3	5.6	4.7	16.4	16.6	15.3
Cancer	NE	NE	NE	0.5	0.6	0.5
Hypertension	11.0	8.4	14.7	20.8	20.2	21.4
Coronary HD*	11.7	10.3	14.3	23.3	22.8	24.1

\*prevalence rate for only 60-64 age group instead of 60 and above.

*Distribution of chronic disabling conditions by age group*

Age in years	45-64 yrs	65-74 yrs	>75 yrs
Arthritis	253	229	383
Hypertension	27	239	360
Hearing loss	118	231	353
Cataracts	16	107	234
Vision loss	45	69	101
Heart disease	118	231	353

Cases per thousand people

National Health Interview Survey, 1989. Vital and health statistics, 1990

**6.4. Dependency**

In old age, inadequate income and poverty lead to dependency on bread earning / care takers group (15 to 59 years of age). Demographic data suggests that old age dependency is gradually increasing from 10.5 percent in 1961 to 11.8 percent in 1991. Dandekar (1996) observed that on

the whole, 51 percent of men in rural and 46 percent in urban areas were economically independent. Of these, 71 percent both in rural and urban areas were totally dependent on others". In turn this trend creates economic, social, health and psychological pressure on care givers.

## **7. SOCIAL SECURITY SYSTEM AND THE WORK STATUS**

With regard to the work status of the elderly, in 1991, in rural areas, 65.36 percent of the elderly males and 18.96 percent of the elderly females were working, whereas in the urban areas, 42.93 percent of the elderly males and 6.30 percent of the elderly females were working (Irudaya Rajan et al. 1999). Two points should be noted about these statistics. Firstly, work force participation of elderly males is quite high in India, unlike in countries like Japan; secondly, compared to men, a very small percentage of women seem to be working. The economic compulsion to work combined with the small size of the organized sector implies that most of the elderly work in the unorganized sector. This in turn means a lack of social security or post retirement benefits, making the economic vulnerability of the elderly even greater.

India has been among the enlightened nations which recognised the need for social security during old age quite early. The Provident Fund Act was introduced way back in 1925 for select public enterprises. We have the Employees Provident Fund and Miscellaneous Provisions Act (EPFMP) of 1952 which covers 177 industries today. From 1995, workers covered under the EPFMP Act, 1952 are also covered by the Employees Pension Scheme. While these have been laudable steps, and are serving the working class well, their coverage is woefully small, with only 11 percent of the working population in India covered by them. There is also the Public Provident Fund (PPF) scheme for self employed and those not covered by the EPFMP Act. Though good in intention, the PPF has not been well publicised, and as a consequence, its clientele is basically confined to large cities. It is not easily accessible either.

Approximately 49% (23.18 million) of the salaried (non-Government) workers in the formal sector are covered by Provident Funds. These mandatory, employer centric, defined contribution plans (including EPFO, Coal Miners Fund, Seamen Fund, et al) cover only 177 industries and classes of establishments notified by the Government. In addition, within these specified industries, only establishments employing 20 or more persons need to provide provident fund benefits to employees. Further, employees drawing a monthly salary of 5000 or more have the option to opt out from contributions to PF.

Over 28% (13 million) of the salaried employees and approximately 89.2% (280 million) of the workers (including self-employed and farmers) are not covered by any pension scheme that enables them to save for economic security during old age. Though the Public Provident Fund (PPF) was introduced in 1968-69 to provide a facility to self employed persons to save for old age, it today serves only as a medium term savings instrument with liberal withdrawal facilities and tax benefits. Thus, the present formal provisions for old age income security in India cover less than 11% of the estimated working population. However, even for these individuals, incomes generally fall below poverty line during old age despite the high levels of contribution (over 20% - among the highest in the world) prevailing in India.

### **7.1. Constitutional & legislative Provisions**

In Constitution of India, entry 24 in list III of Schedule VII deals with the Welfare of Labour including conditions of work, provident funds, liability for workmen's compensation, invalidity and old age pension and maternity benefits. Item No.9 of the State List and Item 20, 23 and 24 of Concurrent List relates to old age pension, social security and social insurance and economic and social planning. Further, Article 41 of Directive Principles of State Policy has particular relevance to Old Age Social Security. According to this article, "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.

The Hindu Adoptions and Maintenance Act, 1956 : section 20 (3) gives a statutory recognition to the well established normal obligation of a Hindu child (male or female) to maintain his aged or infirm parents, as long as they are not able to maintain themselves. Rights of the aged or infirm parent under the old Hindu law is preserved to this extent only. (Section 125 [1] [d] of Code of Criminal Procedure 1973). Maintenance is a term of wide connotation, and is explained as provisions for food, clothing, residence, medical attendance and treatment. If the parents have no sources of income of their own, or even property, the children cannot escape liability to maintain them on the ground that they are able to maintain themselves by their own means! Although it is the moral obligation of every child to maintain his/her parent, the law imposes liability only when the parents are incapable

### **7.2. Retirement Benefits for Organized Sector**

The available retirement benefits to organized sector government employees are – (1) Pension Scheme, (2) Service Gratuity, (3) Dearness relief on pension, (4) Death-cum-retirement Gratuity, (5) Encashment of leave, (6) Central Government Health Service Scheme, (7) Contributory Provident Fund, and (8) Group Insurance and General Provident Fund.

Similarly benefits available to organized sector laborers are – (9) The Works Men Compensation Act 1923, (10) The Maternity Benefit Act, 1961, (11) Coal Mines Provident Fund and Bonus Scheme Act 1948), (12) The Employees State Insurance Act 1948, (12) Employees provident Fund and Miscellaneous Provision Act 1952, (14) The Assam Tea Plantation Provident Fund Act 1955, (15) The Employees Family Pension Scheme, 1971, (16) The Payment of Gratuity Act, 1972, and (17) The Employees Deposit Linked Insurance Scheme 1976.

### **7.3. Income Security for Unorganized Sector**

The unorganized sector labourers are mainly covered under (1) Life Insurance Corporation of India, and (2) Group Superannuation Scheme. Both these are autonomous bodies and Life Insurance Corporation in particular is having mainly five types of Insurance Policies to the people who wish to have regular pension after their retirement. They are Jeevan Dhara, Jeevan Akshay, Jeevan Suraksha, Bhima Nivesh and New Jeevan Dhara. Besides, Unit Trust of India is providing contributory schemes such as Senior Citizens Unit Plan, Medical Insurance Scheme, Group Medical Insurance Scheme and Janarogya.

#### **7.4. National Policy for Older Persons**

The National Policy for Older Persons (NPOP) was announced in January, 1999, with the primary objective viz. to encourage individuals to make provision for their own as well as their spouse's old age; to encourage families to take care of their older family members; to enable and support voluntary and non-governmental organizations to supplement the care provided by the family; to provide care and protection to the vulnerable elderly people, to provide health care facility to the elderly; to promote research and training facilities to train geriatric care givers and organizers of services for the elderly; and to create awareness regarding elderly persons to develop themselves into fully independent citizens. The policy is appended in Annexure I.

#### ***Steps already taken for implementation of NPOP***

The Government has constituted a National Council for Older Persons (NCOP) under the Chairmanship of Hon'ble Minister for Social Justice and Empowerment to advise and aid the Government on policies and programmes for older persons and also to provide feedback to the Government on the implementation of the National Policy on Older Persons as well as on specific programme initiatives for older persons. There are 63 members in this Council, who have emphasized the following areas of concern :

- ◆ Uniform age of 60+ for extending facilities/ benefits to senior citizens;
- ◆ Financial security to the elderly population by: (1) Proposing tax benefits and higher interest rates for senior citizens (2) Promotion of long term savings in both rural and urban areas (3) Increased coverage and revision of old age pension schemes for the destitute elderly and (4) Prompt settlement of pension, provident fund, gratuity and other retirement benefits;
- ◆ Health care and nutritional needs of the elderly populations by: (1) Strengthening of primary health care system to enable it to meet the health care needs of older persons; (2) Training and orientation to medical and para medical personnel in health care of the elderly. (3) Promotion of the concept of healthy ageing. (4) Assistance to societies for production and distribution of material on geriatric care. (5) Provision of separate queues and reservation of beds for elderly patients.
- ◆ Food security and shelter by : (1) Coverage under the Antyodaya Scheme to be increased with emphasis on provisions for the benefit of older persons especially the destitute and marginalized sections. (2) Earmarking ten percent of houses/house sites for allotment to older persons. (3) Barrier-free environment for the disabled and elderly persons. etc.
  - ◆ Meeting the education, training and information needs of older persons.
  - ◆ Identification of the most vulnerable among the older persons and working for their welfare.
  - ◆ Realizing the crucial role by the media in highlighting the situation of older persons and emphasising their continued role in Society
  - ◆ Protection of life and property of the elderly population.

The Ministry has also set up an Inter-Ministerial Committee (IMC) headed by Secretary (SJ & E) for ensuring speedy implementation of the decisions taken in the meetings of the National

Council for Older Persons and also to review the progress of plan of action. An Integrated Programme for Older Persons is being continued into the 10<sup>th</sup> Plan period. Under this scheme financial assistance up to 90% of the project cost is provided to NGOs for establishing and maintaining old age homes, day care centres, mobile medicare units and to provide non-institutional services to older persons. Financial assistance has been given to 323 Old Age Homes, 281 Day Care Centres and 42 Mobile Medicare Units in different parts of the country during the year 2003-04. Another Scheme of Assistance to Panchayati Raj Institutions/Voluntary Organisations/Self Help Groups for Construction of old age homes/multi service centres for older persons provides for one time construction grant for old age homes/multi service centers. The registered societies, public trust, Charitable Companies or registered Self-help Groups of Older Persons in addition to Panchayati Raj Institutions are eligible to get the assistance under this scheme.

## **8. CURRENT SCENARIO AND FUTURE PROJECTIONS**

- ◆ 80% reside in rural areas
- ◆ 40% of them below poverty line and another 35% just marginally over it
- ◆ 58% of women 60+ are widows/unmarried/divorced
- ◆ 70.3% of elderly are illiterate (2000)
- ◆ labour force participation of 65+ in 2000 - 32%
- ◆ dependency ratio - 12.59% in 2001
- ◆ 90% from the unorganised sector
- ◆ the projected figure for the year 2025 is 177 millions. (males 84.96 millions and females 92.04 millions)
- ◆ the number of older persons over the age of 80 years in 2000 was 6,320,000 and is expected to rise to 33,936,000 in the year 2025.
- ◆ Nearly 2,00,000 centenarians in India (Indira Jai Prakash, 2004).

## **9. CONCLUDING REMARKS**

The task of looking after the welfare of these citizens, who are in need of physical, financial and emotional care, is a daunting one for a country where the majority of the population is barely able to live above the poverty line. One aspect of this welfare consists in providing affordable and adequate health care for the elderly, by taking into account the multiple pathologies of old age. A second issue is the socio-economic vulnerability of the elderly. Disease profiles are generally linked to the socio-economic status of the individual.

Corporate health services are beyond the reach of poor rural elderly and the general hospital at district level may have the problem of accessibility. This has to be examined from different corners. In caregivers point of view, taking a sick elder person to government hospital at distance place is difficult because of lack of proper transportation and keeping the sick elderly as inpatient for longer period is also difficult because the young wage earners have to lose their daily wages. Personal care is the major problem for sick elderly in rural areas. Further owing to illiteracy, ignorance, and lack of sufficient financial means, majorities are not even aware of their ailments at the stage where prevention is possible. In some cases, the ailments are not diagnosed at the right time because of ignorance. On all these accounts, to some extent, the benefits of

medical sciences have gone unutilized – a fact that exists in rural India and the worst sufferers are none other than the elderly in general and elderly women in particular.

## **REFERENCES**

1. Aabha Chaudhary (Editor). (2001). Active ageing in the new millennium – An Indian Scenario. India, Anugraha.
2. Census of India, Government of India, 1991 & 2001
3. Indira Jai Prakash. (2004). Aging, search for new paradigms. India, Bangalore University.
4. Irudaya Rajan, U.S., Mishra, P., & Sankara Sarma (1999). India's elderly, burden or challenge?, New Delhi, India, Sage Publications.
5. Rosenblatt & V.S. Natarajan (Eds). (2002). Primer on geriatric care, a clinical approach to the older patient.
6. National Sample Survey Organization, India, 1991.