# Caring for Our Elders: Early Responses

## India Ageing Report - 2017

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## India Ageing Report – 2017

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# Caring for Our Elders: Early Responses

## India Ageing Report - 2017

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# FOREWORD

The United Nations Population Fund (UNFPA) has prepared this Report entitled, "Caring for Our Elders : Early Responses" in an endeavour to highlight the concerns of ageing of the society in India and the response of the Government as well as Non-Governmental Organizations to this demographic phenomenon of population – ageing. The rapid advancements in science and technology including, the medical science and increased access to better nutrition and health care services have helped in achieving longer life expectancy. This coupled with reduced birth rate, have led to an increase in the proportion of senior citizens in the population of our country.

To address the issues relating to welfare of senior citizens, the Central Government had announced a National Policy for Older Persons (NPOP), 1999 which has been under successful implementation. The Central Govt. had also enacted a landmark legislation namely, "The Maintenance & Welfare of Parents & Senior Citizens (MWPSC) Act, 2007". The Ministry of Social Justice & Empowerment has prepared a new policy for senior citizens which is under finalization to replace the NPOP, 1999. A Plan scheme namely, "Integrated Programme for Older Persons (IPOP)" is being implemented since 1992 with the objective of improving the quality of life of senior citizens by providing basic amenities like shelter, food, medical care and by encouraging productive and active ageing. Establishment of a "Senior Citizens Welfare Fund" in 2016 is a new initiative of the Central Government. The Central Government has proposed for another new Central Sector Scheme, 'Rashtriya Vayoshri Yojana' to provide Physical aids and Assisted Living Devices for such senior citizens suffering from age related disabilities/ infirmities, who belong to BPL category. The programmes such as "National Programme for Health Care of the Elderly (NPHCE)" being implemented by the Ministry of Health & Family Welfare, Indira Gandhi National Old Age Pension Scheme (IGNOAPS) being implemented by the Ministry of Rural Development also indicate the commitment of the Government towards senior citizens.

The initiative of the UNFPA in preparing the present Report is highly laudable. I hope that the Report would be useful for all the stakeholders in the field of welfare of senior citizens.

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**(Dr. Thaawarchand Gehlot)**

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## प्राक्कथन

संयुक्त राष्ट्र जनसंख्या निधि (यूएनएफपीए) ने भारतीय समाज में वृद्धजनों की समस्याओं और वृद्धजनों के इस जनसांख्यिकी परिवेश के संबंध में सरकार तथा गैर-सरकारी संगठनों की प्रतिक्रिया पर प्रकाश डालने का प्रयास करते हुए "हमारे वृद्धजनों की देखभाल : शीघ्र प्रतिक्रिया" (केयरिंग फॉर ऑवर एल्डर्स : अर्ली रिस्पान्स) नामक शीर्षक यह रिपोर्ट तैयार की है। विज्ञान और प्रौद्योगिकी के क्षेत्र में तेजी से किया गया विकास, जिसमें चिकित्सा विज्ञान और बेहतर पोषण तथा स्वास्थ्य देखभाल संबंधी सेवाओं को प्रदत्त कराया जाना शामिल है, के परिणामस्वरूप मानव की लम्बी आयु होने में मदद मिली है। इसके साथ-साथ, जन्म दर में भी गिरावट आई है जिसकी वजह से हमारे देश की आबादी में वरिष्ठ नागरिकों के अनुपात में वृद्धि हुई है।

वरिष्ठ नागरिकों के कल्याण से संबंधित मुद्दों को हल करने के लिए, केन्द्र सरकार ने राष्ट्रीय वृद्धजन नीति (एनपीओपी), 1999 की घोषणा की थी जिसे सफलतापूर्वक कार्यान्वित किया जा रहा है। केन्द्र सरकार ने एक ऐतिहासिक विधान नामतः "माता-पिता और वरिष्ठ नागरिकों का भरण-पोषण और कल्याण (एमडब्ल्यूपीएससी) अधिनियम, 2007 भी अधिनियमित किया है। सामाजिक न्याय और अधिकारिता मंत्रालय ने वरिष्ठ नागरिकों के लिए एक नई नीति तैयार की है जिसे एनपीओपी 1999 को परिवर्तित करने के लिए अंतिम रूप दिया जा रहा है। एक प्लान स्कीम नामतः "एकीकृत वृद्धजन कार्यक्रम (आईपीओपी)", जिसे वर्ष 1992 से कार्यान्वित किया जा रहा है, का उद्देश्य आश्रय, भोजन, चिकित्सा देखभाल जैसी बुनियादी सुविधाएं प्रदान करके और उपयोगी तथा सक्रिय
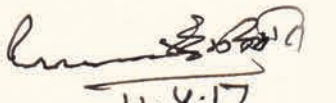
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जीवन को प्रोत्साहित करके वरिष्ठ नागरिकों के जीवन की गुणवत्ता में सुधार लाना है। वर्ष 2016 में स्थापित "वरिष्ठ नागरिक कल्याण निधि" केन्द्र सरकार की एक नई पहल है। केन्द्र सरकार ने गरीबी रेखा से नीचे रहने वाले ऐसे वरिष्ठ नागरिकों, जो वृद्धावस्था के कारण विकलांग/कमजोर हो जाते हैं, को शारीरिक सहायक यंत्र और सहायक उपकरण प्रदान करने के लिए एक नई केन्द्रीय क्षेत्र की योजना, 'राष्ट्रीय वयोश्री योजना' का प्रस्ताव किया है। स्वास्थ्य और परिवार कल्याण मंत्रालय द्वारा कार्यान्वित "राष्ट्रीय वृद्धजन स्वास्थ्य देखभाल कार्यक्रम (एनपीएचसीई)" और ग्रामीण विकास मंत्रालय द्वारा कार्यान्वित इंदिरा गांधी राष्ट्रीय वृद्धावस्था पेंशन योजना (आईजीएनओएपीएस) जैसे कार्यक्रम भी सरकार की वरिष्ठ नागरिकों के प्रतिबद्धता दर्शाते हैं।

वर्तमान रिपोर्ट को तैयार करने की दिशा में यूएनएफपीए द्वारा की पहल काफी प्रशंसनीय है। मुझे आशा है कि यह रिपोर्ट वरिष्ठ नागरिकों के कल्याण के क्षेत्र में कार्यरत सभी हितधारकों के लिए उपयोगी सिद्ध होगी।

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(डॉ. थावरचंद गेहलोत)

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May 31, 2017

## MESSAGE

Investments in social sector especially in health and nutrition have resulted in reduction in mortality rates in the country. The demographic profile of India is now witnessing changes. The ageing population which was just 7.5% in 2001 has increased to 8.6% by 2011. It is predicted that the population of senior citizens in India could be around 19% of total population by the year 2050. This will only mean that caring for the elderly and all aspects of geriatric services would come under greater focus and attention in the coming years.

2.     Both civil society and Government of India and State Governments need to respond to changing demographic profiles. Families will have to provide for both financial and psychological resources to take care of the elderly in the country. Loneliness is one of the major features of nuclear society and it is important that families prepare adequately to cushion their elderly family members against fears of loneliness, deprivation, etc. Governments would need to invest more in schemes and activities for the welfare of senior citizens.

3.     Department of Social Justice & Empowerment, which is mandated with the responsibility of welfare and care of senior citizens would coordinate and integrate the activities amongst other Ministries. The Department is working on a new senior citizens policy framework document which would address all relevant issues. It is hoped that this new policy framework would focus on short term and long term aspects of welfare of senior citizens in an integrated and comprehensive manner.

4.    The United Nations Population Fund's (UNFPA) document on "Caring for Our Elders:  Early Responses" is an attempt in this regard.  I compliment UNFPA for this report and hope that the Department of Social Justice & Empowerment would be able to adopt certain recommendations of this report in Government policies and programmes.

(G. Latha Krishna Rao)

# PREFACE

Ageing does not just affect the elderly (defined as 60 years or more); it affects everyone in society in one way or the other. Globally, the elderly population constitutes about 12 percent of the total population of 7.3 billion. The number of elderly will double by 2050, reaching 2 billion and accounting for 22 per cent of the global population, outnumbering those under the age of 15 for the first time in history.

In India too, the size and percentage of elderly population have been increasing in recent years and this trend is likely to continue in the coming decades. The elderly population has increased from 77 million in 2001 to 104 million in 2011. By 2050, the elderly population is likely to increase by three times to reach around 300 million, accounting for 20 percent of the total population of the country. The relatively young India of today will turn into a rapidly greying society in the coming decades.

Population ageing is an inevitable and irreversible demographic reality associated with improvements in health and medical care, as well as with decline in fertility. While increasing longevity is a matter to celebrate, various studies have found multiple morbidities and disabilities linked to the advancement of age.
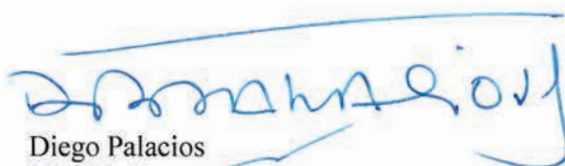
Everyone has a part to play for the wellbeing of the elderly, including the government, civil society, communities, families and we all must ensure that they are valued, respected and become active members of the society.

The Government of India is clearly aware of the demographic transition, and its commitment to plan for the future is evident from the National Policy on Older Persons (NPOP) and implementation of Integrated Programme for the Older Persons (IPOP). Recently NITI Ayog has suggested several initiatives for senior citizens including legislative, policy and institutional reforms, strengthening implementation of existing policies, and linking Aadhaar and Direct Benefit Transfer-based implementation and monitoring of social security programmes including old age pension in its 'Three Year Action Agenda 2017-18 to 2019-20.'

The United Nations Population Fund (UNFPA) has been focusing on the emerging area of population ageing and working to build knowledge base urgently needed to support policies and programmes. This report titled **Caring for Our Elders: Early Responses, India Ageing Report – 2017** takes stock of the ageing scenario, looks at responses from the Government and non-governmental organizations, and documents select good practices in elderly care which could be replicated on scale.

I wish to thank the Ministry of Social Justice and Empowerment for their continued support. I also congratulate the authors and other contributors for their efforts in bringing out this report.

I am confident that this report will be useful for the Government and other stakeholders, including non-governmental organizations, to evolve appropriate policies and programme for ensuring good quality of life for our elders.

Diego Palacios
UNFPA Representative - India

# Acknowledgements

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# Table and Figures

# 1

# The Ageing Scenario

# The Ageing Scenario

## 1.1 Population Ageing in the World, 2012–2050

Population ageing is an inevitable and irreversible demographic reality that is associated with welcome improvements in health and medcal care. With longevity and declining fertility rates, the population of older persons (60 years and above) is globally growing faster than the general population. When populations age rapidly, governments are often caught unprepared to face and mitigate the consequences; this has implications for the socio-economic and health status of the elderly.

Three key demographic changes—declining fertility, reduction in mortality and increasing survival at older ages—contribute to population ageing, reflected in a shift in the age structure from young to old. The demographic transition process of declining fertility and mortality gives rise to increasing bulge in older cohorts, compared to younger cohorts. The old-age dependency in the population therefore gradually increases. The shift from a period of high mortality, short lives, and large families to one with a longer life, far and fewer children is the hallmark of demographic transition. A top-heavy age structure means that the elderly have to depend upon incomes and revenues generated by a dwindling number of younger workers.

In general, ageing is defined in terms of chronological age with a cut off age of 60 or 65 years. This definition is partly due to the fact that retirement age is also similar to this cut off age.

**When populations age rapidly, governments are often unprepared to mitigate the consequences; this has implications for the socio-economic and health status of the elderly.**

However, in many developing countries, chronological age may have very little relevance to retirement as majority of the elderly are engaged in informal sector with no specific retirement age. In such cases, the socially constructed meanings of age are more often significant, such as the roles assigned to older people or loss of certain roles that signify physical decline in old age.[1]

Globally, the 60-plus population constitutes about 11.5 percent of the total population of 7 billion. By 2050, this proportion is projected to increase to about 22 percent when the elderly will out number children (below 15 years of age). The elderly constitute the fastest growing age segment while the children and working age segments reduce gradually (Figure 1.1). In some regions and countries, the proportion of the elderly is however growing faster than the global average. In developed countries, the proportion of the elderly will increase from 22.4 percent in 2012 to 31.9 percent in 2050. This proportion is estimated to more than double in less developed countries with an increase from 9.9 percent in 2012 to 20.2 percent in 2050. In least developed countries, the proportion of the elderly in 2050 is projected to be below 11 percent.[2]

Thus, in some developing countries, the old-age dependency rate could more than double in 50 years, a phenomenon that was stretched over 150–200 years in much of the developed world. The rapid

## Figure 1.1: World Population by Age Category, 1950–2100
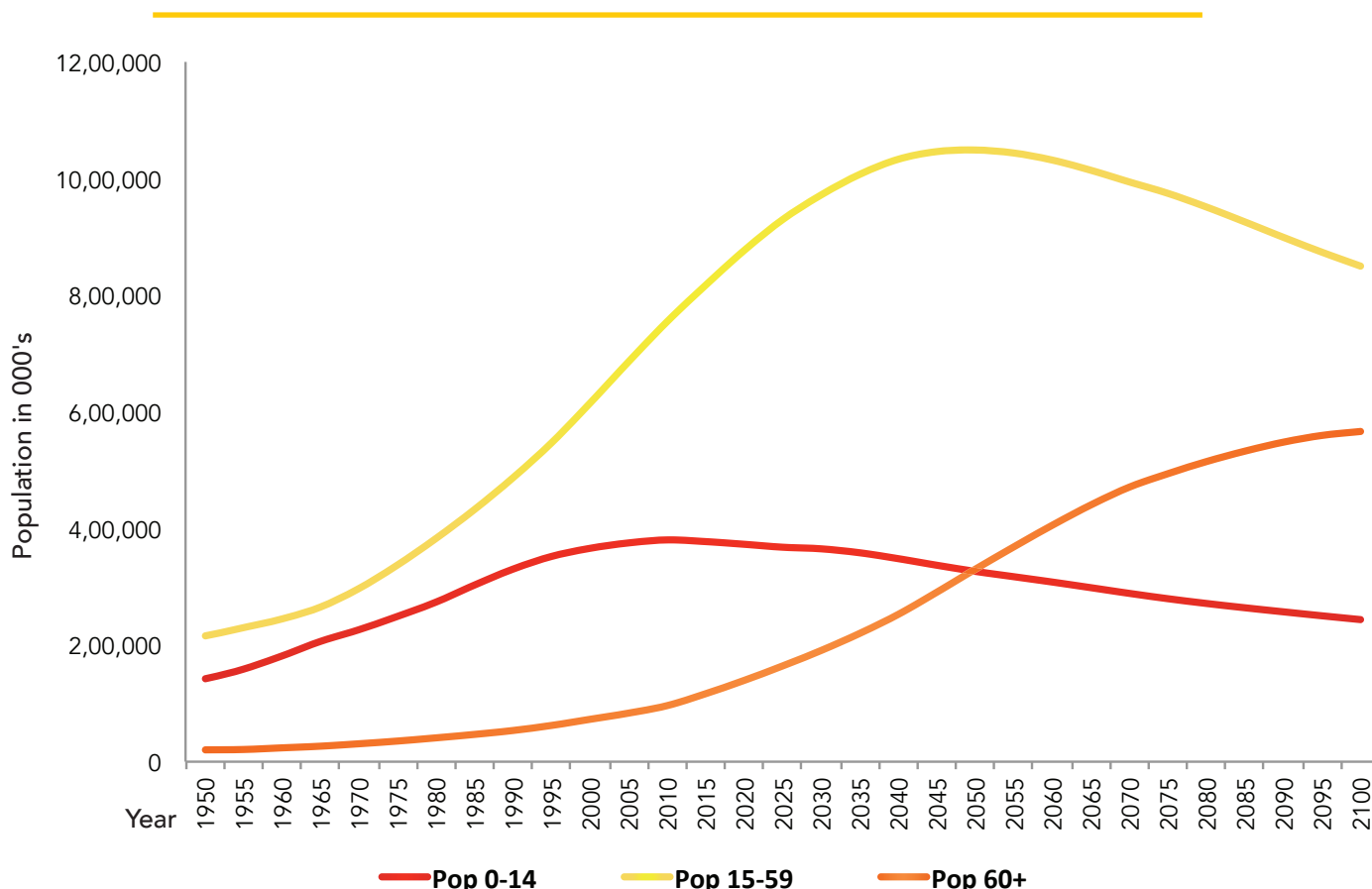


Source: United Nations (2015), World Population Prospects, 2015 Revision, Department of Economic and Social Affairs, United Nations.

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1   Gorman M. (1999), "Development and the Rights of Older People", in Randel J, et al. (eds) The Ageing and Development Report: Poverty, Independence and the World's Older People, Earthscan Publications Ltd., London, pp:3–21.
2   United Nations (2015), World Population Prospects, 2015 Revision, Department of Economic and Social Affairs, United Nations.

## Figure 1.2: Percentage of 60-plus Persons in Total Population, India, 1950–2100
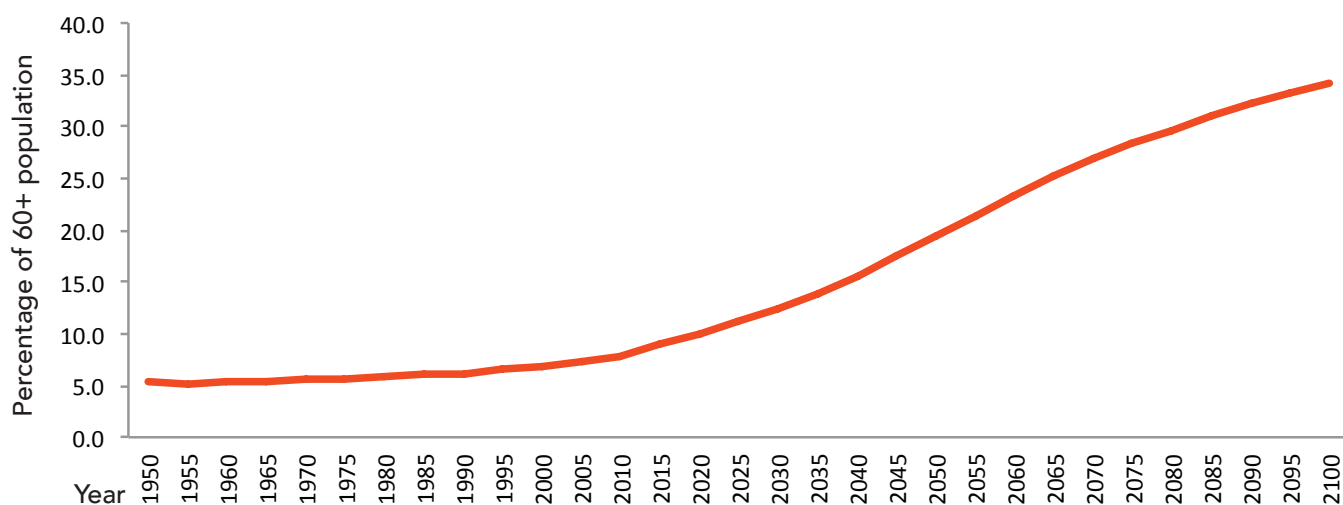


Source: United Nations (2015), World Population Prospects, 2015 Revision, Department of Economic and Social Affairs, United Nations.

ageing of developing countries is not accompanied by the increases in personal incomes witnessed in the developed world during its ageing process. Further, the governments of the rapidly ageing developing countries are slower in recognizing and responding to the demographic shift, largely due to competing development priorities. Countering ageism (the negative stereotyping of older people and prejudice against them) and age discrimination (treating someone differently because of their age) is an added issue.

In Asia as a whole, the proportion of the elderly is expected to increase from 10.5 percent to 22.4 percent during 2012–2050. In East Asia, the proportion of the elderly is expected to be 34.5 percent by 2050. Japan (41.5 percent), South Korea (38.9 percent), China (34 percent) may be expected to report the highest proportions of the elderly population in the region by 2050. The South Asian Association for Regional Cooperation (SAARC) countries, however, are likely to have only about 21

percent population above 60 years by 2050. Within the SAARC, Bangladesh (22.4 percent), Bhutan (24.1 percent), Maldives (31.2 percent) and Sri Lanka (27.4 percent) are estimated to overshoot the SAARC average for the statistic by 2050. While India is not expected to report more than 19 percent elderly by 2050, the absolute numbers will be very large.[3]

## 1.2 India's Elderly: Levels and Trends

The percentage of the elderly in India has been increasing at an increasing rate in recent years and the trend is likely to continue in the coming decades. The share of population over the age of 60 is projected to increase from 8 percent in 2015 to 19 percent in 2050 (Figure 1.2). By the end of the century, the elderly will constitute nearly 34 percent of the total population in the country.

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3   Ibid.

Though the growth rate of the elderly population dipped slightly in the 1960s and 1980s, it was always higher than the general population and the difference between the two has widened over the period. Figure 1.3 presents the size and growth of the elderly population in India between 1950–2100. The figure shows that annual growth rate of the elderly will be over 3 percent till middle of this century indicating faster pace of growth than other age categories. On the contrary, the growth rate of younger age group is already negative in the country. [4]

Undoubtedly, therefore, relatively young India today will turn into a rapidly ageing society in the coming decades. A distinguishing feature of ageing in India is the significant interstate disparity in terms of both levels and growth of the elderly population depending upon the pace of demographic transition in these states.

## 1.2.1 Differentials across States

India has significant interregional and interstate demographic diversity based on the stage of demographic transition, variations in the onset and pace of fertility transition. Consequently, there are considerable variations in the age structure of the population, including the ageing experience. For instance, the southern states are the front runners in population ageing along with Himachal Pradesh, Maharashtra, Odisha and Punjab (Figure 1.4). The central and northern states such as Uttar Pradesh,

### Figure 1.3: Size and Growth Rate of the Elderly Population in India, 1950–2100
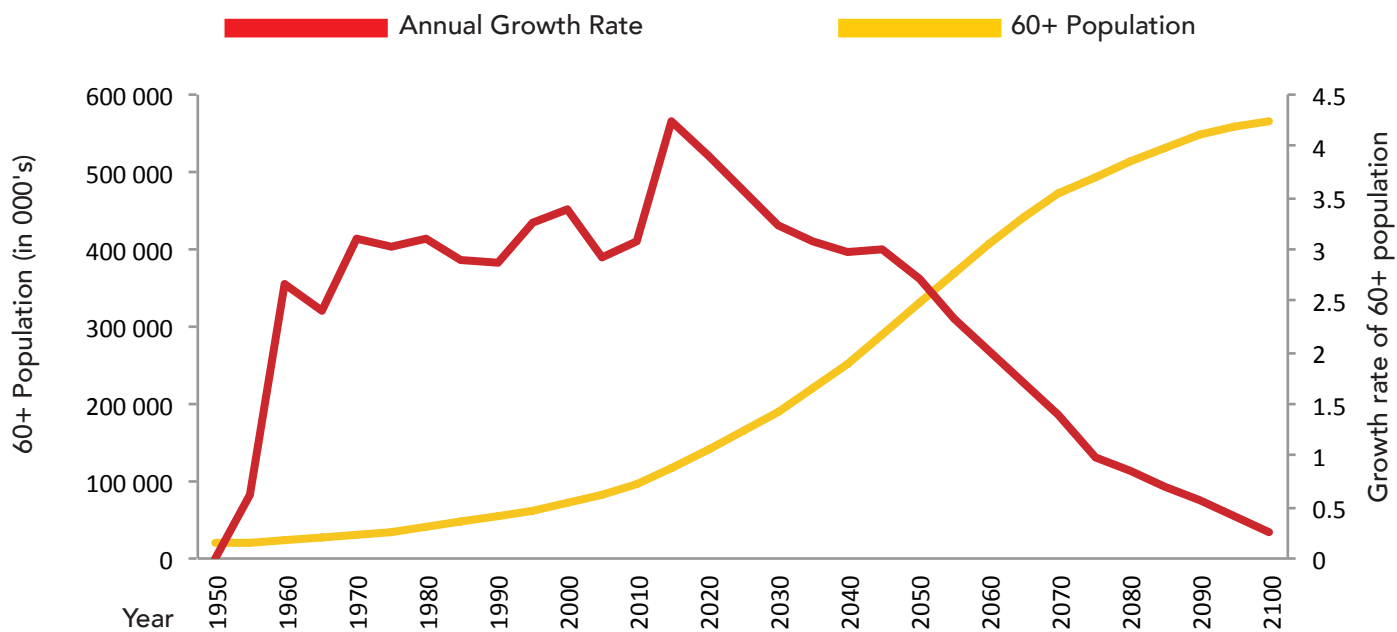


Source: United Nations (2015), World Population Prospects, 2015 Revision, Department of Economic and Social Affairs, United Nations.

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4 ORGI (2011), "Provisional Population Totals, Paper-1 of 2011", Office of the Registrar General and the Census Commissioner of India, Ministry of Home Affairs, Government of India, New Delhi. www.censusindia.gov.in.

## Figure 1.4: Percentage of 60-plus Population across States in India, 2011
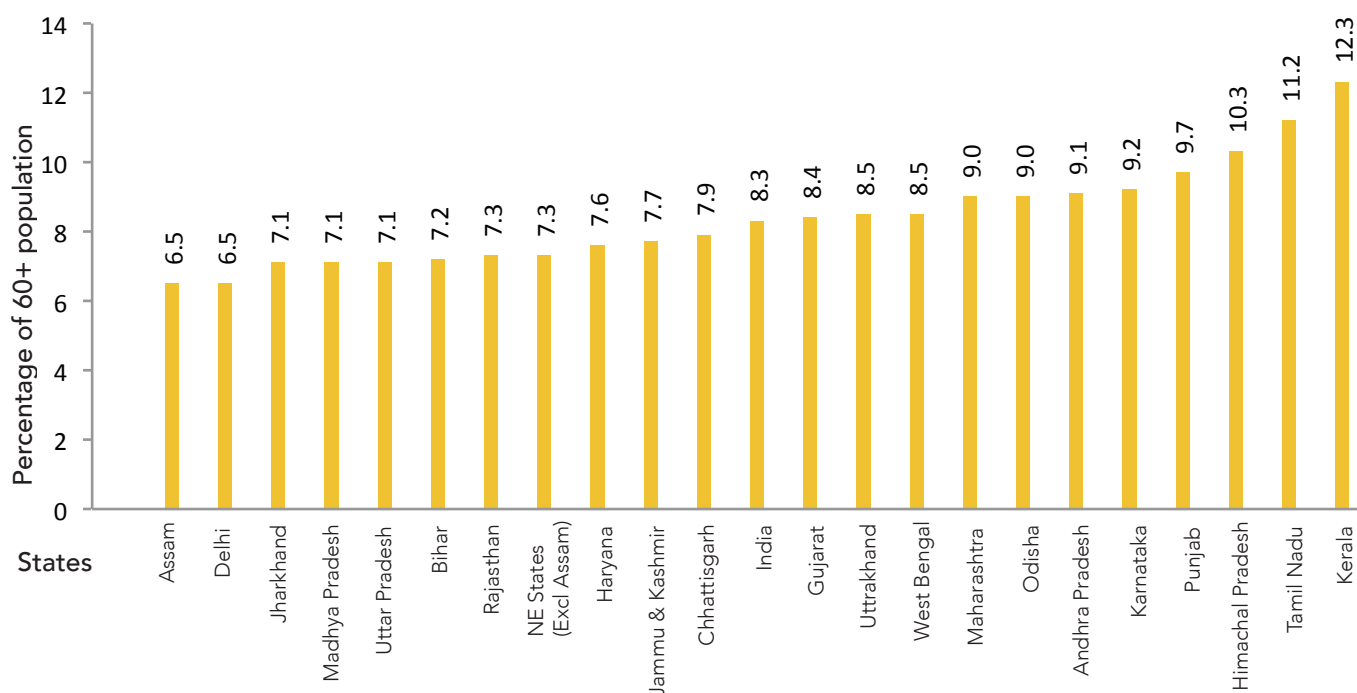


Bar chart — Percentage of 60+ population (y-axis, 0 to 14) across States (x-axis):

| State | Percentage of 60+ population |
|---|---|
| Assam | 6.5 |
| Delhi | 6.5 |
| Jharkhand | 7.1 |
| Madhya Pradesh | 7.1 |
| Uttar Pradesh | 7.1 |
| Bihar | 7.2 |
| Rajasthan | 7.3 |
| NE States (Excl Assam) | 7.3 |
| Haryana | 7.6 |
| Jammu & Kashmir | 7.7 |
| Chhattisgarh | 7.9 |
| India | 8.3 |
| Gujarat | 8.4 |
| Uttrakhand | 8.5 |
| West Bengal | 8.5 |
| Maharashtra | 9.0 |
| Odisha | 9.0 |
| Andhra Pradesh | 9.1 |
| Karnataka | 9.2 |
| Punjab | 9.7 |
| Himachal Pradesh | 10.3 |
| Tamil Nadu | 11.2 |
| Kerala | 12.3 |

Source: Computed from ORGI (2011), Census of India, 2011, Office of the Registrar General and the Census Commissioner of India, Ministry of Home Affairs, Government of India. www.censusindia.gov.in.

Rajasthan, Madhya Pradesh, Bihar, Jharkhand, Chhattisgarh and Uttarakhand have much lower proportions of aged population. Based on 2011 Census, the overall old-age dependency ratio shows that there are over 14 elderly per 100 working age population, with significant variations across states. In Kerala, Goa, Punjab, Himachal Pradesh, Tamil Nadu, Maharashtra, Odisha and Andhra Pradesh, the old-age dependency ratio is higher than 15 (nearly 20 percent in Kerala)  whereas it is less than 10 in Arunachal Pradesh, Meghalaya, Nagaland and Chandigarh. Higher old-age dependency reflects higher level of demand for care from immediate family.[5]

The mortality experience among general population as against the elderly population contributes to the faster growth of the latter group. According to data from the Sample Registration System (SRS), life expectancy at the age of 60 has increased from 14 years in 1970–1975 to 18 years in 2010–2014 with women living about two years longer than men (Figure 1.5). All the Indian states show a life expectancy at 60 of over 15 years currently except males in Chhattisgarh.Thus life expectancy improvement has been substantial in most states of India. Currently all the states have higher life expectancies at old ages for women than for men.

**A distinguishing feature of ageing in India is the significant interstate disparity in terms of both levels and growth of the elderly population depending upon the pace of demographic transition in these states.**

5  ORGI (2011), Census of India, 2011, Office of the Registrar General and the Census Commissioner of India, Ministry of Home Affairs, Government of India, New Delhi. www.censusindia.gov.in.

## 1.3  Challenges of an Ageing Population

As already pointed out, population ageing in any country creates its own challenges and opportunities as well. Four aspects of ageing are particularly relevant for India.

## 1.3.1 Feminization of Ageing

The sex ratio of the elderly has increased from 938 women to 1,000 men in 1971 to 1,033 in 2011 and is projected to increase to 1,060 by 2026 (with some variations across states) given the insignificant decline in mortality among males particularly during adult and older years.

Figure 1.5: State-wise Life Expectancy at Age 60 by Gender, 2010–2014
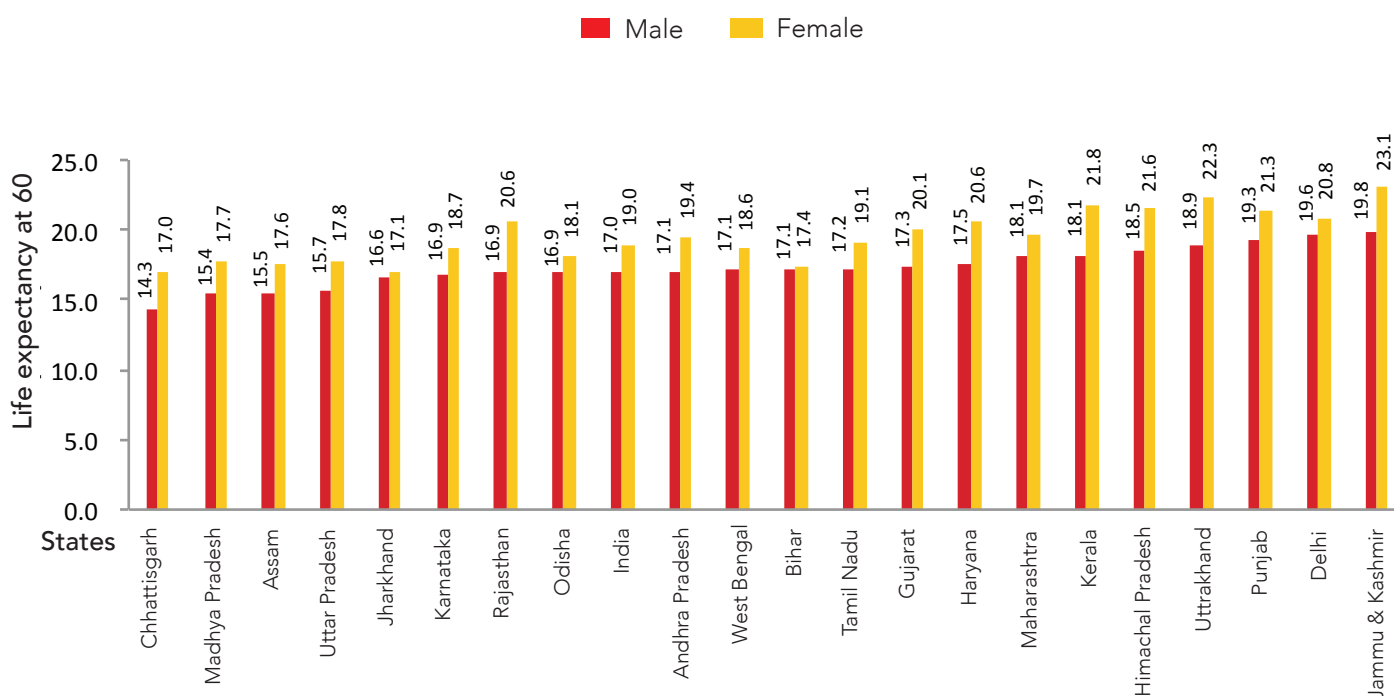


Source: ORGI (2016), SRS Based Life Table 2010–14, Office of the Registrar General and the Census Commissioner of India, Ministry of Home Affairs, Government of India. www.censusindia.gov.in.

**The life expectancy improvement has been substantial in most states of India. Currently all the states have higher life expectancies at old ages for women than for men.**

Frequent outcome of feminization of ageing is the discrimination and neglect experienced by women as they age, often exacerbated by widowhood and complete dependence on others. Loss of spouse in old age adds significant vulnerability in later years. The marital status distribution of the older persons as per 2011 Census data shows that nearly 66 percent are currently married, 32 percent are widowed and about 3 percent are separated or divorced[6]. Among the older men, 82 percent are currently married while among older women only 50 percent are currently married. About 48 percent of older women are widowed while only 15 percent of oler men belong to this category (Figure 1.6).

## 1.3.2  Ruralization of the Elderly

According to 2011 Census, 71 percent of the elderly live in rural India[7]. In all the states, except the two smaller states, Goa and Mizoram, a higher proportion of the elderly lives in rural areas than in urban areas (Figure 1.7). Many rural areas are still remote with poor road and transport access. Income insecurity, lack of adequate access to quality health care and isolation are more acute for the rural elderly than their urban counterparts. It is also noted that poorer states such as Odisha, Bihar and Uttar Pradesh have a larger percentage of the rural elderly.

## Figure 1.6: Marital Status of Elderly (60-plus) in India, 2011
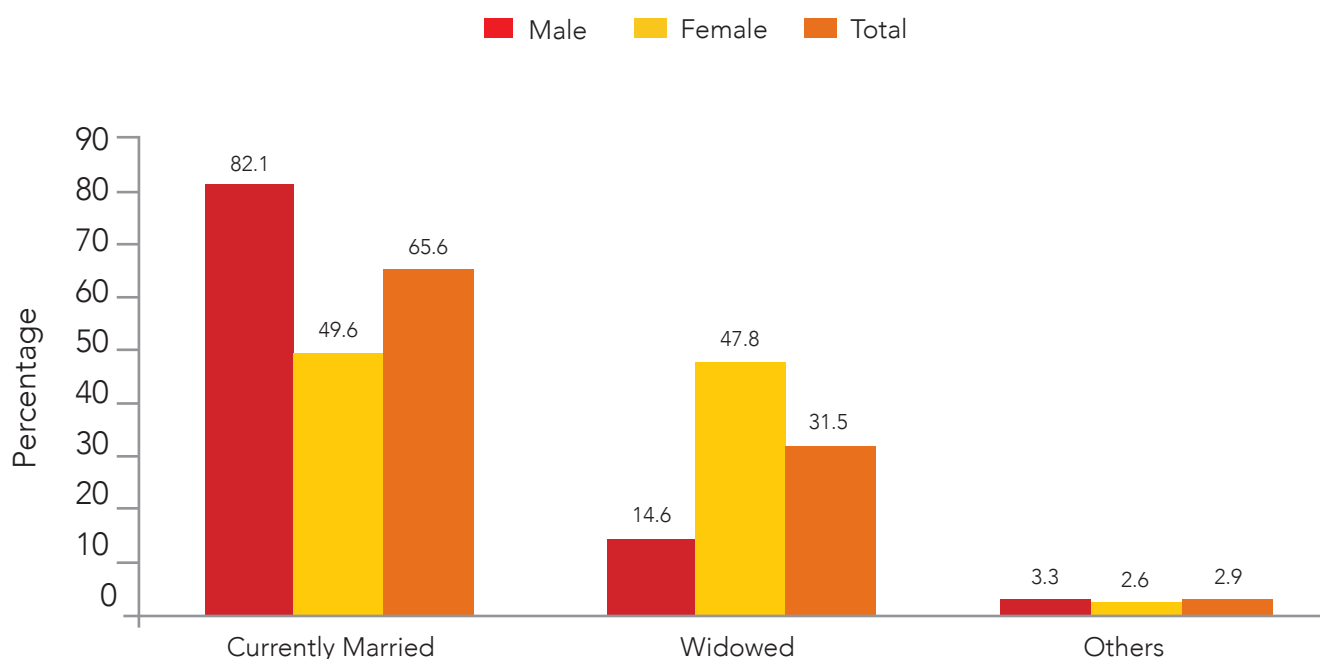


Source: Computed from ORGI (2011), Census of India, 2011, Office of the Registrar General and the Census Commissioner of India, Ministry of Home Affairs, Government of India. www.censusindia.gov.in

**Frequent outcome of feminization of ageing is the discrimination and neglect experienced by older women often related to their life course experiences.**

6  Ibid.
7  Ibid.

## 1.3.3  More 80-plus Women

Projections indicate that during 2000–2050, the overall population of India will grow by 56 percent while the population 60-plus will grow by 326 percent. During the same period, the population 80-plus will grow 700 percent with a predominance of widowed and highly dependent very old women. The number of older women compared to the number of older men will progressively increase with advancing ages from 60 through 80 years. The special needs of such oldest old women would need significant focus of policy and programmes.[8]

## 1.3.4  Migration and its Impact on the Elderly

Migration of younger working age persons from rural areas can have both positive and negative impact on the elderly. Living alone or with only the spouse is usually discussed in terms of social isolation, poverty and distress. However, older people prefer to live in their own homes and community, which is why ageing in place is often a preferred option[9]. Further, this puts some funds in the hands of older persons at a time when they need physical support for health care and to manage household chores. It is also recognized that new technologies are helping the rural elderly stay in touch with their children who can even reach home more easily than in the past.

### Figure 1.7: Percent Population Aged 60 and above Living in Rural India, 2011
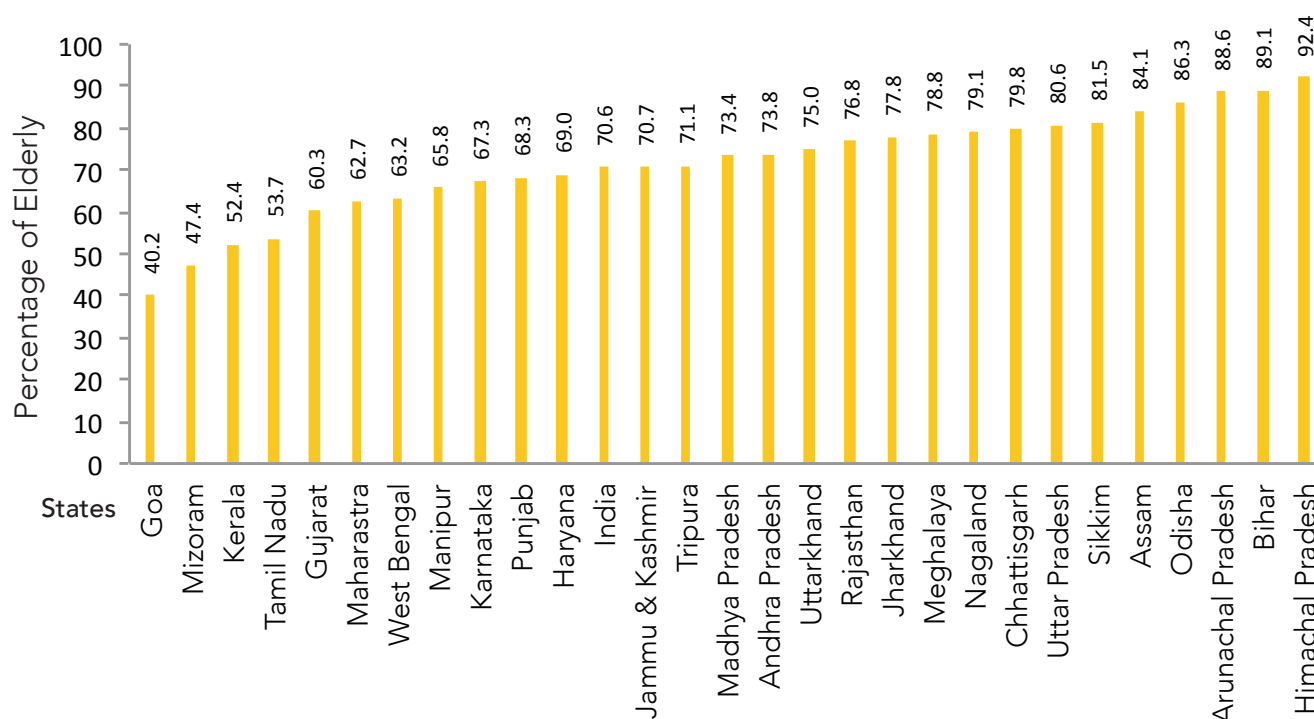


Source: Computed from ORGI (2011), Census of India, 2011, Office of the Registrar General and the Census Commissioner of India, Ministry of Home Affairs, Government of India. www.censusindia.gov.in.

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8  HelpAge India (2015), The State of Elderly in India, 2014, HelpAge India, New Delhi. https://www.helpageindia.org/images/pdf/state-elderly-india-2014.pdf

9   The U.S. Centers for Disease Control and Prevention defines ageing in place as "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level."

## 1.4 Policy Response to Ageing in India

The Indian government's commitment to population ageing concerns is evident in two important ways: (a) being a signatory to all the global conferences, initiatives on ageing as well as the Regional Plans of Action; and (b) formulation of the National Policy on Older Persons (NPOP) in 1999, well ahead of Madrid International Plan of Action on Ageing (MIPAA), the United Nation (UN) sponsored International Plan of Action. The National Social Assistance Programme for the poor is also an outcome of the Directive Principles of our Constitution (Articles 41–42) recognizing concurrent responsibility of the central and state governments in this regard.

India's national response can be seen as evolving along with many multilateral initiatives under the aegis of the UN which spearheaded global attention while encouraging country action to address ageing concerns. The projection scenarios produced by the UN and the attentive ear lent to the voices of elderly men and women contributed to better understanding and clarity on ageing issues. The government also recognized that some of the key concerns of our senior citizens could be best addressed only in partnership with non-governmental organizations (NGOs). India's association with incremental global understanding of ageing issues has been significant—starting from the 1982 Vienna International Plan of Action on Ageing, followed in 1991 by the development of 18 principles for older persons (grouped under five quality-of-life attributes: independence, participation, care, self-fulfilment and dignity) and then the Second World Assembly on Ageing held in Madrid in 2002. As mentioned above, the NPOP formulation in India preceded MIPAA by about three years and has in some ways influenced the Madrid Action Plan.

India also shared with other countries and international NGOs the serious lack of attention to ageing in the Millennium Development Goals (MDGs). The post-2015 development goals called the Sustainable Development Goals (SDGs) in general and SDG-3 in particular has given attention to ageing. In the most recent 2016 UN General Assembly, India further ratified its commitment to SDGs and reported streamlining them into national development indicators. Indian policy response to ageing has also gained from the work of the World Health Organization (WHO) on Active Ageing, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) resolution of January 2010 on older women, the United Nations Population Fund (UNFPA) work on social-economic implications of ageing through the initiative Building a Knowledge-base on Population Ageing in India (BKPAI)[10] , the work of the International Labour Organisation (ILO) on income security and social pensions as well as the large data collection efforts under Longitudinal Ageing Study in India (LASI) and Study of Global Ageing and Adult Health (SAGE).

## 1.5 Organization of the Report

This report takes stock of ageing concerns and policy response in the country. It also briefly documents select good practices across states. The report is divided into seven chapters, of which the present one is the first. Chapter 2 analyses the socio-demographic

**India's national response to ageing can be seen as evolving along with many UN initiatives that enhanced global attention on ageing in general and encouraged country level actions in particular.**

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10  The United Nations Population Fund (UNFPA), India in collaboration with the Institute for Social and Economic Change (ISEC), Bangalore, the Institute for Economic Growth (IEG), New Delhi and the Tata Institute of Social Sciences (TISS), Mumbai launched a research project, Building a Knowledge-base on Population Ageing in India (BKPAI) in 2011. A primary survey was carried out in seven states – Himachal Pradesh, Punjab, West Bengal, Odisha, Maharashtra, Kerala and Tamil Nadu which covered a total of 9852 elderly women and men from 8329 elderly households in rural and urban areas. http://www.isec.ac.in/prc-AginginIndia-Data-Release.html

and economic status of the elderly in terms of work force participation, income security, living arrangements, health status, non-communicable diseases (NCDs) and associated services and cost issues, disability, gender concerns and some key concerns in accessing social welfare services especially those meant for the elderly. The chapter highlights the vulnerability faced by the elderly (particularly the large proportion of widowed women) with respect to the indicators. Poor health and morbidity due to increasing NCDs is a concern. It is a significant challenge for the society and government to reduce vulnerability and improve overall well-being of the elderly.

Chapter 3 explores India's ageing policy and programme landscape. It shows how well the policy addresses the vulnerabilities referred to earlier while implementation continues to present a mixed picture. The chapter refers to four important policy pillars of elderly care—the Maintenance Act 2007[11] , the Integrated Programme for Older Persons (IPOP), the National Programme for the Health Care of the Elderly (NPHCE), and the National Social Assistance Programme (NSAP). The chapter concludes with brief reviews of (i) efforts to influence the policy and (ii) efforts to improve policy implementation through capacity development of National Institute of Social Defence (NISD), emphasis on active ageing and by leveraging the corporate sector. Recent public initiatives relevant to NPOP are also discussed briefly in the chapter.

Chapter 4 focuses on the mapping of NGOs in India—by far the largest provider of development / social services in the country. These services receive routine financial assistance from the government under various schemes of the NPOP.

Chapter 5 documents five case studies: the Elderly Self-help Group as a mechanism to promote economic security and well-being of the elderly; experiences from Kerala (Kudumbashree and Palliative Care); an NGO experience in providing

dementia care, complemented by active ageing initiatives for the overall well-being of the elderly and dementia prevention. The final narrative is on food security in Tamil Nadu. The selection of these good practices is based on suggestions made by experts at a national conference organized by UNFPA in collaboration with Ministry of Social Justice and Empowerment (MOSJE) of the Goverment of India in December 2014.

Chapter 6 provides a platform for presenting elderly voices and concerns and showcasing relevant provisions in the national policy; the work of civil society on issues related to the elderly is also discussed. As the elderly are a heterogeneous group, the chapter premises that the elderly across a variety of contexts must be heard in order for their needs to be addressed. To encourage the elderly to voice their concerns, two mind-set changes would be needed: (a) a shift in perception from looking at the elderly only as beneficiaries to a more positive view of recognizing their contributions to the family and community; and (b) mobilizing political and administrative will to listening and learning and also acting upon their suggestions. The NPOP states that the concerns of older persons are central and therefore they must have a say in matters which affect them. The National Council for Older Persons and the National Association of Older Persons are meant to promote and coordinate initiatives to address the concerns of older persons. Panchayati Raj institutions are encouraged to address local issues and needs of the elderly.

Finally, Chapter 7 begins with the estimation of demand for elder care services including support needed in activities of daily living (ADL) and to deal with chronic ailments. This is followed by the study of ongoing initiatives that offer excellent potential for increased elder care including village level convergence on the issue. The need for aligning the service package with the needs of the elderly through a segmentation approach is highlighted. The chapter then proceeds to suggest the way forward.

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11 Maintenance and Welfare of Parents and Senior Citizens Act, 2007 is a legislation enacted in 2007, initiated by Ministry of Social Justice and Empowerment, Government of India, to provide more effective maintenance and welfare of parents and senior citizens.

# ANNEXURES

## Annex 1.1

### UN Principles for Older Persons

### 1) Independence
a) Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.
b) Older persons should have the opportunity to work or to have access to other income-generating opportunities.
c) Older persons should be able to participate in determining when and at what pace withdrawal from the labour force takes place.
d) Older persons should have access to appropriate educational and training programmes.
e) Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
f) Older persons should be able to reside at home for as long as possible.

### 2) Participation
a) Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
b) Older persons should be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.
c) Older persons should be able to form movements or associations of older persons.

### 3) Care
a) Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.
b) Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.
c) Older persons should have access to social and legal services to enhance their autonomy, protection and care.
d) Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
e) Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

### 4) Self-fulfilment
a) Older persons should be able to pursue opportunities for the full development of their potential.
b) Older persons should have access to the educational, cultural, spiritual and recreational resources of society.

### 5) Dignity
a) Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.
b) Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

# Annex 1.2

Percentage Elderly across Indian States, 1961–2011

| States | 1961 | 1971 | 1981 | 1991 | 2001 | 2011 |
|---|---|---|---|---|---|---|
| Andhra Pradesh | 6.2 | 6.4 | 6.4 | 6.5 | 7.2 | 9.1 |
| Assam | 4.3 | 4.7 | | 5.3 | 5.2 | 6.5 |
| Bihar | 5.6 | 5.9 | 6.3 | 6.1 | 5.5 | 7.2 |
| Jharkhand* | | | | | 5.0 | 7.1 |
| Gujarat | 4.9 | 5.3 | 5.6 | 6.1 | 6.7 | 8.4 |
| Haryana | | 5.8 | 6.4 | 7.5 | 7.0 | 7.6 |
| Himachal Pradesh | 7.4 | 7.2 | 7.5 | 7.8 | 8.8 | 10.3 |
| Jammu & Kashmir | 5.1 | 5.6 | 5.8 | 5.8 | 6.2 | 7.7 |
| Karnataka | 5.7 | 6.1 | 6.3 | 6.8 | 7.3 | 9.2 |
| Kerala | 5.8 | 6.2 | 7.6 | 8.8 | 10.6 | 12.3 |
| Madhya Pradesh | 5.2 | 5.8 | 6.0 | 6.4 | 6.2 | 7.1 |
| Chhattisgarh* | | | | | 6.5 | 7.9 |
| Maharashtra | 5.3 | 5.7 | 6.3 | 6.9 | 8.3 | 9.0 |
| Odisha | 5.7 | 6.0 | 6.3 | 7.0 | 7.8 | 9.0 |
| Punjab | 6.6 | 7.5 | 7.7 | 7.6 | 8.7 | 9.7 |
| Rajasthan | 5.1 | 5.5 | 5.4 | 6.1 | 6.0 | 7.3 |
| Tamil Nadu | 5.6 | 5.7 | 6.5 | 7.3 | 9.0 | 11.2 |
| Uttar Pradesh | 6.3 | 6.8 | 6.5 | 6.6 | 6.1 | 7.1 |
| Uttarakhand* | | | | | 7.3 | 8.5 |
| West Bengal | 5.0 | 5.3 | 5.4 | 6.0 | 6.6 | 8.5 |
| Delhi | 4.1 | 4.3 | 4.5 | 4.7 | 5.1 | 6.5 |
| NE States ( Excluding Assam)* | | | | | 5.3 | 7.3 |
| India | 5.6 | 6.0 | 6.3 | 6.6 | 6.9 | 8.3 |

*State formed in 2000

Source: Compiled from ORGI (various years), Census of India, various years, Office of the Registrar General and the Census Commissioner of India, Ministry of Home Affairs, Government of India. www.censusindia.gov.in.

# 2

# Indian Elderly: Status and Concerns

# Indian Elderly: Status and Concerns

As discussed in Chapter 1, the increasing share of the 60-plus population in India along with ruralization and feminization of ageing has posed several challenges for the country, the increase in old-age dependency ratio being of immediate concern. The elderly have special economic, physical, emotional and medical needs which must be supported decade on decade by a shrinking proportion of working age persons.

This chapter discusses the status of the older persons in India with respect to loss of spouse and living arrangements, income insecurity and work, health and social security. The chapter also highlights certain concerns in the context of gender and outreach of social security schemes that are especially meant for the elderly. The chapter is mainly based on the data from various National Sample Survey Office (NSSO) Rounds, Census of India, the National Family Health Survey (NFHS) and the Building a Knowledge Base on Population Ageing in India (BKPAI) project, a 2011 UNFPA-funded, seven-state initiative.[12]

## 2.1 Loss of Spouse and Living Arrangements

Loss of spouse in old age adds significant vulnerability in later years. Since widowhood adds vulnerability during old age, understanding the proportion of widows among older persons in a society provides a much clearer picture about the status of older persons. The 2011 Census shows that nearly 66 percent of those over 60 years of age are currently married, 32 percent are widowed and nearly 3 percent are separated or divorced[13]. The marital status distribution of elderly men is considerably different from women given that 82 percent of older men (as compared to 50 percent of older women) are currently married. The proportion of those who have lost their spouse is much higher among women compared to men with 48 percent of

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12  The United Nations Population Fund (UNFPA), India in collaboration with the Institute for Social and Economic Change (ISEC), Bangalore, the Institute for Economic Growth (IEG), New Delhi and the Tata Institute of Social Sciences (TISS), Mumbai launched a research project, Building Knowledge-base on Population Ageing in India (BKPAI) in 2011. A primary survey was carried out in seven states – Himachal Pradesh, Punjab, West Bengal, Odisha, Maharashtra, Kerala and Tamil Nadu which covered a total of 9852 elderly women and men from 8329 elderly households in rural and urban areas. http://www.isec.ac.in/prc-AginginIndia-Data-Release.html

13 ORGI (2011), Census of India, 2011, Office of the Registrar General and the Census Commissioner of India, Ministry of Home Affairs, Government of India, New Delhi. http://www.censusindia.gov.in/2011-common/census_2011.html

older women and only 15 percent of the older men being widowed. Since women are more likely to be dependent on men for financial security, women face more adversities due to loss of spouse compared to men.

The well-being of older persons can also greatly depend on whom they live with, particularly in developing countries where the elderly have little recourse to formal welfare systems. Living arrangements among the elderly was not an issue in India till a few decades ago because their families were expected to take care of them. But with the reduction in fertility and increased life expectancy at old ages, conventional living arrangements have been undergoing a transformation. With declining informal social support systems, older persons who live alone are likely to be more vulnerable than those who live with the family, especially in the case of elderly women.

While majority of the elderly are still living with their children in India, about one fifth either live alone or only with the spouse and hence have to manage their material and physical needs on their own. The proportion of older persons living alone without spouse (solo living) has increased over time from 2.4 percent in 1992/93 to 5 percent in 2004/05[14]. The proportion of elderly who live alone varied from 13.7 percent in Tamil Nadu to 1.7 percent in Jammu and Kashmir in 2005/06 (Figure 2.1). Similarly, survey data from the BKPAI collected in 2011 also showed that the proportion of the elderly living alone was the highest in Tamil Nadu (26 percent). Across the seven

Figure 2.1: Elderly Living Alone in Selected States, 2005/06
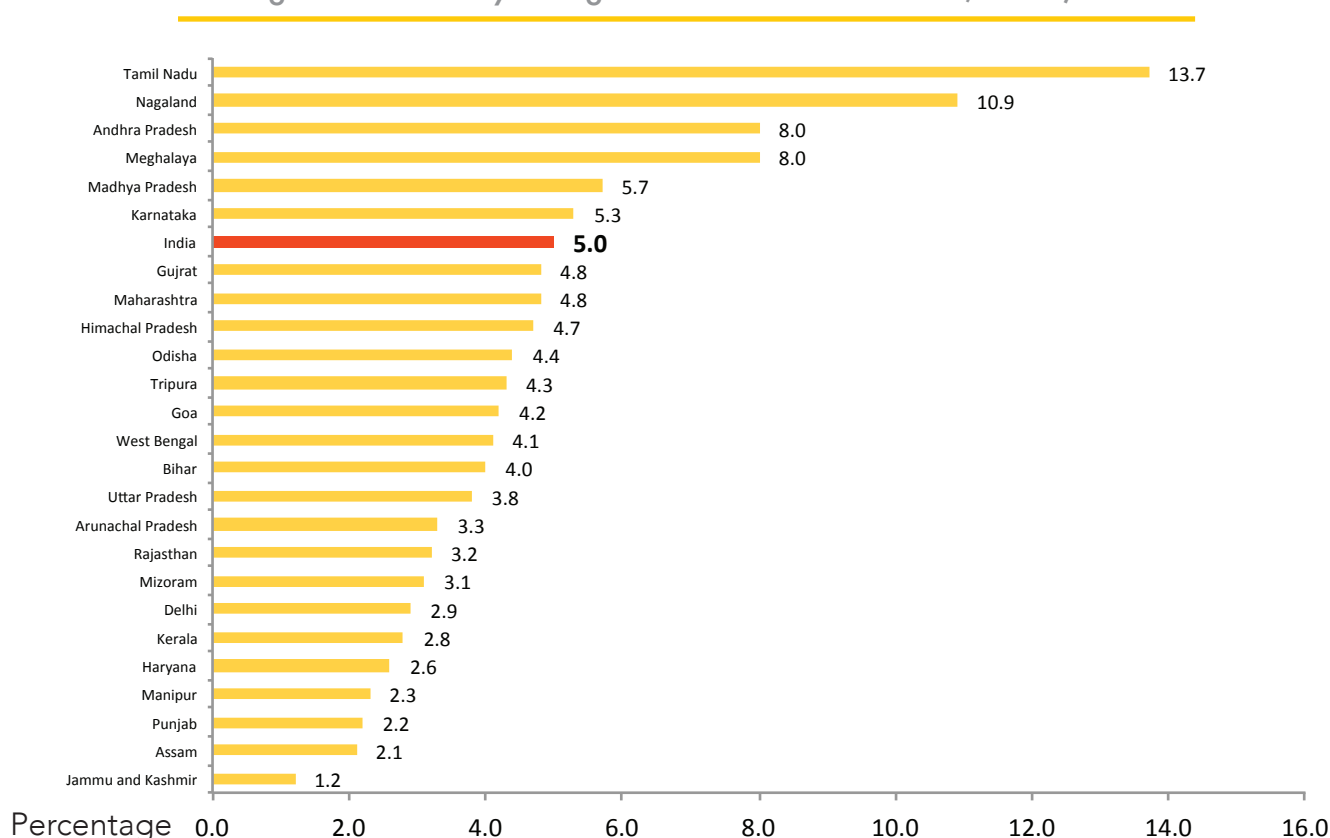
| State | Percentage |
|---|---|
| Tamil Nadu | 13.7 |
| Nagaland | 10.9 |
| Andhra Pradesh | 8.0 |
| Meghalaya | 8.0 |
| Madhya Pradesh | 5.7 |
| Karnataka | 5.3 |
| India | 5.0 |
| Gujrat | 4.8 |
| Maharashtra | 4.8 |
| Himachal Pradesh | 4.7 |
| Odisha | 4.4 |
| Tripura | 4.3 |
| Goa | 4.2 |
| West Bengal | 4.1 |
| Bihar | 4.0 |
| Uttar Pradesh | 3.8 |
| Arunachal Pradesh | 3.3 |
| Rajasthan | 3.2 |
| Mizoram | 3.1 |
| Delhi | 2.9 |
| Kerala | 2.8 |
| Haryana | 2.6 |
| Manipur | 2.3 |
| Punjab | 2.2 |
| Assam | 2.1 |
| Jammu and Kashmir | 1.2 |

Source: National Family Health Survey, Round 3, 2005/06, Ministry of Health and Family Welfare, Government of India, http://rchiips.org/nfhs/nfhs3.shtml

14  Sathyanarayana K.M., Sanjay Kumar and K.S. James (2012), "Living Arrangements of Elderly in India: Policy and Programmatic Implication", Working Paper No. 7, Building a Knowledge-base on Population Ageing in India, Institute for Social and Economic Change, Bangalore, United Nations Population Fund, New Delhi and Institute of Economic Growth, Delhi.

| | | Percentage |
|---|---|---|
| Sex | Women | 7.0 |
| | Men | 2.7 |
| Caste | Others | 3.8 |
| | OBC | 5.4 |
| | SC/ST | 5.7 |
| Marital status | Currently married | 0.7 |
| | Widow | 11.2 |
| Wealth quintile | Richest | 1.6 |
| | Richer | 2.8 |
| | Middle | 4.4 |
| | Poorer | 6.9 |
| | Poorest | 10.5 |

Source: National Family Health Survey, Round 3, 2005/06, Ministry of Health and Family Welfare, Government of India, http://rchiips.org/nfhs/nfhs3.shtml
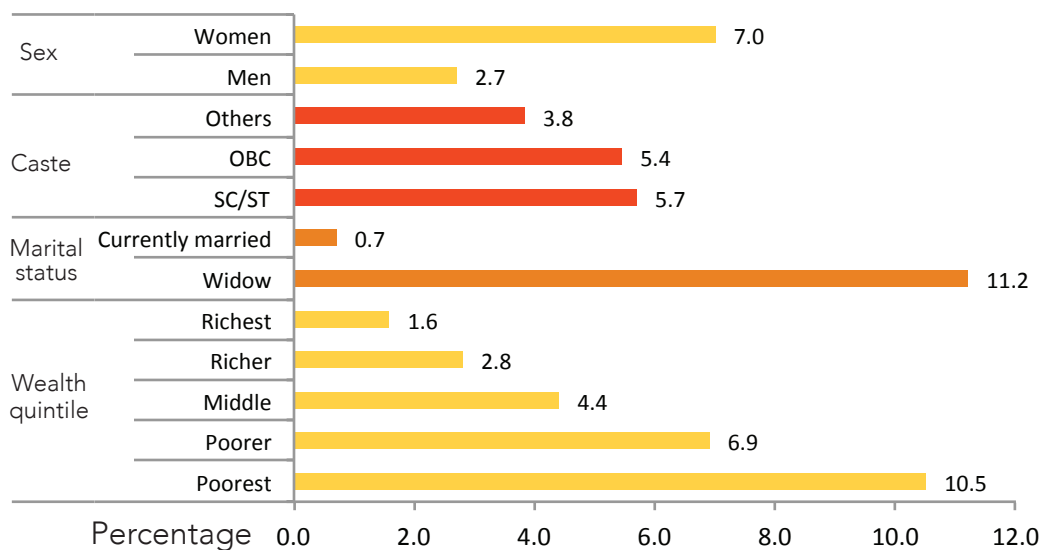
states, a higher percentage of elderly women live alone compared to men. As expected, more elderly who have lost their spouses live alone (Figure 2.2).

## 2.2  Income Insecurity and Compulsion to Work

Income insecurity is one of the major causes of vulnerability in old age. In India, it is normative for families to take care of the needs of older persons, including economic and social needs. With the changing socio-economic, demographic and development scenario, financial security arising from personal income and asset ownership has become a major determinant of well-being of older persons. However, if income primarily accrues from their work, it is very likely that their dependence on work will increase with age. The BKPAI survey data indicates that 26 percent of older men and around 60 percent of older women do not have any personal income. About one third of the older men and women receive income from employers or social pensions (Figure 2.3). The major source of income especially for older men is still salary or wages. This indicates that older men work to support themselves even during old age.

**While majority of the elderly are still living with their children in India, about one fifth either live alone or only with the spouse and hence have to manage their material and physical needs on their own.**

Although around 50 percent of the elderly have some type of personal income, the income earned by the elderly is not sufficient to fulfil their basic needs and therefore they are financially dependent on others. Almost three fourth of the elderly are either fully or partially dependent on others, and such dependency is more for elderly women than men. Financial dependency also increases with age[15]. Elderly persons in India not only work to support themselves but also make economic contributions to their households. About 70 percent of older men and 36 percent older women perceived that they contributed to household expenditure. More

than half of the elderly men perceived that their contribution covered more than 60 percent to the household budget (Figure 2.4). Overall, it appears that elderly still depend greatly on their earnings to support themselves and their family. Work participation in the older ages has different connotations. If older persons work out of their own choice and not due to financial constraints there is a more positive connotation to work. But if this is due to economic compulsions, it shows a greater degree of vulnerability for the worker. The NSSO estimated that in 2012/13, 34 percent of older persons were working[16]. Although the work participation rate

Figure 2.3. Sources of Personal Income of the Elderly, 2011



Source: Alam, et al (2012), "Report on the Status of Elderly in Select States of India 2011", Building a Knowledge-base on Population Ageing in India, United Nations Population Fund, New Delhi

## Elderly people in India not only work to support themselves but also make economic contributions to their households.

15  Alam, Moneer, K S James, G. Giridhar, K. M. Sathyanarayana, Sanjay Kumar, S. Siva Raju, T. S. Syamala, Lekha Subaiya, Dhananjay W. Bansod (2012), "Report on the Status of Elderly in Select States of India 2011", Building Knowledge-base on Population Ageing in India, United Nations Population Fund, New Delhi

16  NSSO (2013), Key Indicators of Employment and Unemployment in India, NSS 68th Round (July 2011–June 2012), National Sample Survey Office, Ministry of Statistics and Programme Implementation, Government of India, New Delhi.

declines with age, data shows that 18 percent of males and 3 percent of females work beyond age 80 years. The work participation rate according to social group also shows that a significantly higher proportion of elderly belonging to scheduled castes/scheduled tribes work than other caste groups (Figure 2.5). The recently conducted BKPAI data also show that elderly work participation is much higher among poor and less educated persons indicating that poverty is an important reason for elderly work participation. The BKPAI collected data on compulsion to work, and showed that 71 percent of the elderly work due to economic compulsion and more so in the case of elderly women (82 percent) than men (68 percent). The occupational structure also clearly indicates that elderly are mostly engaged in

unskilled, informal, low paying occupations like agricultural labour and petty trades where they do not receive any post-retirement benefits nor have any retirement aespecified in the first place.[17]

The elderly work participation rate also varies across the states of India with highest work participation rate in Meghalaya with nearly 60 percent of the older persons are in labour force and lowest in Goa with only 8 percent of the older persons in labour force. Among the major states, elderly work participation rate is above 40 percent in Himachal Pradesh (48.8), Andhra Pradesh (40.3), Chhattisgarh (41.1) and Uttar Pradesh (41.2), whereas in Assam, Kerala, Haryana and West Bengal the work participation rate hovers around 25 percent. A substantial proportion of the

## Figure 2.4. Economic Contribution of Personal Income of the Elderly towards Household Expenditure, 2011
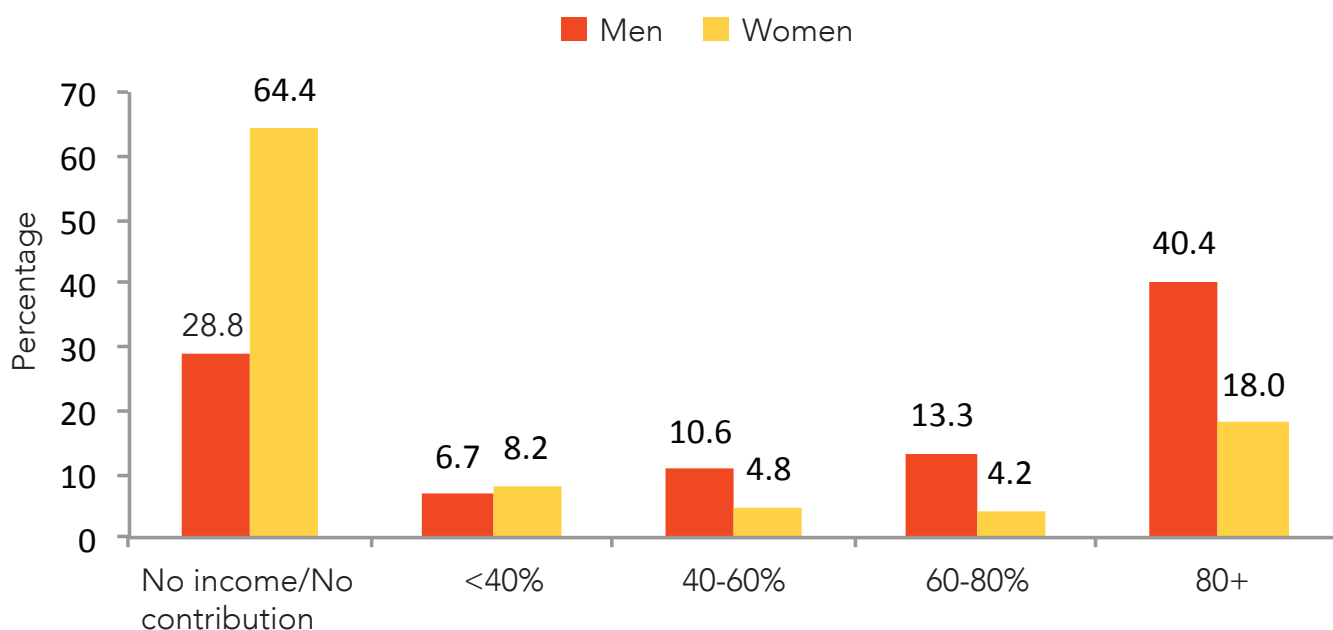


Source: Alam, Moneer, K S James, G. Giridhar, K. M. Sathyanarayana, Sanjay Kumar, S. Siva Raju, T. S. Syamala, Lekha Subaiya, Dhananjay W. Bansod (2012), "Report on the Status of Elderly in Select States of India 2011", Building a Knowledge-base on Population Ageing in India, Institute for Social and Economic Change, Bangalore, United Nations Population Fund, New Delhi and Institute of Economic Growth, Delhi. http://www.isec.ac.in/Ageing Report_28Nov2012_LowRes-1.pdf

17   Ibid, 15

## Figure 2.5. Work Participation of Elderly by Age, Sex and Social Groups, 2012



**Men** **Women**
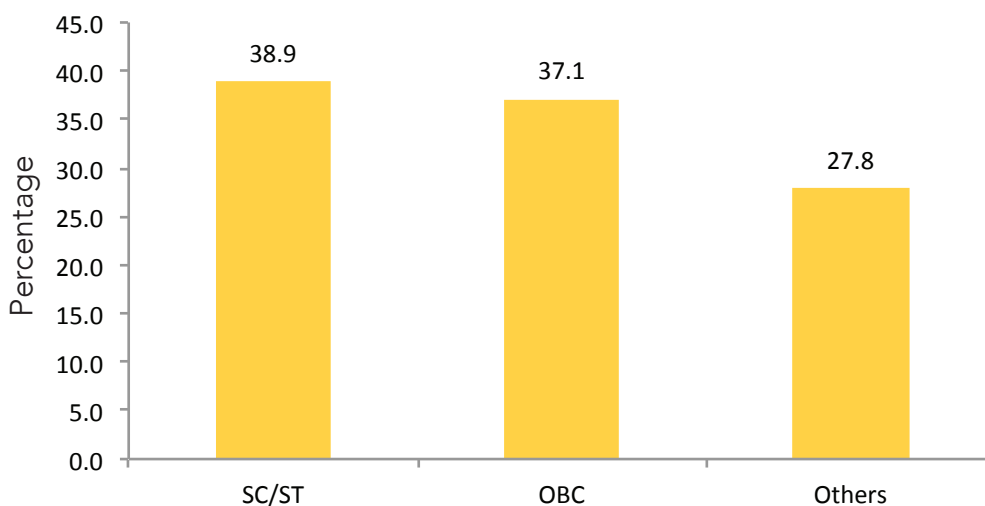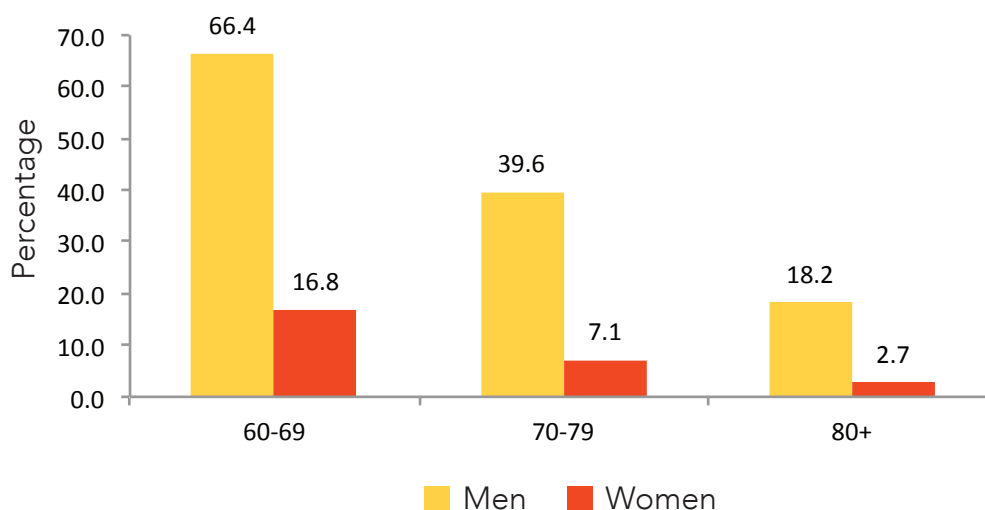


Source: NSSO (2013), Key Indicators of Employment and Unemployment in India, NSS 68th Round (July 2011–June 2012).National Sample Survey Office, Ministry of Statistics and Programme Implementation, Government of India.

older persons also work beyond age 80 particularly in states like Bihar, Madhya Pradesh, Uttar Pradesh and Jammu and Kashmir (Figure 2.6).

## 2.3  Health Status of the Elderly

Health is determined by many economic, social, psychological and physiological factors. Poor health and morbidity diminish the quality of life and well-being of the elderly while increasing psychological distress and perception of vulnerability.

## 2.3.1 Prevalence of Morbidity

When a person reports an event of sickness or poor health during the 15 days prior to the survey, it is recorded as an instance of acute morbidity. With advancing years, the incidence of acute and chronic morbidities increases.  As Figure 2.7 shows, in 2014, the prevalence of acute morbidity increased from 30 percent in the age group 60–69 years to 37 percent for the 80-plus group. Further, it was marginally higher among  women than men.

## Figure 2.6. Work Participation of the Elderly (Select States)

Legend: 60+ (yellow), 80+ (red)

| State | 60+ | 80+ |
|---|---|---|
| Himachal Pradesh | 48.8 | 14.4 |
| Uttar Pradesh | 41.2 | 19.5 |
| Chattisgarh | 41.1 | 2.3 |
| Andhra Pradesh | 40.3 | 11.8 |
| Madhya Pradesh | 39.6 | 19.8 |
| Bihar | 37.7 | 23.2 |
| Rajasthan | 37.2 | 5.2 |
| Tamil Nadu | 34.9 | 5.0 |
| Jharkhand | 34.4 | 6.5 |
| India | 34.4 | 9.78 |
| Karnataka | 33.7 | 7.7 |
| Odisha | 32.5 | 8.2 |
| Jammu & Kashmir | 31.7 | 14.1 |
| Maharashtra | 31.3 | 5.9 |
| Gujarat | 30.8 | 7.2 |
| Punjab | 29.2 | 4.8 |
| West Bengal | 27.3 | 3.3 |
| Hariyana | 26.3 | 1.3 |
| Kerala | 26.1 | 11.4 |
| Assam | 25.5 | 7.8 |
| Delhi | 24.1 | 8.6 |
| Uttarakhand | 24.0 | 5.8 |
| Goa | 8.2 | 0.0 |

Percentage

**Overall, it appears that elderly still depend greatly on their earnings to support themselves and their family.**

Severe morbidities require hospitalization; not surprisingly, the estimates of NSSO 71st Round, 2014 indicate that the rate of hospitalization amongst elderly is much higher than the general population.[18] Furthermore, while the morbidity prevalence rate is higher among elderly women, their hospitalization rate is lower than the men indicating gender differentials in health care. Estimates based on BKPAI data show that of the elderly hospitalized, 47 percent were admitted to government hospitals and the rest availed of private facilities. Preference for private facilities was more visible in urban areas than rural[19].

The cost of the health care during old age appears to be very high and this in turn increases the out of pocket expenditure on health care particularly when private facilities are availed of. Out of the total expenditure, nearly half of the expenditure was towards medicines. Treatment cost for chronic morbidities is also quite high [20]. When older persons are economically dependent, increasing health expenditure adds to the economic burden on the family.

## 2.3.2 Non-communicable Diseases

Chronic diseases are a leading cause of death among elderly in India, increasingly so over the past 25 years. The percentage of elderly with any chronic condition as estimated by SAGE, Wave 1 was 41.8 percent in 2007 [21]. The same figure as per the estimates of BKPAI was 64.8 percent in 2011. Chronic ailments are more prevalent among elderly women (674 per 1,000) than elderly men (619 per 1,000) as also higher in rural areas (658 out of 1,000) than urban (621 out of 1,000). Common chronic ailments such as arthritis, hypertension, cataract and diabetes are more prevalent among women whereas ailments like asthma and heart disease are more prevalent in men. There are also variations in the prevalence of various chronic diseases across states of India. Out of the seven states surveyed, the prevalence of arthritis among elderly is found to be higher in Punjab (478 per 1,000) followed by Himachal Pradesh (390 per 1,000) and Maharashtra (351 per 1,000 while for other chronic ailments, prevalence rates are higher in

## Figure 2.7. Prevalence of Acute Morbidities Among the Elderly (by age and sex)
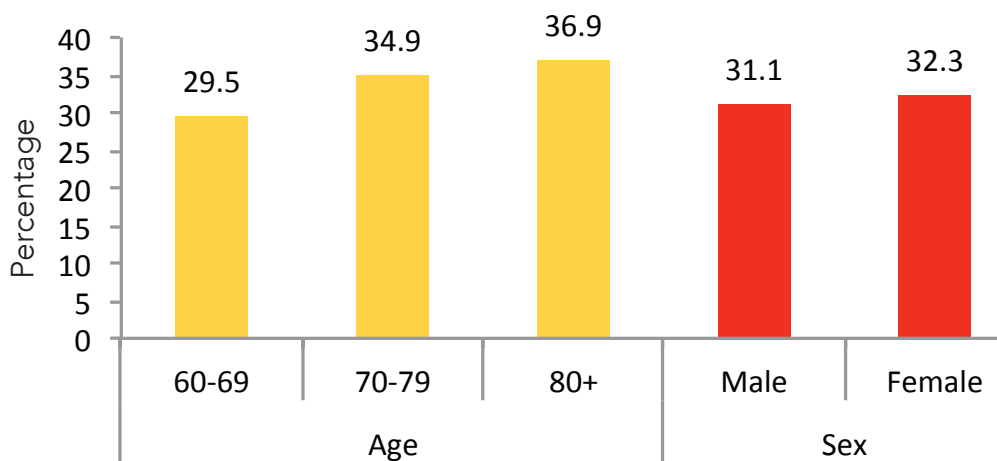


Source: NSSO (2015), Key Indicators of Social Consumption in India, Health (January–June 2014). 71st Round, National Sample Survey Office, Ministry of Statistics & Programme Implementation, Government of India

18 NSSO (2015), Key Indicators of Social Consumption in India, Health (January–June 2014), National Sample Survey Office, Ministry of Statistics and Programme Implementation, Government of India, New Delhi.
19,20  Ibid, 15
21  Arokiasamy, P., Sulabha Parasuraman, T. V. Sekher, H. Lhungdim (2013), Study on Global Ageing and Adult Health (SAGE) Wave 1: India National Report, International Institute for Population Sciences, Mumbai.

Kerala. For treatment of chronic ailments within last three months, most of the elderly have preferred private hospitals over government health facilities with attendant escalations in cost. [22]

## 2.3.3 Self-perceived Health

Self-rated health is an important overall indicator of health status. In studies based on surveys such as SAGE, LASI and BKPAI, respondents were typically asked to rate their health on a 5-point scale. Men tended to have better self-rated health than women and women were more likely to report poor or fair self-rated health[23]. SAGE Wave 1 survey shows that 75 percent elderly women reported their current health as moderate or bad as against 64 percent men[24]. Similarly, according to BKPAI data, nearly three fifth of women rated their health as fair or bad as compared to a little over half the men. Data from these surveys conducted at different periods of time indicated better health perception among older men than among older women.

## 2.3.4 Subjective Well-being

According to WHO, mental health disorders account for 13 percent of the global burden of diseases and is particularly common among older adults. The BKPAI survey collected information on general well-being of older persons through the 12-item General Health

Questionnaire (GHQ) and the 9-item Subjective Well-being Inventory (SUBI). The main scope of the GHQ is to quantify subjective well-being that can indicate mental health in different cultures and settings[25]. The SUBI is designed to measure "feelings of well-being or ill-being as experienced by an individual or a group of individuals in various day-to-day life concerns"[26]. The GHQ score showed that half of the older persons carry some form of psychological distress. Mental health status also worsened with advancing age indicating higher mental health vulnerabilities among the oldest old. Mental health issues were higher for women, those who were poor and less educated. The scores based on SUBI also indicated similar results such as poorer mental health status for women, those who live in rural areas and those who were older among the elderly. Overall, health related vulnerabilities are high in old age. The acute and chronic diseases increase with age and the cost of treatment imposes a significant burden in the absence of health insurance or social security.

## 2.3.5 Disability

With the increase in age, disability becomes a major concern, seriously limiting functioning in daily life and hence increasing the care-giving burden. According to the 2011 census, the disability rate was 51.8 per 1,000 for the elderly and 84.1 per 1,000 for

**The cost of the health care during old age appears to be very high and this in turn increases the out of pocket expenditure on health care particularly when private facilities are availed of. When older persons are economically dependent, increasing health expenditure adds to the economic burden on the family.**

22  Ibid, 15
23  Arokiasamy, P., David Bloom, Jinkook Lee, Kevin Feeney, and Marija Ozolins (2012), "Longitudinal Aging Study in India: Vision, Design, Implementation, and Preliminary Findings", in National Research Council (2012), Aging in Asia: Findings from New and Emerging Data Initiatives, National Academies Press, Washington, DC.
24  Arokiasamy, P., Sulabha Parasuraman, T. V. Sekher, H. Lhungdim (2013), Study on Global Ageing and Adult Health (SAGE) Wave 1: India National Report, International Institute for Population Sciences, Mumbai
25  Goldberg, D.P. and B Blackwell (1970). "Psychiatric illness in general practice. A detailed study using a new method of case identification". British Medical Journal, Vol.1, pp: 439–43
26  Sell, H. and Nagpal R. (1992), "Assessment of Subjective Well-Being: The Subjective Well-Being Inventory", Regional Health Paper, SEARO, No. 24, World Health Organization, Regional Office for South-East Asia, New Delhi.

the 80-plus population as compared to 22.1 per 1,000 of the general population[27]. 80-plus women have higher levels of disability as compared to elderly men indicating greater disadvantages (Figure 2.8).

The census collects information on disabilities relating to visual, speech, hearing, mobility and mental health. The prevalence of mobility and vision-related disabilities are high among both men and women. Visual disabilities are more common among the elderly women while mobility disabilities are higher for elderly men. Around 4 percent of the elderly men and women also suffer from disabilities with respect to mental health (Figure 2.9).

The BKPAI survey data on the use of disability aids such as spectacles, hearing aids, and walking sticks shows that there is significant unmet need among the older persons. For example only 53 percent of the older persons with visual disabilities are using spectacles and only 5 percent of the elderly with hearing difficulties use hearing aids. The use of disability aids is also lower for elderly women indicating higher unmet need amongst them.

## 2.3.6 Activities of Daily Living

Vulnerability among older persons increases with the declining functional abilities. Activities of Daily Living (ADL) are the basic tasks of everyday life such as feeding, bathing, dressing, mobility, use of the toilet and continence and when older persons are not able to perform these activities, they require assistance. ADL limitations are indicative of the care burden in any society. Figure 2.10 shows that ADL limitations are more for

### Figure 2.8. Incidence of Disability per 1,000 Persons (by age and sex), 2011
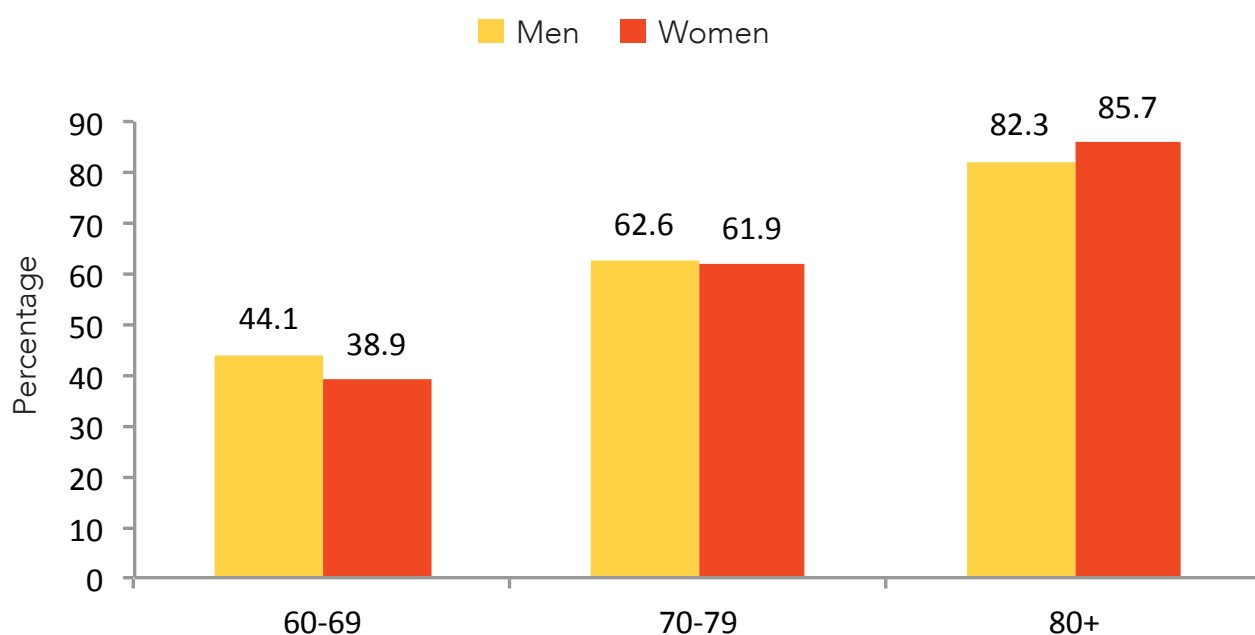
Source: ORGI (2011), Census of India, 2011, Office of the Registrar General and the Census Commissioner of India, Ministry of Home Affairs, Government of India. http://www.censusindia.gov.in/2011-common/census_2011.html

27  ORGI (2011), Census of India, 2011, Office of the Registrar General and the Census Commissioner of India, Ministry of Home Affairs, Government of India, New Delhi. www.censusindia.gov.in.

older women than men with 9 percent of the older women and 6 percent of the older men needing assistance with at least one activity. This indicates a high care burden considering the sheer number of the older persons in the country. Among the activities, highest proportion of the elderly faces some difficulty in bathing, followed by going to the toilet, dressing and mobility. Among all the ADL activities difficulty is higher for elderly women than men indicating higher vulnerability for women. Similarly, limitations with ADL also increase with age.

## 2.3.7 Elder Abuse

Elder abuse refers to any intentional or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult. Abuse of older persons is considered a global public health problem, seriously impairing the well-being of the elderly. Old, vulnerable and frail persons, dependent on others for their daily needs, are routinely abused, neglected, and exploited world wide and India is no exception. The perpetrators are generally family members, relatives, friends, or trusted caregivers. Pan-India information on elder abuse is limited. The BKPAI survey conducted in 2011 collected information on elder abuse from seven states of India. HelpAge India in 2014 also conducted asurvey on elder abuse in select urban centres of the country.The results of the study by Help Age India, published in 2015, showed that about half of the elderly population in the country face some form of abuse, more in case of women than men[28].

Figure 2.9. Multiple Disabilities among Elderly Men and Women, 2011
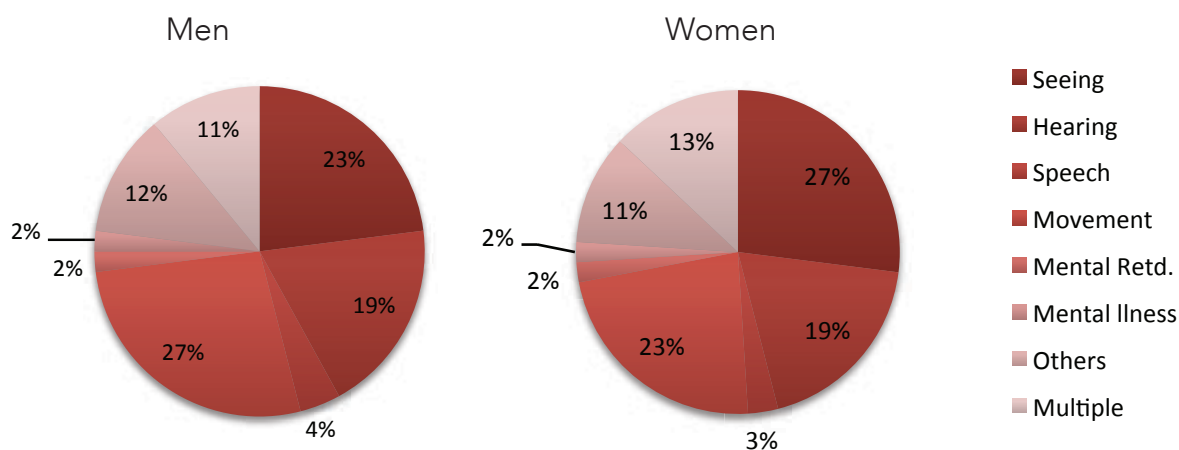


Source: ORGI (2011), Census of India, 2011, Office of the Registrar General and the Census Commissioner of India, Ministry of Home Affairs, Government of India..http://www.censusindia.gov.in/2011-common/census_2011.html

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28  HelpAge India (2015), Elder Abuse in India, HelpAge India, New Delhi.

## Figure 2.10. Need for Full/Partial Assistance in ADL by Sex and Age, 2011
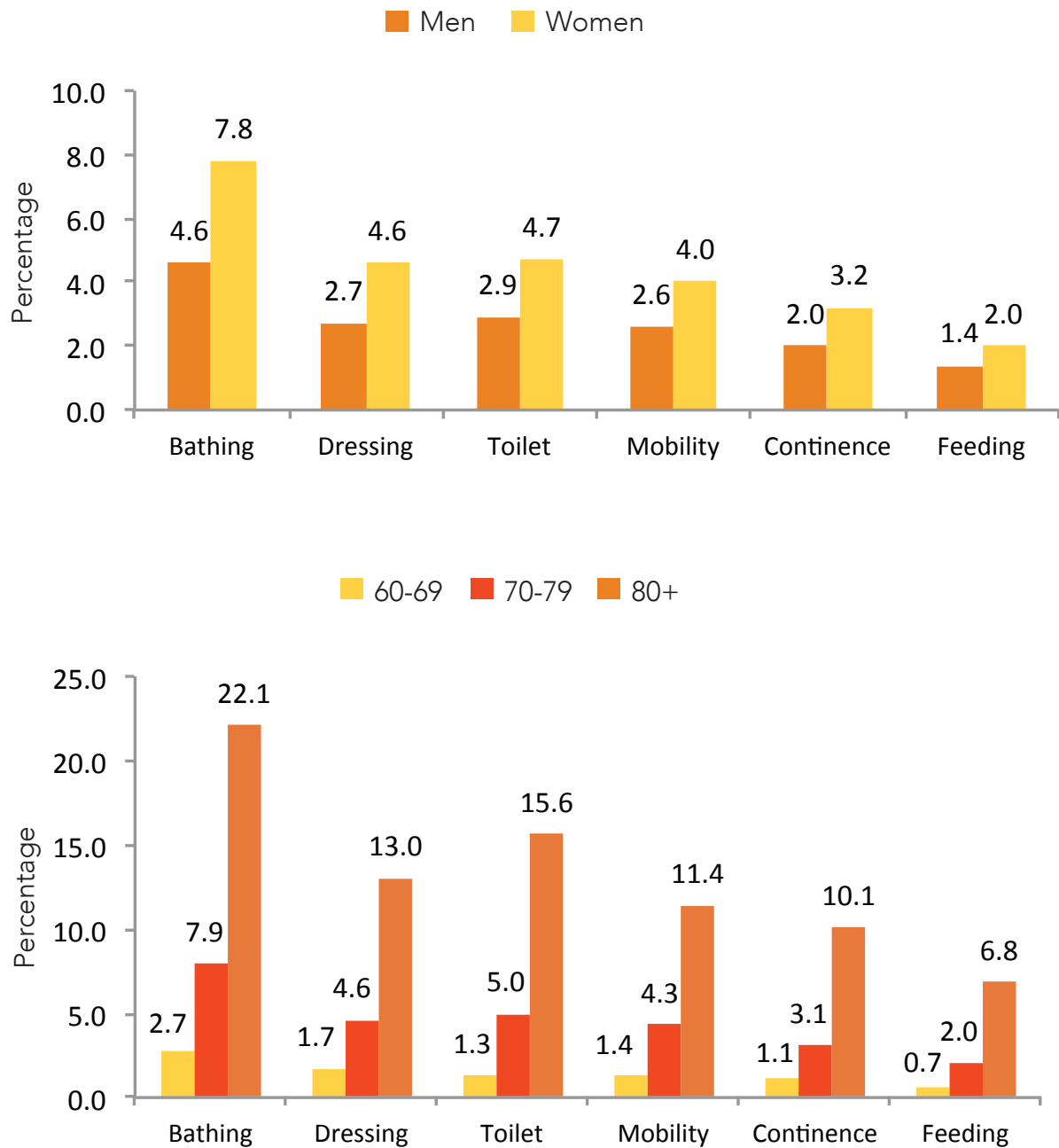
■ Men  ■ Women



| | Bathing | Dressing | Toilet | Mobility | Continence | Feeding |
|---|---|---|---|---|---|---|
| Men | 4.6 | 2.7 | 2.9 | 2.6 | 2.0 | 1.4 |
| Women | 7.8 | 4.6 | 4.7 | 4.0 | 3.2 | 2.0 |

■ 60-69  ■ 70-79  ■ 80+



| | Bathing | Dressing | Toilet | Mobility | Continence | Feeding |
|---|---|---|---|---|---|---|
| 60-69 | 2.7 | 1.7 | 1.3 | 1.4 | 1.1 | 0.7 |
| 70-79 | 7.9 | 4.6 | 5.0 | 4.3 | 3.1 | 2.0 |
| 80+ | 22.1 | 13.0 | 15.6 | 11.4 | 10.1 | 6.8 |

Source: Alam, et al - (2012), "Report on the Status of Elderly in Select States of India 2011", Building a Knowledge-base on Population Ageing in India, United Nations Population Fund, New Delhi

Verbal abuse, disrespect and neglect were the common forms of abuse generally perpetrated by the daughter-in-law and the son. However, the data from BKPAI indicated a lower proportion (11 percent) of elder abuse. While these are not comparable data sets, the levels of abuse reported show that elder abuse is prevalent and that it is an issue that requires further attention. BKPAI data showed that in general, abuse was more toward elderly who lived alone and had low levels of education and poor economic status. Here, the major perpetrators were family members and neighbours.

## 2.4 Some Key Gender Concerns

Gender disparities exist at all ages but when women become old, the consequences of engendered roles become more explicit. Poverty is inherently gendered in old age when older women are more likely to be widowed, living alone, with no income and with fewer assets of their own and fully dependent on family for support. The BKPAI survey shows that households headed by older women are poorer than those headed by older men. Far fewer older women than men accrue personal income or assets and financial dependency among older women is at a much higher level. While living alone is more common among older women than among older men, it is equally true that majority of older women

live with children / grand children and they seem to better accept and cope with such realities of ageing. Detailed research on economic, social and health concerns of older women has been undertaken and published under the BKPAI initiative[29].

As per the BKPAI survey, many older women rate their health as poor and experience relatively low mental health status. One in five older women rated her health to be poor. More than half of all older women indicate signs of mental distress according to measures of subjective well-being. They also carry higher burden of both acute and chronic morbidity than their male counterparts. Yet, among those who report having an ailment, the vast majority seek treatment from private and public sources. In general the reasons for not seeking treatment include financial problems and inadequacy or lack of access to public health facilities. Awareness and use of the Rashtriya Swasthya Bima Yojna (RSBY) or the health insurance programme offered by the government among older women is negligible.

Income insecurity is a significant source of vulnerability among older women. More than four out of five women have either no personal income at all or very little income; income insecurity increases with advancing age. Only a small percentage of older women reporting

**Income insecurity is a significant source of vulnerability among older women. More than four out of five women have either no personal income at all or very little income; income insecurity increases with advancing age. Only a small percentage of older women reporting no income actually receive a social pension.**

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29  Giridhar. G, Lekha Subaiya and Supriya Verma (2015), "Older Women in India: Economic, Social and Health Concerns", Thematic Paper No. 2, Building Knowledge-base on Population Ageing in India, Institute for Social and Economic Change, Bangalore, United Nations Population Fund, New Delhi and Institute of Economic Growth, Delhi.

no income actually receive a social pension. Economic dependency among older women is therefore high. One third of older women do not own any assets. But more widowed women own assets compared to married women because assets are generally owned by the husband but after his death they are passed on to his widow. Only a third of widowed women receive social pension. Among the poor, awareness of social pension schemes is higher among elderly men than women in both urban and rural areas. The same is true of the many special facilities made available by the government for older persons. The accentuated economic vulnerability and poverty of older widowed women is found across all survey states.

Loss of spouse is a significant new vulnerability during the ageing process. More women experience this type of vulnerability as they live longer than men. Many older women live without their spouse and experience a shift in living arrangements in old age. One in ten women over the age of 60 years lives alone and many widowed women have rare contact with their non-co-residing children. In general, living with family, particularly the son, is the most common arrangement among older women. But they are forced to work out a new care receiving environment with children and daughters-in-law that can put them through greater stress. What is positive is that about 70 percent of older women perceive having some role in family decision-making. Further, many are active in various activities such as prayer, yoga, household chores,

## Figure 2.11. Elderly from BPL Households Utilizing National Social Security Schemes in Selected States, 2011
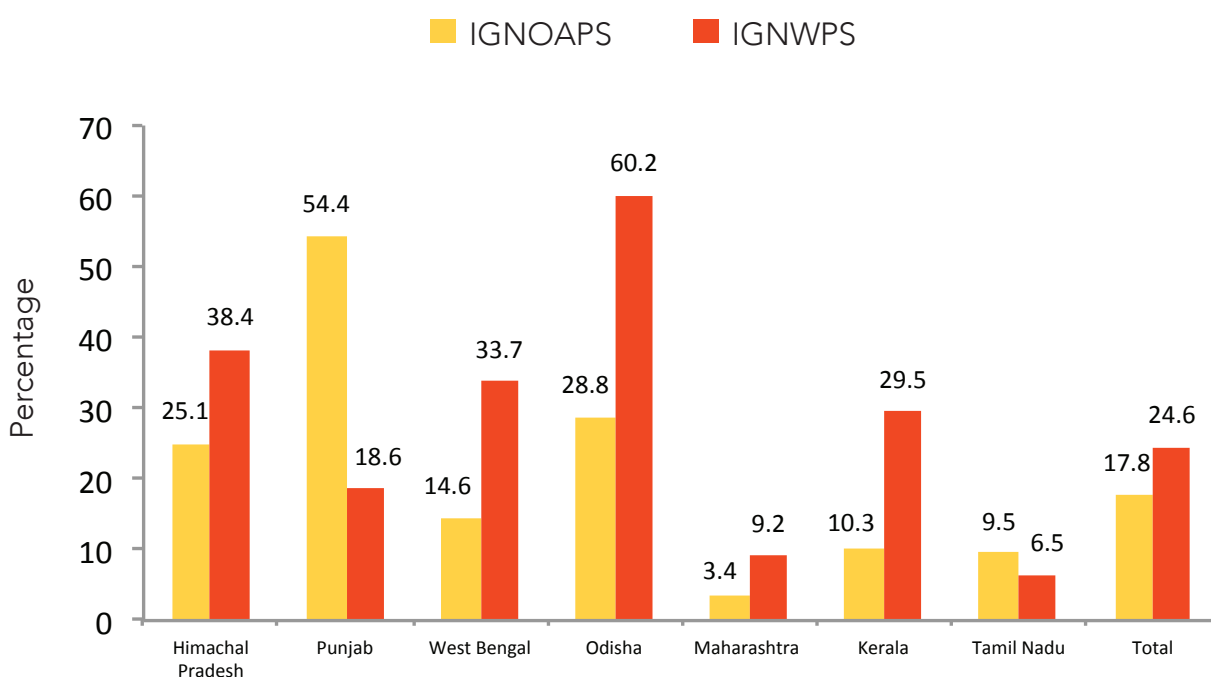


Note: IGNOAPS Indira Gandhi National Old Age Pension Scheme; IGNWPS Indira Gandhi National Widow Pension Scheme, which is only for women
Source: Alam, et al (2012), "Report on the Status of Elderly in Select States of India 2011", Building a Knowledge-base on Population Ageing in India, United Nations Population Fund, New Delhi

taking care of grand children etc. Their social networking outside home is also reasonable, albeit limited to religious activities, visiting family or chatting with neighbours. Over a third of older women having some personal income feel that they are making useful contributions to family expenditure. This is an important aspect of ageing with dignity.

Ageing among women is accompanied by low work participation, low earnings and high economic need. Poverty drives over 10 percent of older women to work, largely in informal sectors with low wages, no retirement or post-work benefits. Work participation rate differs significantly between married men (41 percent) and widowers (24 percent) but there is no such decline for older women suggesting that higher economic need for widowed older women to work even after death of their spouse.

## 2.5 Some Key Concerns about the Reach of Social Security Schemes

Over the years the Government of India has launched various schemes and policies for older persons which are meant to promote health, well-being and independence of senior citizens. The National Policy for Older Persons (NPOP) was formulated in 1999 to promote health, safety and social security of older persons. Several government ministries are involved with providing benefits to senior citizens. The Ministry of Social Justice and Empowerment (MOSJE), Ministry of Health and Family Welfare (MOHFW) and Ministry of Rural Development (MORD) implement many of these schemes such as the Integrated Programme for Older Persons (IPOP), National Programme for the Health Care of the Elderly (NPHCE), National Old Age Pension schemes and Annapurna scheme etc. The Ministry of Labour and Employment implements the RSBY, Ministry of Finance provides some special tax concessions and Ministry of Railways offers special concessions for

senior citizens. The approach paper for the Twelfth Five Year Plan (2012–2017) recommends special health care for the elderly along with pension and insurance reform to enhance the quality of life in later years. While there are many such schemes, how far are the senior citizens aware of them and actually use them? The BKPAI survey shows that about 70 percent are aware of the national old age pension scheme and the widow pension schemes and awareness level is higher in rural areas (than in urban areas); non-BPL elderly have a slightly higher level of awareness than BPL elderly (the real target group). Elderly men are more aware of these schemes than elderly women. But actual use seems low with only a quarter of widowed elderly women benefitting from the widow pension scheme; only about 18 percent of all elderly are accessing old-age pensions (Figure 2.11). Both awareness about and use of Annapurna scheme is low. About 10 percent and 15 percent of non-BPL elderly persons were beneficiaries of old-age pension scheme and widow pension scheme respectively. But in general, there is a higher utilization of these schemes in rural areas than in urban areas.

Similar low levels of awareness and utilization was found in the case of railway concessions and seat reservations for elderly in buses. Maharashtra was the only state where about one in four elderly are using these facilities. There is also much work to be done in increasing awareness and coverage of health insurance schemes, especially RSBY[30].

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30 Ibid, 15

# 3

# India's Policy and Programme Response to Ageing

# India's Policy and Programme Response to Ageing

## 3.1 National Policy on Older Persons: The Context

Enhancing human welfare through social services such as education, health, housing and income security is usually the main aim of social policy. Formulation of such social policy is generally within a governmental public policy mandate. Analysis of public policy requires a full understanding of the problem that the policy is addressing, its causes and consequences. This chapter is on the National Policy on Older Persons (NPOP)[31]. There are four features of our ageing society that have influenced the national policy response in India (see Chapter 1):

(i) feminization of ageing reflected in the sex ratio of the 60-plus population which according to the Census of India 2011 was 1,033 women per 1,000 men[32]; older women face adverse socio-economic differentials in terms of incomes streams, health care and care-giving in daily living which increases their vulnerability; (ii) ruralization of ageing reflected in the fact that 71 percent of the elderly live in rural India where service delivery already faces many challenges; (iii) increasing 80-plus population; oldest of the old is the fastest growing age segment, often called the ageing of the aged; (iv) an increasing population of solo-living persons after loss of spouse increasing the vulnerability of poor older women with no personal income. As longevity increases, and "70 becomes the new 60", the policy response to ageing must address the significant age-related health care needs of all senior ages[33].

The NPOP in India has been formulated as a forward-looking vision of the government for improving quality of life of older people in India through increased income security, health and nutrition, shelter, education, empowerment and welfare. The policy makes it clear that it is neither feasible nor desirable for the state alone to attain the

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31  MOSJE (1999), National Policy on Older Persons, 1999, Ministry of Social Justice and Empowerment, Government of India, New Delhi. Available online at: http://socialjustice.nic.in/writereaddata/UploadFile/National%20Policy%20for%20Older%20Persons%20Year%201999.pdf

32  ORGI (2011), Census of India, 2011, Office of the Registrar General and the Census Commissioner of India, Ministry of Home Affairs, Government of India, New Delhi. www.censusindia.gov.in.

33  WHO (2015), World Report on Ageing and Health, World Health Organization, Geneva.

policy objectives. Individuals, families, communities and institutions of civil society and private sector have to join hands as partners. The policy views the life cycle as a continuum, of which the post-60 phase of life is an integral part. It does not view the age 60 as the beginning of a life of dependency. At the same time, the policy emphasizes the need for developing a formal and informal social support system, and strengthening the capacity of families to take care of older persons so that elderly continue to live with their family. It aims to strengthen integration between generations and develop a bond between the young and the old and facilitate two-way flows and interactions. It calls for special attention towards older women who often become victims of triple neglect and discrimination on account of widowhood, old age and gender biases. The policy encourages research on ageing as well as introduction of courses on geriatric care in medical and paramedical institutions.

There is an early recognition of population ageing concerns in India at the policy level both in terms of (i) demographic consequences (such as increasing numbers and proportions of older persons, shrinking support base, disparities in ageing across regions, oldest old being the fastest growing population segment, feminization of ageing etc.) and also (ii) the quality of life of older persons (in terms of income insecurity, distinct health care needs of the elderly, high degree of dependency, inadequate recognition of elderly contribution to family and community). India's active participation in many UN sponsored global and regional assemblies and conferences on ageing and more specifically the formulation of NPOP in June 1999, two years ahead of the landmark UN sponsored Madrid International Plan of Action (MIPAA) in 2001 are tangible examples in this context[34]. Judging from the appropriate policy interventions relevant to the situation of older persons in India, it is clear that a sound situation analysis must have preceded the NPOP formulation in 1999. It is also likely that the MIPAA has benefitted from some highlights of the NPOP.

## 3.2 National Policy on Older Persons: Implementation

The mandate for coordinating NPOP implementation across several ministries of the government lies with the nodal Ministry of Social Justice and Empowerment (MOSJE). The ministry's mandate includes welfare, social justice and empowerment of disadvantaged and marginalized sections such as scheduled castes (SCs), backward classes (OBCs), persons with disabilities, aged persons, transgender people as also users of drugs and those who need to beg for sustenance. The main objective of MOSJE is to bring the target groups into the mainstream of development by making them self-reliant and empowered (as evident from the name of the Ministry) through its Department of Social Justice and Empowerment and the Department of Empowerment of Persons with Disabilities. The Results Framework Document (RFD) of 2014/15 of MOSJE articulates five elements of its vision: (i) social empowerment of scheduled castes (weight 50); (ii) social empowerment of other backward castes (weight 20); (iii) senior citizens (weight 7); (iv) alcoholics (weight 6); and (v) transgender people and those who beg for sustenance (weight 2). The weights indicate the relative priority accorded to the vulnerable group by the ministry within its overall mandate. According to the above RFD, the senior citizens mandate is one among five objectives but receives much less priority and attention than social empowerment of SCs and OBCs. MOSJE pulled together various elements of NPOP under the National Initiative on Care of Elderly (NICE).

The four activity clusters included in the RFD under the senior citizens mandate are: (i) Integrated Programme for Older Persons (IPOP); (ii) national awards for senior citizens; (iii) revisions of IPOP (revised in 2008 and 2015) and (iv) formulation of new draft policy on senior citizens and submission to cabinet for approval.

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34  MIPAA (2001). The Madrid International Plan of Action on Ageing, UN Second World Assembly on Ageing, Madrid, 2001. www.un.org/en/events/pastevents/pdfs/Madrid_plan.pdf

As many as 19 different ministries of government are involved in implementing various NPOP components, according to their respective mandates (Annexe 3.1). However, four ministries may be considered core as they are responsible for a large and important chunk of services to older persons. These are:

- Ministry of Social Justice and Empowerment (MOSJE) is responsible for coordination across ministries and also for implementing the central sector IPOP with the objective of improving the quality of life of senior citizens by providing basic amenities like shelter, food, medical care and entertainment activities and by encouraging productive and active ageing. MOSJE also took the lead in the Maintenance Act, an important legislation and is responsible for its effective implementation[35].

- Ministry of Health and Family Welfare (MOHFW) is responsible for implementing the National Programme for Health Care of Elderly (NPHCE) through primary, secondary and tertiary services, dedicated for older persons.

- Ministry of Rural Development (MORD) administers the National Social Assistance Programme (NSAP) under which old-age pensions and family benefits are provided to BPL families.

- Ministry of Panchayati Raj (MOPR) is responsible for empowerment, enablement and accountability of Panchayati Raj Institutions (PRIs) to ensure inclusive development with social justice and efficient delivery of services and participatory self-governance. Under the Sansad Adarsh Gram Yojana (SAGY), each Member of Parliament has to adopt

a Panchayat and work towards convergence of various programmes to improve quality of life in rural areas. When implemented, this scheme will help rural elderly in many direct and indirect ways.

Further, the NPOP envisaged two autonomous bodies (i) the National Council for Older Persons (NCOP) to promote the concerns of older persons and to oversee the policy implementation; and (ii) the National Association of Older Persons (NAOP) to encourage participation of senior citizens in issues that concern them and to lend an attentive ear to their voices. The policy also emphasizes the role of Panchayats and other community-based agencies in effective implementation of policy intentions. Although the onus of implementing several facets of NPOP lies with different ministries, there are clear connections between them. This offers a scope for mainstreaming elderly issues in sector-specific plans as well as to enable their convergence at the community level for more efficient and effective delivery of age care services.

Four special schemes/ programmes with complementary objectives within the overall vision of the NPOP are covered below. These are: (i) Maintenance Act 2007; (ii) IPOP; (iii) NPHCE; and (iv) National Social Assistance Programme. In addition, the NPOP gives importance to the empowerment of PRIs as a key aspect for improving the quality of life of the elderly.

## 3.2.1 Maintenance Act 2007

The MOSJE championed the landmark legislation called the Maintenance and Welfare of Parents and Senior Citizens 2007, (henceforth referred as

**The main objective of MOSJE is to bring the target groups into the mainstream of development by making them self-reliant and empowered.**

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35  Maintenance and Welfare of Parents and Senior Citizens Act, 2007 is a legislation enacted in 2007, initiated by Ministry of Social Justice and Empowerment, Government of India, to provide more effective maintenance and welfare of parents and senior citizens.

the Maintenance Act) to provide a legal framework in support of the elderly. Parents and grandparents who are unable to maintain themselves from their own income can demand maintenance from their children, inclusive of food, clothing, residence, medical attendance and treatment, to a maximum of ₹ 10,000 per month. The Act provides for a tribunal to receive and take action on complaints. In case the children themselves do not have sufficient means to maintain them, the state governments are expected to provide old-age homes in each district to accommodate a minimum of 150 elderly. An important provision under the Act legally empowers the elderly to claim their property back from their children if the condition of maintenance is not satisfied. The state is responsible for setting up tribunals and no civil court will have jurisdiction on any matters of this Act. Sensitization of police and judiciary on protection of life and property of the elderly and other provisions of this Act is also the responsibility of the state.

The effective implementation of this Act is however, left to the states due to which there is uneven and unsatisfactory implementation[36]. Availability of old-age homes for destitute older persons as well as provision for geriatric care, care units and other concessions in government-aided hospitals as per the Act are also problem areas. There have been no campaigns to educate the elderly or deter adult children from neglecting their parents; such campaigns are necessary to create social pressure for implementing provisions of the Act. The survey shows that awareness among dependent elderly about the NPOP in general and the Act in particular is quite poor. The handful of cases brought to the tribunals demonstrates the poor reach and utilization of this Act. To review the provisions of this Act, its implementation experience and its effect on senior citizens, the MOSJE has recently set up a committee consisting of experts in these areas.

## 3.2.2 Integrated Programme for Older Persons

From 1992, much ahead of the 1999 NPOP, the MOSJE has been implementing the Integrated Programme for Older Persons (IPOP) with the objective of improving the quality of life of senior citizens by providing basic amenities like shelter, food, medical care and entertainment opportunities and by encouraging productive and active ageing. The IPOP provides financial assistance (up to 90 percent) to PRIs/local bodies, NGOs, educational institutions, charitable hospitals/nursing homes etc. for implementing a variety of facilities such as old-age homes, mobile medical units for older persons living in rural and isolated areas, day care centres, physiotherapy clinics, provision of disability aids, running helplines and counselling centres and sensitization of school and college students to ageing issues. Although all these are essential ingredients of NPOP, it must be recognized that the effectiveness of the IPOP depends to a large extent on states for supporting financial security, health care, shelter, welfare and other needs of older persons.

With the introduction of the Maintenance Act 2007, the state governments were expected to establish and maintain old-age homes, initially at least one in each district for 150 older persons. Subsequently, the IPOP got revised in 2008. However, studies indicate that the rapid growth of old-age homes resulted in significant variation with respect to intake capacity, type of accommodation, staffing patterns and financial source and ability. Some homes located away from the city had significant differences in type of building and cost of accommodation[37]. In 2014, the Standing Committee on Social Justice and Empowerment reviewed IPOP implementation and recommended standardization of old-age homes and preparation of guidelines for state-run old age homes to ensure the maintenance of strict minimum standards. Following the Standing Committee

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36  HelpAge India (2014), State of Elderly in India, HelpAge India, New Delhi, https://www.helpageindia.org/images/pdf/state-elderly-india-2014.pdf
37  Ramdas  Gambhir (work in progress), A Study of Old-age homes: Assessment of Quality of Services and Suggestions for Improvement, incomplete draft, study commissioned by United Nations Population Fund, 2016.

recommendations of 2014, the Government of Tamil Nadu, issued a Gazette notification in February 2016 fixing Minimum Standards in Old-age Homes. This may also encourage other states to announce similar standards as demand for institutional care seems to be increasing. The IPOP support for old-age homes, day care centres and mobile medical units combined with the Maintenance Act 2007 represents public policy response to the emerging ageing scenario in India. Apart from old-age homes, IPOP also supports eight Regional Resource and Training Centres (RRTCs) as lead NGOs located in different regions of the country in order to develop capacity of community-based NGOs for training of caregivers, awareness generation amongst older persons and caregivers on self-care, preventive health care, healthy and productive ageing, intergenerational bonding etc. Under IPOP the MOSJE also supports formation of senior citizen associations. Although the approach of working through RRTCs is most appropriate, managing the large number of NGOs to which grants-in-aid is provided under IPOP (around 550 and expected to increase to over 700 across the country) implies heavy administrative work load, leaving little time for more strategic thinking on enhancing policy effectiveness. MOSJE along with the erstwhile Planning Commission also supported an initiative for building government–NGO partnerships to foster transparency, efficiency and accountability towards inclusive growth.

## 3.2.3 Health care for Older Persons

The health care programme for the elderly is being implemented by the MOHFW from 2011 under the National Rural Health Mission (NRHM). The National Programme of Health Care for Elderly (NPHCE) aims to provide dedicated health care facilities to the elderly through primary, secondary and tertiary health care delivery systems consisting of district hospitals with regional medical institutions providing a strong referral backup. For this purpose, the programme builds capacity of the medical and paramedical professionals as well as family-based caretakers for providing health care to the elderly. It is meant to be implemented in convergence with the National Health Mission, Ministry of AYUSH[38] and the MOSJE. It provides for supplies and additional staff at primary health centres (PHCs) and community health centres (CHCs), delicated 10-bedded wards at district hospitals, strengthening of the eight regional medical institutes to provide dedicated tertiary-level medical facilities for the elderly, introducing postgraduate courses in Geriatric Medicine, and in-service training of health personnel at all levels. Regional geriatric centres with dedicated geriatric out-patients' departments and 30-bedded geriatric wards are planned with necessary equipment such as video conferencing facility etc. Clearly, NPHCE is a very substantive contribution from MOHFW towards health goals of elderly formulated in NPOP as well as the Maintenance Act 2007.

NPHCE functions under the control, coordination and monitoring and supervision of the national, state and district cells for non-communicable diseases (NCD). An exploratory study[39] in two districts each in Odisha and Karnataka based on programme implementation, fund release and utilization, physical infrastructure development, human resources, planning and monitoring systems

**Following the Standing Committee recommendations of 2014, the Government of Tamil Nadu, issued a Gazette notification in February 2016 fixing Minimum Standards in Old-age Homes. This may encourage other states to announce similar standards as demand for institutional care seems to be increasing.**

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38  The Ministry of AYUSH was formed on 9 November 2014 to ensure the optimal development and propagation of AYUSH systems of health care through education and research in Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy.

39  Bhat T.N., K. S. James and G. Giridhar (2014), "An Appraisal of the Functioning of the National Programme for the Health Care of the Elderly (NPHCE) in Karnataka and Odisha", Working Paper 7, Series II, Building a Knowledge-base on Population Ageing in India, Institute for Social and Economic Change, Bangalore, United Nations Population Fund, and Institute of Economic Growth, Delhi.

showed the real health needs being addressed by NPHCE and its value for health care of older persons but found some key bottlenecks in implementation that need to be addressed. It is through the field realities of such schemes for the elderly that national policy intentions will ultimately come alive.

## 3.2.4 Social Pensions

The National Social Assistance Programme (NSAP) was launched in 1995 to provide social assistance to the poor and the destitute. Initially the programme included the National Old Age Pension Scheme (NOAPS), National Family Benefit Scheme (NFBS), and National Maternity Benefit Scheme (NMBS). In the event of death of a household breadwinner (in the 18–60 years age group), the NFBS will give the bereaved family a lump sum assistance of ₹ 20,000 per breadwinner deceased.

The Annapurna Yojana got added to the NFBS in 2000 while the NMBS was transferred to the Department of Family Welfare. The Annapurna Yojana aims to provide food security to meet the requirement of those senior citizens who, though eligible, have remained outside the old-age pension scheme. It provides 10 kg of free rice every month to each beneficiary. In 2007, the old-age pension scheme was renamed Indira Gandhi National Old Age Pension Scheme (IGNOAPS) and covered all families below the poverty line (BPL). Subsequently in 2009, NSAP was expanded to include the Indira Gandhi National Widow Pension Scheme (IGNWPS) covering widows aged 40–64 years, and the Indira Gandhi National Disability Pension Scheme (IGNDPS) for persons with multiple or severe disabilities aged 18–64 years living below poverty line. In 2011, the age limit for IGNOAPS was lowered from 65 to 60 years and monthly pension amount for those 80 years and above was increased from ₹ 200 to ₹ 500. Age limits for IGNWPS and IGNDPS were changed to 40–79 years and 18–79 years respectively and amount increased from ₹ 200 to ₹ 300 per month.

The pension amount varies across states; while the central share remains ₹ 200, states top it up with varying amounts. The scheme needs some improvements: mode of pension delivery should be made easier; regularity of pension payments should also be improved; and when the pension is deposited in pensioner's account, he/she should be notified.

The 2013 Task Force to review and suggest more comprehensive social assistance has recommended further increase of monthly pension and expansion of coverage. Some of the recommendations are:

- Increase IGNOAPS from ₹ 200– ₹ 300 per month.
- Reduce minimum age requirement for IGNWPS from 40 years to 18 years.
- Revise eligibility criteria for IGNWPS to include divorced/separated/abandoned women.
- Provide assistance in the event of the death of any adult member (and not just male members) to the bereaved family under NFBS.
- Index pension amounts to inflation.
- Identify beneficiaries proactively without demanding elaborate documentary proof.

The MORD released revised programme guidelines for NSAP in October 2014, reflecting many of the above suggestions made by the Task Force.

The Building a Knowledge-base for Population Ageing in India (BKPAI)[40] survey in seven states, showed that among the BPL households the overall awareness of these social security schemes is reasonably high (close to 70 percent), although awareness level (i) was generally higher among older men than older women; and (ii) generally decreased with age. The problem however is with the utilization of these schemes by BPL elderly (17–20 percent only) with significant interstate variations. The utilization of the widow pension scheme even among BPL widows is only around 25 percent. These findings indicate administrative access hurdles that need to be removed by state governments with active support from PRIs.

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40 The United Nations Population Fund (UNFPA), India in collaboration with the Institute for Social and Economic Change (ISEC), Bangalore, the Institute for Economic Growth (IEG), New Delhi and the Tata Institute of Social Sciences (TISS), Mumbai launched a research project, Building Knowledge-base on Population Ageing in India (BKPAI) in 2011. A primary survey was carried out in seven states – Himachal Pradesh, Punjab, West Bengal, Odisha, Maharashtra, Kerala and Tamil Nadu which covered a total of 9852 elderly women and men from 8329 elderly households in rural and urban areas. http://www.isec.ac.in/prc-AginginIndia-Data-Release.html

## 3.2.5 Building Effective PRIs

The vision of decentralized and participatory self-governance is a long standing one in India. Empowerment, enablement and accountability of PRIs to ensure inclusive development with social justice and efficient delivery of services is the core mission of the MOPR. This involves the development of strong PRIs through capacity building of elected representatives and other officials. This also includes developing participatory planning processes involving the people, the PRIs and the District Planning Committees for convergence of a large number of schemes and pooling of resources from many sources for better outcomes. The NPOP also emphasizes the importance of PRIs in creating better access to schemes as well as for improved quality of life of senior citizens in rural areas. The MOPR therefore needs to work with several other ministries for effective implementation of the Panchayat Extension to Scheduled Areas Act of 1996. One among them is the MORD which is responsible for social pensions covered above.

As covered in Chapter 7 of this report, the SAGY launched in October 2014, creates an excellent opportunity to catalyse active involvement of PRIs as they help various government schemes at the village level to converge and create an overall effect that is more than the sum of effects of individual schemes. Convergence of state and central initiatives, as well as private and voluntary initiatives to achieve more comprehensive development in line with people's aspirations and local potential is one of the key approaches of the model (Adarsh) village. Active involvement of the Member of Parliament of the area under which the village falls, combined with

a strong PRI will be essential for the concept of convergence to work for the benefit of elderly.

## 3.2.6 Issues in NPOP Implementation

Over the last 15 years of NPOP implementation, many initiatives have been taken and some of the existing benefits such as pension schemes and old-age home initiatives have been brought together under one policy for older persons. Some new initiatives such as the NPHCE are also being implemented as dedicated health care initiatives for the elderly. While the policy intentions are very appropriate for the current situation, many implementation issues have somewhat dampened policy effectiveness[41].

For example, the NPHCE does address many health concerns of elderly (such as increasing incidence of NCDs) which demand the strengthening and reorientation of the primary health care system to the special needs of the elderly, improving geriatric care at all levels, promoting concept of healthy ageing and encouraging greater NGO involvement in service delivery. But these are essentially supply side intentions and do not answer demand-related questions—to what extent are the elderly able to actually access these services and what is their feed-back on the quantity and quality of care.

Another example could be the NSAP which enhances income security through social pensions, but the amounts are inadequate and their disbursement process complex. The interministerial committee to coordinate NPOP implementation and monitor its progress could not establish a strong presence.

**The vision of decentralized and participatory self-governance is a long standing one in India. Empowerment, enablement and accountability of PRIs to ensure inclusive development with social justice and efficient delivery of services is the core mission of the MOPR.**

41  S. Irudaya Rajan and U.S. Mishra (2014), "The National Policy for Older Persons: Critical Issues in Implementation", in G. Giridhar, K. M. Sathyanarayana, Sanjay Kumar, K. S. James, and Moneer Alam (edited), Population Ageing in India, Cambridge University Press, New Delhi.

Similarly, state level Directorates of Older Persons for coordination and monitoring did not show uniform achievements across states.

## 3.3 National Policy for Senior Citizens

After about ten years of NPOP implementation, the government formally set up a committee for review and revision. The draft revised National Policy for Senior Citizens (NPSC) was submitted in 2011 but still awaits cabinet approval. NPSC also follows a rights perspective and calls for special attention on elderly women and rural poor. It identifies income security as a key intervention as more than two thirds of elderly live below poverty line. Hence the draft policy recommends a monthly pension of ₹ 1,000 per person to be revised periodically for inflation adjustment. It also calls for expanded implementation of NPHCE and lays specific emphasis on support for productive ageing. In terms of implementation mechanism, the draft NPSC proposes establishment of a Department of Senior Citizens at the MOSJE and corresponding Directorates in states and union territories. Similarly, National Commission for Senior Citizens at the centre and similar commissions at the state level are proposed as laid down in the NPOP. At the community level, the draft calls for active involvement of Block Development Officers and Panchayats, urban councils or Gram Sabhas in the implementation of NPSC. The NPSC has not yet been officially adopted, although some recommendations are being implemented.

## 3.4 Efforts to Enhance Policy Implementation

### 3.4.1 Capacity Development

Almost all initiatives of the government under NPOP involved capacity development of human resources and infrastructure resources. As mentioned earlier, the NPHCE is meant to create a dedicated healthcare capacity for the elderly through primary, secondary and tertiary healthcare delivery by providing additional beds in district hospitals and regional medical institutions. The programme further provides for capacity development of medical and paramedical professionals and family-based caregivers in dedicated health care for the elderly. Both long-term and short-term geriatric training courses are also sponsored by the government.

The MOSJE has promoted systematic capacity development efforts to enhance policy implementation. These are at three levels: (i) at the national level by developing the National Institute of Social Defence (NISD) as a Centre of Excellence; (ii) at the regional level through RRTCs identified and supported as lead NGOs; and (iii) community-based NGOs which are involved in directly providing elder care services.

### National Institute of Social Defence

The National Institute of Social Defence or NISD is an autonomous institute set up in 1961 under the Ministry of Home Affairs but attached to MOSJE since 1975. It acquired autonomous status in 2002 and was mandated to work for the welfare of senior citizens, in addition to a few other areas of social defence such as prevention of drug use, prevention of begging, and addressing the issues of the transgender community. The shift in emphasis from social welfare to empowerment of disadvantaged communities is a very significant aspect of the evolution of NISD.

With a focus on capacity development necessary for effective implementation of MOSJE initiatives, NISD is responsible for research, training, building community awareness and facilitating knowledge exchange through seminars and workshops. The institute also advises state and central governments on social defence issues, and functions as a forum for exchange of information on social defence

among states, union territories and voluntary organizations and serves as a clearing house in the field of social defence. NISD is also responsible for establishing liaisons with universities, research institutions and voluntary agencies and bringing out professional publications. Under the National Initiative on Care for Elderly (NICE), NISD contributes to improved care for the elderly through awareness creation, targeted interventions and capacity development of other relevant stakeholders. Towards this end, NISD undertakes the development of a cadre of geriatric caregivers in the family and community for the welfare of older persons. It also helps in identifying and promoting support systems and networking for care of older persons and facilitates convergence of services from government and other sources for better impact.

Specifically, the courses under the NICE initiative are:

- A one-year postgraduate diploma course to develop quality geriatric care personnel
- A two-month certificate course on geriatric bedside assistance and care-giving
- A one-month certificate course in geriatric care for voluntary agencies
- Dementia-care programmes and workshops as also conferences for schools and colleges
- A one-day sensitization programme on bridging intergenerational gap covering a large number of school children, counsellors, parents and grandparents

NISD fully depends on grants-in-aid from MOSJE that has adverse implications for decisions on staffing patterns, flexible recruitment and an effective performance appraisal mechanism appropriate for its autonomous status. NISD plays a crucial role in capacity development of a large number of community-based NGOs which receive funds from MOSJE towards the implementation of various elements of NPOP.

At the request of MOSJE, UNFPA conducted a management study in September 2015 to suggest management actions needed to transform NISD into a Centre of Excellence[42]. The study indicated important priorities like recruitment and retention of competent staff, staff development and motivation, monitoring of progress and impact assessment. Quality assurance mechanisms of all NISD functions are necessary to develop it into a Centre of Excellence.

## Regional Resource Training Centres

For improved policy implementation, the MOSJE identified several well-performing and larger NGOs and designated them as RRTCs, which are lead NGOs at the regional level for capacity development. RRTCs are expected to play the role of collaborating partners for ensuring effective implementation of the policies and programmes of the MOSJE. Broadly, the mandate of RRTCs for age care includes training and capacity building for effective delivery of age care services by the NGOs funded by the MOSJE. They also need to interface with state government, local bodies, schools and colleges, senior citizens forums etc. for building linkages and networking aimed at improved care of the elderly. With funding from the MOSJE, RRTCs also conduct short-term vocational training, other courses on geriatric care, other regional workshops as required by the MOSJE, and interface with students and senior citizens. NISD has the mandate to develop capacity of eight RRTCs in age care across the country. These RRTCs in turn are mandated to build the capacities of community-based NGOs which receive funds from MOSJE for delivering various services to the elderly at the community level.

**The draft NPSC also follows a rights perspective and calls for special attention on elderly women and rural poor. It identifies income security as a key intervention as more than two thirds of elderly live below poverty line.**

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42  UNFPA (2015), Management Study of the National Institute of Social Defence, United Nations Population Fund, New Delhi.

## Community-based grantee

With financial support under IPOP, these NGOs train village-based caregivers, generate awareness among the elderly (and caregivers) on self-care, healthy and productive ageing, intergenerational bonding etc. The RRTCs work through the community-based grantee NGOs and ensure that the planned policy objectives are achieved. Monitoring the work of these NGOs and providing necessary support and corrective measures are the responsibility of the RRTCs.

## 3.4.2 Emphasis on Active Ageing

The Age Watch Index 2015 ranks 96 countries covering 91 percent of the world's population aged 60 years and over[43]. One of the four elements of the index is health status (the others being: income security, capability and enabling environment). India ranks 71 on this index (behind Sri Lanka, Bangladesh and Nepal). Rank of health status for India is particularly low—lowest in South Asia barring Afghanistan. Prepared at a time when the UN was finalizing Sustainable Development Goals (SDGs), it is good to see a new health SDG in the final list of 17 SDGs. SDG-3 closely related to healthy ageing states: "To ensure healthy lives and promote well-being for all at all ages through universal health coverage including financial risk protection".

The theme of the World Health Day 2012 was Ageing and Health with a tagline good health adds life to years. WHO's contribution to developing regional strategies for healthy ageing and encouraging healthy ageing initiatives in member states has been significant. WHO has suggested a Regional Strategy for Healthy Ageing (2013–2018) which seeks to promote care of older persons through life-course approach[44]. The strategy considers age-friendly primary health care as the corner stone of healthy ageing when NCDs become more prevalent among older persons. Ageing is among the major contributory factors to the rising incidence and prevalence of NCDs which in turn

are leading causes of preventable morbidity and disability. Participation of the elderly in economic and social activities is also seen necessary for their overall well-being. Hence policies and programmes that recognize and support the contribution of older men and women, gender equity and special attention to older women who often face greater vulnerability due to life-course experiences are essential elements of healthy ageing.

In the most recent World Health Assembly, WHO offered a multisectoral action for life course approach to healthy ageing and suggested a global strategy and plan of action on ageing and health[45]. Healthy ageing is viewed as a process that spans the entire life course and that can be relevant to everyone, not just those who are currently free of disease. The five proposed strategies are:

- Commitment to action on healthy ageing in every country
- Developing age-friendly environments
- Aligning health systems to the needs of older populations
- Developing sustainable and equitable systems for providing long-term care (through home, communities and institutions)
- Improving measurement, monitoring and research on healthy ageing.

Broadly, healthy ageing would require establishment of a national framework for healthy ageing, which unfortunately is not emphasized in the new health policy in India. Among other things, the WHO strategy also calls for developing an age-friendly environment and fostering of autonomy of older persons, including financial resources and opportunities available for them. There is a need to enhance their engagement in decisions so that they are not left as just as passive recipients of welfare. Finally, WHO stresses on aligning health systems around the needs of older persons, particularly for long-term care. Measurement, monitoring and research for healthy ageing are also part of the strategy.

43  HelpAge International Global Network (2015), Global Health Watch Index 2015: Insight Report, 2015. http://www.helpage.org/global-agewatch/reports/global-agewatch-index-2015-insight-report-summary-and-methodology/
44  WHO (2014), Regional Strategy for Healthy Ageing (2013–18). http://www.searo.who.int/entity/healthy_ageing/documents/regional-strategy-2013-2018.pdf?ua=1
45  WHO (2016), Multisectoral Action for Life Course Approach to Healthy Ageing: Global Strategy and Plan of Action on Ageing and Health, World Health Assembly, April 2016.

The NPHCE in India addresses many aspects of the WHO strategy, particularly the ones relating to developing appropriate human resources for meeting the health needs of older persons with required upgrading of knowledge and skills of medical and para-medical personnel. Further, NPOP is based on a multisectoral approach and partnership involving social welfare, finance, health, education, urban planning etc. While good in terms of design and policy intent, implementation of this national programme needs attention.

## 3.4.3 Leveraging the Corporate Sector

Corporate social responsibility is not a new concept in India. However, the Ministry of Corporate Affairs, Government of India has recently notified the Section 135 of the Companies Act, 2013 along with Companies (Corporate Social Responsibility Policy) Rules, 2014 called the CSR Rules. The CSR policy recognizes that CSR is not merely about compliance; it is a commitment to support initiatives that measurably improve the lives of underprivileged by one or more of the focus areas under Section 135 of the Companies Act 2013 and Companies (Corporate Social Responsibility Policy) Rules 2014. Initially the areas of attention under CSR were largely fashioned around the eight MDGs that did not include any reference to support for senior citizens. While the list of possible areas of support is long, the following have more direct relevance to senior citizens:

• Eradicating hunger, poverty and malnutrition, promoting preventive health care, sanitation and safe drinking water
• Promoting education, including employment enhancing vocational skills especially among children, women, elderly and other livelihood enhancement projects
• Promoting gender equality, setting up homes and hostels for women and orphans, setting up old-age

homes, day care centres and such other facilities for senior citizens and measures for reducing inequalities faced by socially and economically backward groups
• Ensuring environmental sustainability, ecological balance, protection of flora and fauna, animal welfare, agro forestry, conservation of natural resources and maintaining quality of soil, air and water.

All activities under the CSR should be environment friendly and socially acceptable to the local people and society.

The Tata Institute of Social Sciences, Mumbai hosts the CSR Hub with the basic aim of supporting CSR initiatives of public sector enterprises (PSEs) for better targeting of benefits to the poor and the marginalized. Some of the key areas of intervention include: strengthening of PRIs in planning and implementation of local development initiatives; enhancing quality of education with adequate attention to the education of girl children; addressing key health issues such as maternal health; and improving access and utilization of health services, food and nutrition issues and income security. All these activities entail strong involvement of the community. The CSR Hub aims to facilitate a more integrated CSR support by providing common strategic directions at regional level and help public enterprises achieve greater impact. Various development indices at the local and regional levels (district, village, ward) linked to the key areas of action are also part of the Hub actions for creation of a socially responsible business environment. In doing so, the Hub will facilitate convergence among policies and programmes supported by different stakeholders (government, NGOs, peoples groups and networks, PSEs and private sector) to create better impact.

There is a significant need for capacity development among PSEs, partners and civil society organizations (CSOs) to focus more on results rather than only on resources spent or activities carried out. More emphasis on programme planning, implementation, monitoring and evaluation skills would be required. For this purpose, a system of empanelment of NGOs, research and management training institutions is being carried out. Community participation in planning, monitoring and evaluation and impact assessment continues to be the overall emphasis of all these activities.

## 3.5 Recent Initiatives Relevant to NPOP

### 3.5.1 Pradhan Mantri Suraksha Bima Yojana

This scheme gives a one year (June–May) accidental death and disability cover, renewable every year. The scheme is offered/administered through Public Sector General Insurance Companies (PSGICs) and other General Insurance Companies (GICs) willing to offer the product. All savings bank account holders 18–70 years old can join the scheme. It offers a coverage of ₹ 200,000 for death or total and irrevocable loss of both eyes and ₹ 100,000 coverage for the loss of an eye or a limb. The premium is ₹ 12 per annum per member, deductible directly from the bank account of the member. The policy however is terminated on the attainment of age 70 years and/or closure of bank account or insufficiency of balance to keep the insurance in force. The scheme which started in June 2015 will be monitored on a yearly basis to review the experience and make mid-course corrections. While the scheme has very affordable premium rates, some experts feel that the benefit is too low for middle income persons.

### 3.5.2 Atal Pension Yojana

The economic compulsion to work even in later years in the unorganized sector with no pension benefits is commonly associated with income insecurity in old age. The government started the Swavalamban Scheme in 2010/11 which was replaced by the Atal Pension Yojana (APY) in June 2015 for those persons engaged in the unorganized sector, who are not members of any statutory social security scheme. APY is administered by the Pension Fund Regulatory and Development Authority. Under the APY, the subscribers would receive the fixed pension of ₹ 1,000 – ₹ 5,000 per month from the age of 60 years onward, depending on their contribution, which would vary with the age of joining the APY. The minimum age of joining APY is 18 years and maximum age is 40 years. Therefore, the period of contribution by the subscriber under APY would be 20 years or more. The government would also co-contribute 50 percent of the subscriber's contribution or ₹ 1,000 per annum, whichever is lower,to each eligible subscriber account, for a period of five years, that is, from 2015/16 to 2019/20. The existing subscribers of Swavalamban Scheme would be automatically migrated to APY, unless they opt out. The contribution levels would vary and would be low if subscriber joins early and increase if he/she joins late. For example, to get a fixed monthly pension in the range ₹ 1,000 – ₹ 5,000, the subscriber has to make a monthly contribution of ₹ 42 – ₹ 210, if he joins at the age of 18 years. For the same fixed pension levels, the contribution would range between ₹ 291 and ₹ 1,454, if the subscriber joins at the age of 40 years. Holding a bank account is mandatory for joining APY with auto-debit facility.

### 3.5.3 Health Insurance for Senior Citizens

This is seen as a logical extension of the ongoing low premium life insurance (Pradhan Mantri Jeevan Jyoti Bima Yojana), general insurance (Pradhan Mantri Suraksha Bima Yojana), and the pension plan (Atal Pension Yojana). It is proposed to utilize around ₹ 100 billion of unclaimed funds under the Employees Provident Fund Organization (EPFO) and small savings for providing health insurance cover to the elderly.  It is proposed to implement this through the Department of Financial Services of the Ministry of Finance. It is proposed to link this to bank accounts of beneficiaries to directly transfer the subsidy to the accounts. The government would subsidize the premium for BPL elderly by up to 90 percent through direct benefit transfer.

### 3.5.4 Varishtha Pension Bima Yojana 2017

This scheme is a part of the government's commitment to financial inclusion and social security during old age and to protect those aged 60 years and above against a future fall in their interest income due to uncertain market conditions. The scheme will provide an assured pension based on a guaranteed rate of return of 8 percent per annum for 10 years, with an option to opt for pension on a monthly / quarterly / half yearly and annual basis.The scheme will be implemented through the Life Insurance Corporation

of India (LIC). The differential return, that is, the difference between the return generated by LIC and the assured return of 8 percent per annum would be borne by Government of India as subsidy on an annual basis. The scheme is proposed to be open for subscription for a period of one year from the date of launch.

### 3.5.5  Scheme for providing Aids and Assisted Living Devices to Senior Citizens below Poverty Line

A scheme for providing Physical Aids and Assisted Living Devices for Senior Citizens belonging to BPL category has been approved by the Hon'ble Minister of Social Justice and Empowerment. The scheme aims at providing senior citizens, belonging to the BPL category and suffering from any age-related disability/infirmity, such as low vision, hearing impairment, loss of teeth and locomotor disability. The assistive devices to be provided shall be of high quality and conforming to the standards laid down by the Bureau of Indian Standards. Initially, the scheme will be launched in two districts each of all States as well as in two districts of NCT of Delhi, and in one district each of the remaining 6 Union Territories. In the subsequent years, it will be implemented in four districts each in twenty larger States; two districts each in the remaining nine States and also in NCT Delhi and in one district each in the other six Union Territories (Annual Report, 2016-2017, MoSJE).

**The economic compulsion to work even in later years in the unorganized sector with no pension benefits is commonly associated with income insecurity in old age.  The government started the Swavalamban Scheme in 2010/11 which was replaced by the Atal Pension Yojana (APY) in June 2015 for those persons engaged in the unorganized sector.**

## 3.5.6 Senior Citizens Welfare Fund

In pursuance of the announcement made in the Budget Speech of Finance Minister – 2015-16, a Senior Citizens' Welfare Fund was established in March 2016. The fund consists of the unclaimed amounts transferred by government institutions holding such funds. This will be utilized for schemes for senior citizen welfare schemes, in line with the National Policy on Older Persons and the National Policy for Senior Citizens, including schemes for promoting financial security of senior citizens, healthcare and nutrition of senior citizens, welfare of elderly widows, schemes relating to old-age homes, day care centres, etc. The fund will be administered by an Inter-Ministerial Committee, with the Ministry of Social Justice and Empowerment as the nodal ministry for administration of the fund (Annual Report, 2016-2017, MoSJE).

## 3.5.7 South Asia Partnership on Ageing: The Kathmandu Declaration 2016

A regional body called South Asia Senior Citizens' Working Group has been established at the workshop on South Asia Senior Citizens' in Nepal July 2016 on the basis of a 36-point Kathmandu Declaration signed during the 18th SAARC Summit meeting in 2014 with focus on the special needs of the elderly population in the region.

The working group also reaffirms commitments to the Older Peoples' Rights enshrined in the Vienna International Plan of Action on Ageing, the United Nations Principles for Older Persons, the Madrid International Plan of Action on Ageing, 2002; General Recommendation number 27 of the CEDAW Convention on the Protection of Human Rights of Older Women (adopted in 2010) and Sustainable Development Goals, aiming to leave no one behind in order to create an inclusive society for all by 2030. The working group aims to work closely with the respective governments, NGOs and civil society

members of the region in order to improve the well-being of the ageing population. South Asia Senior Citizens' Working Group will recognize, promote and protect human rights of older people as manifested in the policies, programmes and legal instruments for senior citizens in the South Asia region.

The newly established regional body will also maintain close liaison with the global network, which helps older people claim their rights, challenge discrimination and overcome poverty so that they can lead dignified, secure, active and healthy lives and act jointly as a pressure group for an UN Convention on the Rights of Older Persons.

# ANNEXURE

## Annex 3.1

List of Ministries/ Department of The Inter-Ministerial Committee Implementing Indian National Policies On Older Persons

1. Ministry of Social Justice and Empowerment
2. Ministry of Health and Family Welfare
3. Ministry of Finance
4. Ministry of Rural Development and Employment
5. Ministry of Urban Affairs and Employment
6. Ministry of Human Resource Development
7. Ministry of Labour
8. Ministry of Personnel, Public Grievances and Pensions
9. Ministry of Law Justice and Company Affairs
10. Ministry of Home Affairs
11. Ministry of Information and Broadcasting
12. Ministry of Communication
13. Ministry of Railways
14. Ministry of Agriculture
15. Ministry of Surface Transport
16. Ministry of Civil Aviation
17. Ministry of Petroleum and Natural Gas
18. Ministry of Food and Consumer Affairs
19. Ministry of External Affairs

# 4

# Mapping of Elder Care Services in India

# Mapping of Elder Care Services in India

## 4.1 Public Services in Elder Care

In the domain of public systems, there are two overarching initiatives that are (i) large in coverage; (ii) more comprehensive/integrated in design than many others; and (iii) backed by financial and administrative resources. They facilitate and create an environment for different kinds of elder services and have been referred in the previous chapter as enabling initiatives of the government: the National Programme for Health Care of the Elderly (NPHCE) and the Integrated Plan for Older Persons (IPOP).

### 4.1.1 National Programme for Health Care of the Elderly

NPHCE is meant to create a new architecture for the care of the elderly including (i) referral services through district hospitals and regional medical institutions; (ii) convergence with National Rural Health Mission (NRHM) and initiatives of the Ministry of Social Justice and Empowerment (MOSJE); and (c) promoting a community-based approach integrated with the existing primary health centres (PHCs) and capacity building. NPHCE provides for dedicated beds for the elderly and revision of health care curricula to support geriatric service packages at different levels, focussing on non-communicable diseases (NCDs). As briefly covered in Chapter 3, NPHCE invests in infrastructure and capacity development covering a large geographic area but does not focus sufficiently on home-based care of the elderly, awareness creation and other family support. As a result, the programme is not able to incentivize families to treat the elderly with dignity and provide adequate care. The programme adopts a centralized supply-oriented approach with little attention to decentralized demand-driven service delivery. Yet, NPHCE remains the single most comprehensive and dedicated programme for elderly health care in India.

Building on the inherent complementarity of the government and non-governmental sectors, the NPHCE develops the infrastructure which supports the community-based services of NGOs in elder care. Therefore, almost every elder care service provided by NGOs grows out of the NPHCE.

## 4.1.2 Integrated Plan for Older Persons

The Integrated Plan for Older Persons or the IPOP (covered briefly in Chapter 3) is the second such government initiative that does not provide services directly but enables NGOs whose strength lies in service delivery to provide them to senior citizens. This central government scheme implemented since 1992 supports provision of shelter, food, medical care and activities towards productive and active ageing. It also supports capacity development of government agencies and NGOs, Panchayati Raj Institutions (PRIs) and urban local bodies (ULBs) and the community. Finally, there are elements of strengthening of the family, awareness generation and promotion of the concept of lifelong productive ageing. In this sense, IPOP is an integrated design for improving services for the elderly.

After about 15 years of implementation, IPOP was reviewed in 2008 and augmented with additional elements of care for which the government will provide financial assistance. The plan now aims to support:

- Old-age homes for destitute older persons which are linked to the provisions of the Maintenance Act 2007;
- Mobile medicare units for older persons living in slums, rural and inaccessible areas where proper health facilities are not available; and
- Respite-care and continuous-care homes for older persons with health conditions that demand such care.

## 4.2 Elder Care Services in the Non-governmental Sector

There are four essential features of an integrated package of elder services: (i) affordable medical care at home; (ii) improved access to institutional health care while linking home-based care with institution-based services; (iii) training staff and family in home-based rehabilitation services; and (iv) greater integration of the elderly into the society, increasing the level of acceptance by fighting against ageism and continued enjoyment of home life. While NPHCE and IPOP address aspects related to institutional health care, the rest of the aspects are facilitated by NGOs all over the country with public and private funding. Below is a brief narration of 12 such NGO initiatives in India. The report admits that there are many other NGO initiatives in the country that must be included for a more complete coverage.

**NPHCE is meant to create a new architecture for the care of the elderly including referral services through district hospitals and regional medical institutions; convergence with National Rural Health Mission and initiatives of the Ministry of Social Justice and Empowerment and promoting a community-based approach integrated with the existing primary health centres and capacity building.**

## 4.2.1 Agewell Foundation[46]

Agewell Foundation, India has been working for the welfare and empowerment of older persons since 1999. It interfaces with over 25,000 older persons on daily basis through a two-tier network of primary and secondary volunteers spread across 640 districts of India. Agewell Foundation has a UN-ECOSOC consultative status and has contributed to different national plans through participation in various Working Groups and Steering Committees on the social sector. The Foundation seeks to strengthen intergenerational solidarity and better quality of life for the elderly through a range of services that includes: a helpline, an employment exchange for older persons, a research and advocacy centre, health care in old age, sensitization programme for school children, police personnel sensitization and training and the Agewell Handicraft Unit.

## 4.2.2 Alzheimer's and Related Disorders Society of India[47]

Alzheimer's and Related Disorders Society of India (ARDSI), established in 1992 is a national voluntary organization dedicated to the care, support and research on dementia. It is a member of Alzheimer's Disease International (ADI) of the UK. Its dedicated team of volunteers works across the country with a commitment to developing a society which is dementia friendly. ARDSI provides day care centres, respite care centres, memory clinics, training programmes in geriatric care, research and awareness campaigns on dementia. Some of the initiatives are listed below:

- The first of its kind, the Harmony Home Respite Care Centre was established in August 2005 at Kottapady, near Guruvayur, Kerala. The centre provides round the clock care to people with dementia with respite care service and day care service. Harmony centres established later in

other parts of the country also initiated long-term care as well as respite care services.

- The first day care centre established in Cochin in 1995 provides training to professionals and also guidance service to the caregivers. Home care service is also available for those who need regular care and supervision at home.
- The first memory clinic in India was set up in 1999 for evaluation and diagnostic purposes. Now there are nearly 100 memory clinics in various parts of India.
- ARDSI also organizes caregiver's meetings, individual and group counselling, lectures on various methods of care-giving and related issues.
- A 12-month certificate course in Community Geriatric Care Training recognized by Christian Medical Association of India, trains students with special focus in dementia care.
- A 10-month certificate course in care-giving recognized by the Rehabilitation Council of India is being conducted with the support from Help Age India. Each batch trains 20 students in various disability fields.
- In collaboration with the National Institute of Social Defence (NISD), an orientation training programme on dementia care for managers of old-age homes and a 6-month certificate course in geriatric care are being conducted.
- National conferences, seminars and workshops aimed at awareness creation through visual, audio and print media, commemoration of World Alzheimer's Day through ARDSI chapters, social work and setting up nursing colleges and courses are also noteworthy activities of ARDSI.
- Research studies on prevalence of dementia in rural and urban areas of Cochin and Thrissur districts of Kerala have been completed.

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46  http://www.agewellfoundation.org/
47  http://ardsi.org/ARDSIToday.aspx

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## 4.2.3 Calcutta Metropolitan Institute of Gerontology[48]

The Calcutta Metropolitan Institute of Gerontology (CMIG) was started in 1988 to promote research and create an actionable knowledge base to improve the living conditions of the large number of aged women in the city with no social security. CMIG initiated many services such as day care centres, provision of livelihood and a health care system based on mobile clinics in slum areas. The service package consisted on five main components:

* Community economic development
* Capacity building and social capital
* Community-based participation research
* Community empowerment
* Community participation

## 4.2.4 Ekal Nari Shakti Sangathan[49]

Ekal Nari Shakti Sangathan (ENSS) is an NGO established in 1999 that works for the welfare of widows and single women in both rural and urban Rajasthan who have been abandoned by their families. With 43,000 members at present, ENSS mobilizes the power of the collective to drive social and community reform. It engages directly with the state administration to address social and entitlement issues faced by its members and helps them claim their rights and lead a dignified life.

## 4.2.5 Guild for Services[50]

The Guild for Service, an NGO with UN-ECOSOC consultative status initiated in 1972, is dedicated to the economic, political and social empowerment of marginalized women and children affected by conflict situations, natural disasters and other crises. The Guild initiates, writes and presents papers on policy issues, reviews gender laws and gender impact of development projects and budgets. During

disasters it distributes essential supplies and runs refuge and empowerment centres for the crisis affected persons. Other activities include building of homes and care-giving services for the elderly, particularly women living alone. The Guild runs homes for women in distress, like the Raahat Ghar in Srinagar, and many other areas in north India. It functions through a combination of voluntary services and paid staff.

In collaboration with NISD, the Guild has recently taken the responsibility of running the geriatric training for marginalized girls in Ma-Dham, Vrindavan and Raahat Ghar, Srinagar. This training will provide a source of livelihood for the young girls and increase elderly care services in general. The Vrindavan centre offers a safe home for widowed women including food, shelter, clothing, medical aid and civic amenities.

## 4.2.6 HelpAge India[51]

HelpAge India is by far the largest and oldest NGO for the elderly in India providing a variety of services with significant coverage across the country. Its activities in 12 different areas are described briefly below:

**1. Mobile Health Services:** HelpAge India provides affordable and quality primary health care services to the elderly living in rural and remote areas. The mobile health unit (MHU) is a four-wheeler van, customized to carry medicines, consumables and equipment, stationed at designated locations on a regular basis (weekly or fortnightly) as per a fixed schedule. An MHU, staffed by a medical consultant, a pharmacist and social worker and a driver, covers 10 locations per week across morning and afternoon shifts. Each unit is equipped to provide primary health consultation, basic diagnostic services, free medicines, referrals to specialized health care providers and counselling services. The social worker also informs and educates the

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48 http://www.cmig.in/
49 Information accessed at http://www.streeshakti.com/Collection-Safe-Haven.aspx
50  http://www.guild.org.in/about-us.html
51  https://www.helpageindia.org/

community on preventive health care, hygiene and relevant government schemes.

**2. Gram Chikitsa Centres:** Health care workers and volunteers identified from within the community and trained in basic care of the elderly form the core of the Gram Chikitsa Centres. These centres are operated, monitored and managed by elderly self-help groups (ESHGs) which are described in detail further in the chapter. The costs including the fees of one visiting doctor are initially borne by HelpAge India. Eventually, the Gram Chikitsa Centres are expected to mature into self-funded institutions, fully managed by the ESHGs.

**3. Accredited clinics:** HelpAge will identify accredited clinics being run by existing local qualified medical practitioners to provide continued health services to supplement MHUs. There will be regular monitoring and structured reporting of such accredited clinics. Subsequently, the community is expected make the programme self-sustaining.

**4. Health camps:** Health camps are organized with the objective of diagnosis, treatment and referrals for general ailments, dental care, gynaecological conditions and ophthalmic care. The preventive health care programme aims at behavioural change and adoption of hygienic community habits.

**5. Geriatric physiotherapy:** This is a very successful programme of HelpAge India for rural and urban elderly with musculoskeletal diseases such as back pain, arthritis and even paralysis and other age-related mobility challenges. Open six days a week, the physiotherapy clinics are operational in 70 locations across 23 states. The services are provided to the elderly living at home, old-age homes, and those in remote areas through a combination of stationary clinics and mobile services.

**6. Cancer care:** HelpAge India also runs a cancer care charity for the elderly. Financial viability is one of the biggest challenges faced in providing sustained health care to needy elderly cancer patients. Even the most basic cancer treatment lasts for at least a year.

As the treatment schedule is prolonged and costs are high, many cancer patients drop out midway without completing the full treatment programme. In fact many elderly who are unable to put together the necessary funds for cancer treatment do not opt for treatment at all. HelpAge India has forged partnerships with a number of credible and competent cancer hospitals and organizations for carrying out cancer treatment including surgeries, radiation and chemotherapy. These partners also conduct cancer awareness and cancer detection camps and deliver quality cancer care for elders in need. HelpAge India supported cancer screening of about 25,000 elderly persons and treatment of over 10,000. It has worked with 38 hospitals and institutions in 12 states across the country with significant contribution from its funding sources.

**7. Cataract surgeries:** Over the last 30 years, Help Age India has supported a large number of cataract surgeries of the poor by partnering with nearly 400 eye hospitals, trusts, NGOs. Every year, more than 20,000 cataract surgeries are performed all over the country through credible and competent hospitals and eye care institutions. The project includes awareness generation in the community on eye care, prevention of eye diseases/infections, precautions to be taken during infections etc. Surgeries are performed only in base hospitals by qualified medical teams and not in make-shift camps. Eye camps staffed by competent technical personnel treat eye diseases, refer cases for surgeries, and undertake post-surgical follow up, reporting and documentation.

**8. Income generation:** HelpAge India supports income generation amongst the elderly by reviving and upgrading traditional crafts, cottage industries and animal husbandry units. Collectivization of the elderly leads to greater participation in individual and group-based income generating activities including small scale enterprises. These elderly collectives are involved in procuring raw materials,

managing the production process, and marketing the finished products through Apni Dukan (Our Own Shop) outlets, which are self-managed and self-sustained. Candle making in Bhopal and carpet weaving in Bhadoi are just two examples of many such small scale enterprises. Revolving loans facilitate these small enterprises to enable a life of dignity for many senior citizens.

## 9. Elderly self-help groups

a) In the areas covered by MHUs, community-based ESHGs serve as springboards for the Gram Chikitsa centres and accredited clinics within the 10 HelpAge sites.

b) ESHGs are provided with seed capital to develop sustainable livelihood options. The funds are invested in livelihoods assets like processing units, pump sets, agriculture equipment etc. Through ESHGs, the project actively strives to reach various government entitlements to the village elderly. Further, the project invests in imparting knowledge and skills to local volunteers and develops them as village-level para-professionals working towards the institutions of poor elderly.

c) ESHG experiences in Bihar and Tamil Nadu were covered in Chapter 5. A third project located in Vidarbha in Maharashtra was implemented to reduce the financial burden on aged women affected by farmers' suicides. In 2005, over 70 percent of such suicides in Maharashtra occurred in the Vidarbha region. HelpAge India, with its primary intervention aimed at providing short-term credit loans to farmer widows expanded its project to cover nine villages in the area. Project activities included microfinancing, training aimed at income generation, initiation of government schemes and health care through mobile medical camps. The ESHGs were able to reduce the debt burden on farmer widows, ensuring economic independence through sustainable livelihoods. Participation of women in small business activities increased, improving their self-confidence; farmer suicides in the area also reduced.

d) The role of HelpAge in ESHGs (covered in Chapter 5) has been identified as a good practice in collectivization of the rural elderly into a viable and sustainable group, supported by local and district federations.

**10. Elderly helpline:** A toll-free senior citizen helpline has been initiated by HelpAge to service queries of elders, provide information and address issues related to isolation, abuse and neglect. It offers assistance to older persons in need of care and protection. It links the elderly to services and resources for a longer-term solution to their problems. Information on medical assistance and emergency services, advice, guidance and counselling support, financial and legal advice are also provided by family counsellors and psychologists. The helpline also coordinates with the police, NGOs, government agencies, old-age homes and centres working for the older persons. HelpAge senior citizen helpline services operate from 23 locations across the country.

**11. Disaster response:** HelpAge India's disaster intervention activities include training and equipping of teams to bring swift and effective countermeasures during disasters. The HelpAge team carries its own tents, tarpaulins and cooking equipment, making no demand on local resources, which is a major relief factor during such emergencies. It also helps in setting up grain banks in small villages entrusted to the elderly in each village to operate. This contributes to a sense of solidarity in the community and respect for the elderly. During relief and rehabilitation phase, the project provides food, clothing and shelter. It raises donations, provides medical facilities and relief and has helped establish longer term rehabilitation projects in many states affected by natural disasters over the years.

**12.** In 2009, Helpage India produced and disseminated widely a revised edition of the Senior Citizens Guide that compiled information on various issues of relevance to the elderly such as legislative provisions, government schemes and private sector contributions.

## 4.2.7 Heritage Foundation[52]

The Sishrusha Health Management Trust formed in 1994 later came to be known as the Heritage Foundation with special focus on geriatric care. The Foundation aims to provide quality care services to the elderly at affordable prices. Some of the initiatives of the foundation are: training in bedside homecare assistance to the elderly, including nursing, diagnostics, physiotherapy, free health assessment by a multidisciplinary team of professionals, doctor on call and meal supply,courses on active and productive ageing, formation of self-help groups, computer literacy, neighbourhood watch and organizing events to draw public attention on elder care issues.

## 4.2.8 ILC's Elder Care Services[53]

The International Longevity Centre-India (ILC-I), established in 2003 has initiated many activities towards a healthy, productive and participatory life to the elderly, especially women in Pune. There are currently three projects—Aajibai Sathi Batwa, providing medical assistance to needy elderly women through sponsorship; Elders' Volunteers Bureau, a group of senior citizens working on a voluntary basis on various projects that give them financial independence while reducing their loneliness; and Athashri Housing project which are residential complexes built exclusively for the aged. ILC's successful and innovative projects have provided a platform for other NGOs to replicate and enhance them elsewhere.

## 4.2.9 Janaseva Foundation[54]

Janaseva Foundation, founded in January 1988, is a UN-accredited trust dedicated to the service of the elderly, the disabled, the disaster-stricken and the destitute. It began modestly by organizing health camps in rural Maharashtra and went on to set up a rural hospital and an old-age home. With a wide range of charitable projects to its credit, the

Foundation is headquartered in Pune, Maharashtra and recognized by Pune University.

## 4.2.10 Nightingale Medical Trust[55]

Dementia and active ageing initiatives of Nightingale Medical Trust (NMT), Bangalore are covered in some detail in Section 5.4.2. In addition to these initiatives, NMT runs three enrichment centres (with over 300 participants at present) with services that include health care, counselling, physiotherapy, fitness programmes, total day care and some recreational, cultural activities. A joint initiative with Bangalore City Corporation for poor elderly includes the above facilities plus income generation by the making of newspaper bags, candles and other products. All services, including midday meals are provided free of cost. Over 60 poor elders attend this facility regularly. NMT also provides vocational training and manages a free job portal (http://www.nightingalesjobs60plus.com) for senior citizens. Job fairs exclusively for senior citizens are organized. NMT also runs an Elders' Helpline in association with the Bangalore City Police and provides necessary follow up care and services.

## 4.2.11 Silver Innings Foundation[56]

Silver Innings (SI) is a for-profit social enterprise formed to provide need-based services to elderly. It started with the launched of a dedicated website for senior citizens (www.silverinnings.com) in April 2008 to provide one stop source for all the information related to "Graceful Ageing" and a platform for discussing issues regarding the elderly. The enterprise runs an assisted living elder care home in Mumbai, a Senior Citizens Helpline and is expecting to launch matrimonial services for 40-plus persons soon.

The Silver Innings Foundation (SIF) (a not-for-profit NGO) was also formed in July 2008 to work with 50-plus citizens and their family members to address both micro- and macro-issues of the elderly

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52  http://www.heritagefoundationindia.org/
53  http://ilcindia.org/53
54  http://janasevafoundation.org/
55  http://www.nightingaleseldercare.com/
56  www.silverinnings.com

tocreate an elder-friendly world. The SIF is engaged in multiple activities like: counselling, elder helpline, need-based services, advocacy & networking, research & development, training, lectures, workshops and conferences. It frequently organizes health camps / memory camps and Alzheimer's / dementia support group meetings. Various other activities like talent promotion, capacity building, social media and publications, internship and volunteer activities, and activities in intergenerational bonding are organized.

The specific service delivery initiatives are based in Mumbai and include a successful ageing centre, consultancy for old-age homes, day care centre, retirement township and dementia care.

## 4.2.12 Sulabh International: Services for Widows in Ashrams[57]

Sulabh International's work with the widows of Vrindavan started early in 2012 and has now spread to Varanasi, and Deoli, Uttarakhand. Vrindavan is home to large number of aged women, mostly widows, abandoned by their families. The living conditions are often poor with no health care or sustainable income. Sulabh International began by providing financial assistance to make these widows economically independent; later medical facilities such as ambulances, medicine and treatment support and some vocational training and a helpline for widows in need of assistance were also added. The project was implemented across eight ashrays (homes/ shelters), covering approximately 800 widows. As a result of this intervention, there is a marked difference in living conditions of these women. They live independently, work on various vocational projects and are more aware of their rights.

## 4.3 Services from Old-Age Institutions

There are many old-age homes in India but four Mumbai homes are showcased below for their good practices (see below).

|  | Shraddhanand Mahila Ashram | Our Lady Of Piety Home | Dignity Dementia Day Care Center | Ashadaan |
|---|---|---|---|---|
| Type of old-age home | Paid and unpaid residency with the responsibility of maintenance being shared by a trust | Unpaid with support from government and other local charities sponsors | Private, paid day care centre | Charity-based old-age home founded by Mother Teresa |
| Medical facilities | In-house nursing staff on internship basis; weekly and monthly check ups by local doctors; yearly check-ups by specialist | On-call physician; free-of cost treatment for minor ailments | Trained employees for dementia care; on call physician | Sisters trained in medical care; on call physicians |
| Domestic aide | Two full-time and two part-time domestic aides | One full-time domestic aide for menial and heavy chores; the women in the home cook for themselves on a regular basis | Food prepared by cooks hired on the basis of daily wages; eight volunteers to look after all other chores | Full-time aides along with residents who can work contributing according to a schedule |
| Vocational training and opportunities to earn | Staff often finds work for some of the residents to help them earn; basic computer training is encouraged | Residents permitted to seek work outside on both full-time and part-time basis |  |  |

## 4.4 Initiatives of the Government of Kerala[58]

### 4.4.1 Vayomithram

This scheme was implemented in 2011 to provide health care and support to elderly residents (65-plus) in the corporation/municipal areas. The project mainly provides free medicines through mobile clinics, palliative care and a help-desk to the old. Mobile medical units and helplines are also part of the project. The project is implemented in collaboration with the urban local bodies (municipalities). While Vayomithram supports all older persons it has a special focus on the needs of older women.

### 4.4.2 Aswasakiranam

This scheme provides financial support to bedridden and mentally challenged patients, their families and primary caregivers. A monthly assistance of ₹ 525 is being provided under the scheme to caregivers of all bedridden patients who need a full-time care. At present, about 49,000 beneficiaries are receiving assistance under the scheme of which about 40 percent are reported to be elderly. The scheme has reached out to a lot of elderly women.

### 4.4.3 Snehapoorvam

This is a new initiative that provides financial support to orphans or those who have lost one parent and are living with the support of their family. Aged grandparents who are often the caregivers receive financial assistance for the education of such children, ranging from ₹ 300 per month (for primary school goers) to ₹ 1000 per month (for undergrad students). In Kerala, since the rate of family disintegration is on the rise, the burden of childcare frequently falls on old women and hence this scheme has special significance for them.

### 4.4.4 Kerala Police Janamaithri Suraksha

The Kerala Police initiated the project in 2008 with 20 select police stations and it has now expanded to 248 stations across the 14 districts of the state. It is a unique concept of community policing whereby the state joins hands with the citizens in crime prevention. One of the components of this scheme is the protection of senior citizens. The police help to monitor the senior citizens by interacting with them on phone, visiting them regularly, organizing field visits and advising them on their personal problems. This one-to-one interaction with the police is especially beneficial for elderly women, since a large number of them are living alone and are unable to go to the police station to register their complaints. The scheme is relevant in the state where family and social security bonds are no longer as strong and old people, especially women, are plagued by feelings of insecurity and isolation.

## 4.5 Gradations of Eldercare Services: International Practices

Broadly there are two variants of family provided elder care, one in which elders continue to live where they are in their familiar environment but family members provide them assistance and the other in which elders move in with the family or relatives wherever that may be. Regardless of the location, the care could be skilled or custodial in nature. Skilled care can be given only by skilled or licensed medical personnel while custodial care (also called non-skilled care) includes help with activities of daily living, such as bathing, dressing and eating. Custodial care is typical for seniors with Alzheimer's or dementia. Both skilled and custodial care can be provided at home, in adult day care or in a residential care setting such as a nursing home, assisted living community or adult foster care home.

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57  http://www.sulabhinternational.org/sulabh-dons-the-mantle-of-good-samaritan-to-save-vrindavan-widows/
58  Source: Innovative Practices for Care of Elderly Women in India by Stree Shakti and UNFPA
(http://india.unfpa.org/publications/innovative-practices-care-elderly-women-india-stree-shakti)

The eight gradations of elder care services as practiced internationally are as follows:

**1. Telephone call assistance:** Regular calls are made to check on the elderly, including reminders to take medicines etc.

**2. Companion and/or caregivers:** A person coming in periodically to assist older persons with chores, shopping, housekeeping etc.

**3. Respite care providers:** In the absence of primary or family caregivers, short-term or emergency care givers stand-in to provide in-home care.

**4. Visiting nurses:** Trained nurses come home and provide a range of medical care, rehab and hospice services.

**5. Continuing care:** Continuing care retirement communities are developed with different housing options aligned to needs.

**6. Assisted living facilities:** These are congregate housing facilities that allow continued independence while providing some care, social stimulation and meals.

**7. Nursing homes:** Nursing homes provide full-time medical care, some activities, housekeeping etc.

**8. Hospice care:** This includes nursing and care for patients who are terminally ill. This could be either at home or in a hospice facility.

Palliative care focuses on relieving patients of their pain and suffering rather than curing or treating the underlying conditions.  Hospice care, on the other hand aims at treating terminally ill patients in the last weeks or months of their lives. While hospice very often includes palliative care, not all persons receiving palliative care are in hospice care.

# 5

## Good Practices in Elder Care and Support: Some Narratives

# Good Practices in Elder Care and Support: Some Narratives

This chapter presents key highlights of five initiatives in elder care to exemplify some civil society responses to ageing with community involvement and support. These documentations followed the suggestions made at a conference organized by UNFPA during 4–5 December 2014 on India's Elderly: Dignity, Health and Security. This chapter includes shorter versions of detailed reports on these five initiatives mentioned below:

- Elderly self-help groups (already mentioned in Chapter 4 under the initiatives of HelpAge India) help the members to achieve a degree of economic security, confidence and a feeling of self-worth.
- Kudumbashree is a community-based poverty reduction and women's empowerment initiative in Kerala with significant scope for direct and indirect benefits to the elderly.
- Kerala has also developed a powerful community based palliative care model mostly availed of by very old persons during final stages of their lives.
- Two complementary elder care service models related to "dementia care" and "elderly well-being and active ageing" deserve mention as these are services provided by NGOs and high light the scope for corporate partnerships through corporate social responsibility or CSR projects.
- Cooked food is available at heavily subsidized rates all across Tamil Nadu through kitchens run by the state government. This scheme has successfully addressed the critical challenge of food security of the elderly amongst the poor which constitutes an especially vulnerable group.

These five initiatives have been selected because they bring with them powerful lessons and models for replication in a bid to meet the challenges of population ageing.

## Figure 5.1. Formation and Functioning of ESHGs

**Elders come together to form an ESHG**

• 10-20 elders who are 55 years and above and living in the same tola/village

**Leaders are chosen to carry out day - to - day activities**

• President, Secretary and treasurer are elected from amongst members.

**Decision about monthly saving and regularity of meetings**

• ESHGs work on the principle of collective responsibility.

**ESHG carries out thrift and credit activities**

• ESHG members can loan money from the group at a certain rate of interest.

**Bank account for ESHG**

• Every ESHG must be graded in six month from the date of its formation. The local bank is approached to open an account for the ESHG name.

## 5.1 Elderly Self-help Groups[59]

### 5.1.1 Origin of ESHGs

Elderly self-help groups (ESHGs) evolved as an emergency response to the 2004 tsunami that had severely affected lives of elderly persons in Tamil Nadu, Kerala and other coastal areas. HelpAge India used the SHG model to help the elderly become bankable. This initiative led to the creation of ESHGs.

Since 2005 when the first ESHG was started, these groups have grown rapidly to over 6,710 in number with an impressive spread across the country including Bihar, West Bengal, Kerala, Odisha and Uttarakhand. The number of working ESHGs in Bihar and Tamil Nadu is significantly higher than in other states. North eastern Bihar experiences severe annual flooding of the Kosi River, affecting the lives of large poor populations including elderly men and women who are then able to fall back upon the ESHGs for sustenance and risk mitigation.

### 5.1.2 Evolution, Formation and Major Activities

ESHGs are community-managed collectives of the elderly aimed at improving their livelihoods and enabling them to become economically active through the disbursement of small loans and other required support. The elderly are not a homogenous group; their situations could range from the physically active to those who are partially disabled but mentally alert and semi-active to the very old, frail and fully dependent, including the destitute. ESHG rests on the concept that the third group needs support from the first and the second. Hence, ESHGs form "Elders for Elders" groups and extend support to meet their basic livelihood needs. Currently, an "Elders for Elders Foundation" has been established in Cuddalore district of Tamil Nadu for providing support to more than 500 disabled and destitute elderly with support from the state's ESHGs.

The formation of ESHGs espouses the view that the elderly are bankable and deserve financial support based on standard practices followed by the SHGs such as holding regular meetings, maintaining their minutes, general ledger, savings and credit ledger, individual passbooks, receipt and vouchers of every transaction and a separate bank account for each ESHG. Although started as a thrift and credit arrangement, ESHGs have broader objectives such as capacity development of their members, resolving livelihood and other major issues and helping them find community-based solutions, suggesting new schemes and participating in improved implementation, increasing awareness of rural elderly about different welfare schemes available from government and civil society organizations including NGOs and enhancing the dignity of the elderly.

An ESHG consists of 10–20 members of 55 years and above, the majority of whom are illiterate and from rural areas. ESHGs aim to inculcate thrift and savings habit amongst the elderly and to extend easy access to small credits to meet their critical needs (in some cases up to ₹ 50,000). The discussions and interviews undertaken in 2015/16 suggest that being part of such a thrift group enhances the overall well-being of the members while gradually enhancing their economic worth and security. Beyond immediate relief, ESHGs help their members gain a life of their own, helping them remain economically engaged, reduce dependency and regain their self-worth both within and outside the family (Figure 5.1).

## 5.1.3 Functioning of ESHGs

ESHG functionaries are selected from amongst the members and in most cases, ESHGs also form village and district federations to approach their local banks for capital (Figure 5.2). In order to provide microcredit, ESHGs generate their own resources and in addition borrow from their higher level federations when required.  During the initial years, funds were accessed from HelpAge India or from other external agencies such as the GIZ[60].  ESHGs have to follow a stringent procedure to reassure the federations of their financial viability.

The amount borrowed by members is generally decided on the basis of their need as well as maturity of groups. It also depends on the availability of funds in the group. The loans could range from petty amounts like ₹ 50 to meet urgent requirements

### Figure 5.2. Salient Features of ESHGs

Most members are illiterate

All accounts and records are maintained by members themselves

Every ESHG must have a bank account

No non - performing assets

Encourages fraternity among elders in village

Women - married, single, divorced or widowed - participate as members and functionaries

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60  GIZ (India) is the German Agency for International Cooperation and is working in India on various social issues. It has also been supporting the formation of ESHGs in Bihar since 2007.

to ₹ 20,000 or more to buy agricultural inputs depending upon the financial strength of the group. Sometimes borrowings from the ESHG are used to repay old loans taken from money lender at higher interest. The loans (principal and interest) are mostly paid within few weeks to few months depending upon the size of the loan. These payments are made by members themselves or their family from agricultural produce, daily wages, business earnings, etc. For the purpose of lending, ESHGs largely rely on members' contributions, accumulated savings and interest earnings.

The loan repayment experience in both Tamil Nadu and Bihar has been timely and hassle free, and without any incidence of bad loans. Since timely repayments pave the way for easier access to future credit and better creditworthiness of the members, they are generally keen to maintain a good repayment record. ESHG federations frequently avail of bank loans to onward lend to their member ESHGs at an interest of 1 percent per month or 12 percent per annum. ESHGs charge twice the interest rate charged by the federations, that is, 2 percent per month or 24 percent per annum, which compares favourably with the exorbitant rates that the members had to commit when previously they were forced to borrow from private money lenders. Money lenders in many villages are now facing competition from ESHGs.

## 5.1.4 Support for Old, Handicapped and Frail Members

The old members are supported by their families and co-members for required paper work. In many cases, the groups are advised to hold weekly meetings at the residence of incapacitated members to ensure their participation. In addition, some groups appoint a local youth as volunteer for documentation and record keeping who helps frail or immobilized old members with their paper work, which is mostly minimal.

## 5.1.5 Interface with the Banking System

As mandated, all ESHGs are linked with a nearby bank where they maintain a savings bank account. In some cases, banks do not fully cooperate with ESHGs because of their background or unorganized nature and because they do not form part of any government scheme. National Rural Livelihood Mission in Tamil Nadu has brought ESHGs under its umbrella but Bihar ESHGs are still not covered under the scheme.

## 5.1.6 Socio-economic Impact of ESHGs on the Elderly

### Economic well-being

The interviews and focus group discussions of the elderly indicated an improved sense of well-being in their lives after joining ESHGs. Specifically, joining ESHGs improved their perception of current and future income security and fostered a sense of independence. In the context of increasing cost of living and decreasing agricultural income, they were happy to be independent and not be a burden on their families or anybody else. Their contribution to family expenditure helped them retain their respect in the family. It also helped them stay active and engage in various economic activities depending upon their physical condition and family support. Both self-confidence and socio-filial respect reportedly improved considerably after they joined these groups. Elderly respondents attributed these gains to their ESHG membership.

They also proudly reported that they could now foot their own medical expenses and their grand-children's school fees; help run family businesses and buy agricultural equipment at the time of need. Some elders were also paying off old loans drawn from local money-lenders or making purchases of essential food items from fair price shops with the

loans made available by ESHGs. In some instances, ESHGs even supported non-members during emergencies.As the ESHGs enhance their presence, local self-government institutions (Panchayats) begin to take more interest in facilitating ESHG activities in the village. Panchayats have expanded the role of ESHGs from helping the elderly access old-age pension to assisting elderly access other social benefits provided in the area by the central and state governments. Panchayats now tend to perceive the elderly as important stakeholders in local politics.

## Social well-being

The various activities that ESHGs undertake for the welfare of its members and other marginalized groups in the village give the members an opportunity to actively participate in the larger social milieu by interacting with like-minded peers. They share a sense of belonging that makes them happy and gives them moral satisfaction. Overall, ESHGs have made significant contributions towards improving the quality of life of the elderly members and reducing anxiety, dissatisfaction and helplessness.

## 5.2 Kudumbashree

There are a number of government initiatives to create an enabling environment for women and children. As these initiatives do not always produce expected outcomes, the National Mission for Empowerment of Women was launched in 2010 to enhance convergence of various initiatives to drive synergistic outcomes. The practice of including a Gender Budgeting Statement (GBS) was also started as part of the Union Budget 2010. Though this increased allocations that directly benefit women and children, many initiatives suffered due to lack of local flexibility and implementation bottlenecks. There was also a degree of incongruence between programmes and people's problems and needs.

In response to this concern, Kerala launched the Kudumbashree (Family Prosperity) based on the premise that women's empowerment is essential, particularly in poorer rural areas. Kudumbashree expects to reach out to the families through the women; and reach out to the community through the family.

The Kudumbashree community organization is built around a three-tier system. First tier is a Neighbourhood Group (NHG) formed with 10–20 women from poor families in the same neighbourhood, called Ayalkoottam in Malayalam. The second tier is an Area Development Society (ADS) which is a federation of NHGs within a ward of the local self-government (LSG). The third tier is the Community Development Society (CDS), which is a registered society as federation of ADSs within the LSG (Figure 5.3).

Figure 5.3. Functional Structure of the Kudumbashree Community Organization

**NHG**
- Community Health Volunteer, Income generation activities volunteer
- Infrastructure Volunteer
- Secretary
- 10-20 members of the poor families from neighbourhood

**ADS**
- General Body – consists of all presidents and secretaries of federation NHGs
- Governing Body – constituted by electing a president, Secretary & 5 members committee from among the General Body
- Monitoring & Advisory Committee – Under chairmanship of Ward Members of Local Body

**CDS**
- General Body (EC Members of all ADs)
- EC (One per ADs, five from LSG,2 EX CDS, Member Secretary)
- Chair person, Vice chair person, 5 sub committee conveners, Member Secretary)

Five volunteers are selected in every NHG, each assigned activities related to: (i) health, (ii) income generation, (iii) infrastructure, (iv) a Secretary, to record meeting proceedings and track follow up actions, and (v) team building. Each NHG appoints a President, who chairs the weekly meetings and leads its activities. The NHGs prepare micro-plans according to local needs for submission to the ADS for further action. The General Body of ADS comprises of Presidents and Secretaries of all NHGs within its oversight. An ADS coordinates and monitors the functioning of NHGs. The functioning of the ADS is similar to NHGs but it additionally forges links with the LSG via the Panchayat ward member who acts as the Chairperson of that ADS. At the apex, the CDS (like ADS) has a general body consisting of all chairpersons; its governing body consists of ADS members, resource persons and officers of the LSG implementing various public programmes. It is this inclusive structure of Kudumbashree that contributes significantly to its success.

Inaugurated in 1998 by the then Prime Minister Atal Bihari Vajpayee in Malappuram district (later extended to urban local bodies of the state) the governing body of Kudumbashree is chaired by the Minister for Panchayats and Social Welfare, Government of Kerala. Kudumbashree draws significant strength from being conceived as a joint programme of the Government of Kerala and National Bank for Agriculture and Rural Development (NABARD). The fact that services of all departments and agencies can be brought under one umbrella at the community level is perceived by LSG as a useful arrangement and the LSG therefore is supportive of Kudumbashree community structures and processes. There is a unique coordination between the two. Kudumbashree is embedded within the LSG but is autonomous. In turn, LSG uses the Kudumbashree network to identify and select the beneficiary for state programmes.Kudumbashree combined four strategies to respond to the many dimensions of poverty:

- Convergence of various government schemes at the community level to produce better results
- Participatory planning and implementation
- Formation of thrift and credit societies
- Nurturing microenterprises

Recognizing the importance of care for the elderly, Kudumbashree has recently added (i) elderly inclusion programme, (ii) destitute rehabilitation programme (Asraya) and (iii) palliative care, as areas of latest focus evolving its intervention areas with changing needs of the community.

## 5.2.1 Elderly Inclusion: Pilot Intervention

The elderly inclusion pilot project largely follows the Kudumbashree model, except that it does not exclude the elderly men. Social development activities include social security to vulnerable rural elders in terms of health care, social protection, psychosocial care, livelihood support, etc. This pilot effort across 79 wards of five Panchayats is being implemented in three phases from 2015 to 2018.

- Phase-I: Formation of Elderly Neighbourhood Groups (ENHGs) with focus on livelihood support, skill development, health care, social care, protection and formation of redressal committee to protect the rights of elders.
- Phase-II: Strengthening ENHG movements at the Panchayat level, achieving 100 percent inclusion of elders in ENHGs and further consolidation of activities initiated during the first phase.
- Phase-III: Ensuring financial assistance to the ENHGs through the National Rural Livelihoods

Programme (NRLP) /Bank linkages, ensuring livelihood support to all active and assisted elders, convergence of psycho health care support and ensuring the sustainability of elder care through mainstreaming and convergence with LSGs.

## 5.2.2 Asraya

### Background

Designed by Kudumbashree, Asraya, the Destitute Identification Rehabilitation and Monitoring Project identified target families using a transparent risk index and assessed specific individual and family needs through a participatory need assessment exercise. The project sought to address issues that assailed the destitute such as lack of food, health problems including chronic illness, lack of pension, educational facilities to children, land for home, shelter, drinking water, safe sanitation facilities, skill development, employment opportunities, etc.

The Asraya project, supported by the state government, was tried in 179 gram Panchayats in the year 2003. From the XI Five Year Plan, the Asraya programme was universalized and plan preparation began in the remaining gram Panchayats and urban local bodies. Currently, there are 1,469 Asraya projects across 14 districts of Kerala, that is, an average of about 105 projects per district.

### Selecting the target beneficiaries

As a community-based initiative to provide social security to the poorest of the poor, Asraya starts with a participatory identification of the destitute through simple social criteria developed by Kudumbashree in order to avoid patronage and introduce transparency and community ownership. At the first stage, the criteria included nine risk factors:
- Landlessness
- Homelessness
- Lack of access to drinking water
- Lack of access to toilet
- Lack of gainful employment
- Woman-headed households
- SC/ST households
- Households with least one physically/mentally challenged member
- Households with least one illiterate adult member

At the second level, the risk factors included in the participatory identification of the destitute are:
- Squatter families
- Families sleeping in public places
- Families headed by widows/abandoned women/ unwed mothers living in distress
- Those with terminal or incurable disease
- Beggars
- Women victims of atrocities/trafficking
- Families with no earning members

### Support provided by Asraya

Asraya covers the following needs of destitute families:
- Food security: Food grains through PDS, supplementary nutrition where needed, cooked food where needed
- Health care: Medicines, palliative care, counselling, support for hospitalization in convergence with Rashtriya Swasthya Bima Yojana (RSBY), transportation
- Old-age care
- Support for obtaining welfare pensions
- Provision for permanent shelter: Land, house, drinking water and sanitation
- Support for education: Learning materials, uniform, transportation support
- Livelihood support: Special support for productive employment
- Asraya Plan: It is not only in the intensity of processes but also in the minute detailing that Asraya Plans are significant

### Asraya in five Panchayats

An elderly-specific baseline survey was conducted classifying them into three groups: active and healthy; needing health assistance; and dependent /fully bedridden. Mobilization started with ward level campaigns and meetings of elders in each ward to explain the project and to initiate ENHGs with 10–20 members each. By 2015, nearly 550 ENHGs were formed in the five Panchayats.

Members were supported through formalities such as preparing register entries, writing minutes of the meeting, follow up actions, etc. Opportunity for elders to interact with children was also provided through Balasabhas. Like NHGs, Kudumbashree provided training and economic support to the active ENHG members to suit individual abilities and local needs through livelihood projects.

The Asraya families in five Panchayats received project support for food, treatment,self-employment training, home maintenance or clothing, according to identified needs in two phases. Funds were granted for construction of house, drinking water facilities and sanitation in all the five Panchayats. Funding sources for Asraya included Challenge Fund from Kudumbashree Fund, district/block/Panchayat funds, central funds, social welfare funds and bank loans.

Asraya was nationally recognized as a successful project for which Kudumbashree received Prime Minister's award for excellence in 2007/08.

## 5.2.3 Palliative Care in Five Panchayats

Palliative care in Kerala (covered in greater detail in Section 5.3) is a unique initiative involving a net-work of organizations that provide home-care teams and clinics and hospitals with both outpatient and inpatient services. Some of the important institutions involved in palliative care in Kerala are: the Community Resource Centre in Palliative Care,

Malappuram Initiative in Community Psychiatry, vocational rehabilitation, Kidney Patients Welfare Society and activities for HIV patients. Community Resource Centre in Palliative Care is a training unit for doctors, nurses, volunteers and students that also coordinates research and other activities in the field of palliative care. The Malappuram Initiative in Community Psychiatry leads activities on mental health care. Follow up and the required treatment is also provided by the society.

Majority of the palliative care patients suffer from non-communicable diseases (NCD) such as cancer, dementia, Parkinson's disease and cerebral stroke. These elderly NCD patients are visited once in a month while other elderly are visited once in three months. Information about the need for palliative care is communicated to the family by accredited social health activists (ASHAs) or Anganwaadi and Kudumbashree workers of the area.

The premise that women's empowerment is vital governs the community-based Kudumbashree initiative, particularly in rural areas. A key feature is the active involvement of women in transparent identification of poor families using a standard set of risk factors. The three-tier community organization —NHG, ADS and CDS—with clearly defined structure, functioning and roles is key to the success of this model. Further it is a joint programme between the state government and NABARD and this contributes to its success.

**Palliative care focuses on relieving patients of their pain and suffering rather than curing or treating the underlying conditions. Hospice care, on the other hand aims at treating terminally ill patients in the last weeks or months of their lives. While hospice very often includes palliative care, not all persons receiving palliative care are in hospice care.**

## 5.3 Palliative Care

The World Health Organization (WHO) defines palliative care as an approach that improves the quality of life of those patients and their families which are facing life-threatening illnesses, through prevention and relief from suffering. Palliative care concept evolved in the context of cancer patients as the pain is progressive and not curable. In India, palliative care facilities were established in a few cities during 1980s and 1990s. The Indian Association for Palliative Care (IAPC) was formed in 1994 with a mission to promote affordable and quality palliative care across the country. As per 2012 data, there were approximately 908 palliative care service centres delivering care on home based or out-patient based care, of which about 840 were in Kerala[61]. It was recognized that palliative care services needed to be integrated with other medical services as well as the National Health Mission and national standards developed for such care. The need for changing the attitude of service providers as well as behavioural change in the community through public awareness, knowledge and skills was also realized. In other words, palliative care must become a part of public health care combined with physical, psychological and spiritual support to patients.

In 2001, Kerala established the Neighbourhood Network of Palliative Care (NNPC) as a joint venture of four NGOs already working in this area as the largest network for palliative care in the world. The uniqueness of the Kerala model lies in the active involvement of home-care teams. It is built on the strong presence of women NHGs developed under the Kudumbashree mission. As discussed in Section 5.2, Kudumbashree had such a ubiquitous presence in the state that every development programme starts from NHGs linking up to LSGs and beyond through ADS and CDS. For the elderly, the Asraya initiative and palliative care initiative are so significant that the NNPC and Kudumbashree members recognized that collaborative effort would be synergistic, as home-based service and care is the basis for both.

In Kerala, three government departments support the palliative care programme: the State Department for Health, the Department of Social Welfare and the Local Self-Government Department. Besides other NGOs, the role of HelpAge India and Pallium India in service delivery has been significant. The Institute of Palliative Medicine in Kozhikode district evolved from an outpatient clinic to an important arm of Palliative Care Society for training, research and outreach care purposes. It was also designated as the WHO Collaborating Centre for community participation in palliative and long-term care. In 2009, Kerala became the first state in India to implement the state Palliative Care Policy.

**The need for changing the attitude of service providers as well as behavioural change in the community through public awareness, knowledge and skills was also realized. In other words, palliative care must become a part of public health care combined with physical, psychological and spiritual support to patients.**

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61  MOHFW (2012), Proposal for Palliative Care Strategies in India (Expert Group Report), Ministry of Health and Family Welfare, Government of India, New Delhi. http://palliumindia.org/cms/wp-content/uploads/2014/01/National-Palliative-Care-Strategy-Nov_2012.pdf

## 5.3.1 The Malappuram Model of Palliative Care

Malappuram is the first district of the country to implement an effective palliative care programme with community participation. Malappuram is now far ahead in the fields of palliative and elderly care, compared to other districts of Kerala and serves as a model for rest of the country. Success of the palliative care programme in Malappuram district encouraged other districts of Kerala to start palliative care units as well. As the demand for palliative care increased with rapidly ageing population, family members of those suffering from chronic pain and other volunteers in the state were given training to provide palliative care, including care for destitute elders.

The first community-based palliative care clinic was established in 1998. Trained volunteers managed the clinic, conducting home care visits with trained nurses, supported by health care workers and Panchayat members. Efforts to increase community participation resulted in people from various streams joining hands in palliative care. Several community-based organizations (CBOs) and Panchayats started establishing community-based palliative clinics in their areas.Subsequently, a need was felt for evolving a common platform for planning and quality improvement. This resulted in the development of the Malappuram Initiative in Community Participation (MICP) and the Student Initiative in Palliative Care (SIP) to further strengthen the activities. Night home care was also started in five CBOs with male nurses. Gradually, monthly home visits became fortnightly with more frequent visits for severe cases. At present there are 83 clinics run by CBOs in the district out of which 20 are newly formed and need support. After the formulation of Palliative Care Policy by the Government of Kerala, palliative care units were started at the Panchayat level under the National Rural Health Mission (NRHM). All Panchayats in Malappuram district had government palliative care units by 2011.

As the demand is likely to increase, the plan is to start local associations of the aged at the Panchayat level. Day care centres are also part of this proposed plan. Much of the success of the palliative care programme was achieved due to dedicated volunteerism and the coordination between CBOs and the government health staff. In order to assess the quality of care and for further improving the services, 20 palliative care patients from Manjeri and Nilambur taluks of Malappuram (where palliative care programme was first introduced), were interviewed by the Panchayat in 2012 which revealed high level of user satisfaction. By the end of the year 2013, nearly 1,000 Panchayats started to provide palliative care services.

During the evolution of palliative care in Malappuram, a major support came from the LSGs in the form of medicines, equipment, vehicles for home care, etc. Significantly, LSGs also supported administratively, including permission to use facilities and land under health ministry and financially, to meet training costs. Regular meetings of volunteers were conducted to form common strategies for improving quality of care. Operational guidelines were issued and funds mandatory for palliative care continue to be allocated for LSGs by the Government of Kerala. From 2015, CBOs adopted a new strategy of family training in which all immediate relatives of the patient are trained in care-giving.

## 5.3.2 State Model for Palliative Care

Success of the Malappuram model of palliative care laid the foundation for the palliative care initiative at the state level (Figure 5.4). The State Palliative Care Policy facilitated integrating palliative care with the public health system. Department of Health Services, LSG institutions, Department of Social Welfare and CBOs collectively implemented the programme in the state. The Palliative Care

Management Committee conducted home care and monitoring.

At the primary level, the home care unit of each LSG consists of a trained community nurse, ward member of LSG, the field staff of primary/community health centre, ASHA and trained volunteers. The home care team visits the patients and trains the family members in care-giving.

The trained volunteer or ASHA plays a vital role in identifying the palliative care patient. The ASHA gets an incentive of ₹ 100 for every visit to a patient's home. She uses the volunteer case sheet to collect preliminary information on each targeted patient, including the patient's background, home location, profiles of family members, details of diseases, treatment history, source of income for the treatment, mode of treatment, approximate monthly treatment expenses, awareness of the patient and the family about the disease, financial aid availed, if any, etc. The volunteer submits the completed case sheet to the primary/community health centre.

As the next step, the community nurse and medical officer visit the homes of patients to assess the additional care required beyond what primary caregiver(s)—usually, family members—offer. The information collected is submitted to the LSG, which is then forwarded to the Project Management Committee. The secondary care is provided by the Taluka hospitals through both in-patient and out-patient clinics. Tertiary level care is provided by the district health facilities.

Now, in addition to Malappuram district all Panchayats in Thiruvananthapuram, the capital district of Kerala, have a palliative care unit. Wayanad district also has made progress in palliative care. But other districts are yet to catch up with these districts. University of Kerala, Institute of Social and Economic Change (ISEC), Bengaluru and UNFPA conducted a study in 2015, to gather feedback on the palliative care initiative. Most patients found the information shared by the health worker useful. They also considered the competence of the nurse, quality of medicines and equipment satisfactory. The time spent during home care was also reported to be adequate.

Overall, the palliative care programme is running successfully at the Panchayat level and the main reason for the success is the linkage between the LSG and the CBOs. Though there are concerns about the secondary level palliative care, primary level care is running successfully. The palliative care programme has so far been successful in rural areas but it needs to be extended to urban areas too.

## Figure 5.4. State Delivery Mechanisms of the Palliative Care Scheme
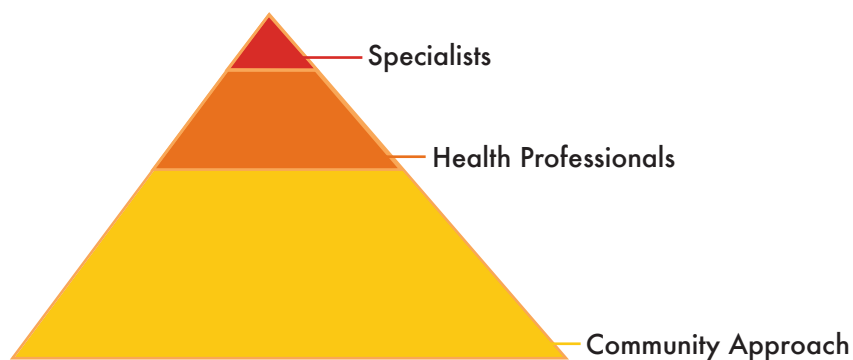
## 5.3.3 Vayomithram

Vayomithram is a successful programme under the Kerala Social Security Mission which provides health care and support to the aged in corporation and municipal areas. Vayomithram was implemented first in Kollam and Thiruvananthapuram districts during 2010–2011 and expanded over the years.

The programme provides medicines free of cost through mobile clinics and runs a help desk for the needy elderly. Round-the-clock service desks operate at the district level through which the elderly can access counsellors and mobile clinic services. Besides these, eye camps, health camps and general welfare activities are conducted in the project area for the aged. Vayomithram also provides home care for the elderly who are bedridden. Palliative care is an important component of Vayomithram.

Apart from these programmes, NGOs such as HelpAge India and Pallium India, played a crucial role in palliative care programme in Kerala.

## 5.4 Dementia Care and Active Ageing Initiatives

### 5.4.1 Dementia Care

One of the biggest health challenges in old age is dementia. The Dementia India Report 2010 has estimated that over 3.7 million people in India are affected by dementia, a number that is expected to double by 2030[62].

The illness is widespread and the existing support systems are inadequate to meet this need. With fragmentation of joint families and urbanization, the support available within the family and community is rapidly depleting. Many such families are often forced by circumstances to consider institutional care for dementia patients. Most dementia patients require such care at some point in their illness. There is a felt shortage of professionals who can diagnose and provide the appropriate care required at different stages of the illness. As the numbers affected by dementia in the coming years increase with population ageing, the current inadequacy in professional care and services for dementia must be addressed.

However, during the initial stages of dementia, institutional or professional care may not be necessary. Mental stimulation, social engagement and physical activities can help slow down the onset of dementia. These activities also reduce the risks of cognitive impairment associated with chronic illnesses such as hypertension and diabetes. Such pre-emptive action may allow the elderly to attend to personal needs without help for longer. There is still a degree of stigma attached to the illness and this makes it difficult for families to seek help early. Due to lack of awareness about dementia and its varied manifestations, there is a tendency to attribute symptoms of dementia to normal ageing process and hence families delay seeking support. The length of care and its cost are also reasons for not seeking timely and right care. As care for dementia is long and protracted, family and community support is necessary to reduce the burden of care on the primary caregiver alone.

During institutional care, the feedback received from families is the only way to know if the treatment is on the right path. There is also a tendency amongst patients and their families to consult different professionals at different stages. Services for dementia and other mental health patients, if integrated under a single umbrella, could provide continuity of care resulting in better maintenance of patient case history that may be accessed by all professionals in a patient's lifetime.

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62 Shaji KS, Jotheeswaran AT, Girish N, Srikala Bharath, Amit Dias, Meera Pattabiraman, Mathew Varghese (2010), The Dementia India Report 2010: Prevalence, Impact, Costs and Services for Dementia, Alzheimer's and Related Disorders Society of India, http://www.alzheimer.org.in/assets/dementia.pdf.

The Nightingales Centre for Ageing and Alzheimer's (NCAA), Bengaluru was established in 2010 and is now the largest comprehensive care facility for dementia with 88 inpatient beds. The centre provides services including memory clinics, short-term and long-term admissions and assessment of challenging behaviours in dementia. A multidisciplinary team including physicians, geriatric psychiatrist, psychologists, physiotherapists and occupational therapists and trained nursing staff take care of all aspects of dementia care and prepare an individualized plan for each patient. Non-pharmacological interventions such as music, art, craft and other related therapies are integrated with professional counselling and care to create a supportive, dementia-friendly environment. In the last six years, over 1,000 patients have been assessed in the memory clinic and nearly 600 patients have availed such support and care. To ease the burden on caregivers during the day and to delay institutionalization, Nightingales Medical Trust (NMT) runs four day care centres in various parts of the city. Patients at the centre are taken care of by professionals and trained nursing aids. These centres can handle up to 35 patients per day and have proved very useful in providing respite to families.

In order to reduce costs and increase access to specialists/experts, NMT developed the first technology leveraged telemedicine project in Kolar district of Karnataka. The telemedicine management software allows for assessments, monitoring and training without compromising the quality of care.

This Dementia Care Centre is located within the premises of the Ellen Thombern Cowen Memorial Hospital in Kolar, about 60 km from the main centre in Bangalore. This facility has been operational for the last two years offering a financially viable service for dementia. The core team of senior medical staff in Bangalore is able to remotely monitor patients and provide advice to the 35-bed facility. This has significantly reduced the cost of care.

While dementia care centres are for the patients, NMT also emphasizes on wellness through active ageing that helps delay / prevent the onset of dementia.

## 5.4.2 Wellness through Active Ageing

The UNFPA's BKPAI survey and the pilot phase of the Longitudinal Ageing Survey in India (LASI) highlight many health risks faced by older Indians including those related to mental health and chronic diseases such as diabetes, hypertension and dementia[63]. These conditions affect activities of daily living and increase dependency in old age. These conditions are not treatable and require lifelong management. However, they can be prevented and managed through physical exercise, cognitive stimulation and social interaction. Research shows that engaging older persons in regular activities is a promising prevention strategy for dementia and other chronic illnesses.

**Many health risks faced by older Indians including those related to mental health and chronic diseases affect activities of daily living and increase dependency in old age. These conditions are not treatable and require lifelong management. However, they can be prevented and managed through physical exercise, cognitive stimulation and social interaction.**

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63  The United Nations Population Fund (UNFPA), India in collaboration with the  Institute for Social and Economic Change (ISEC), Bangalore, the Institute for Economic Growth (IEG), New Delhi and the Tata Institute of Social Sciences (TISS), Mumbai launched a research project, Building Knowledge-base on Population Ageing in India (BKPAI) in 2011. A primary survey was carried out in seven states – Himachal Pradesh, Punjab, West Bengal, Odisha, Maharashtra, Kerala and Tamil Nadu which covered a total of 9852 elderly women and men from 8329 elderly households in rural and urban areas. http://www.isec.ac.in/prc-AginginIndia-Data-Release.html

The Bagchi Centre for Active Ageing, Bengaluru was established in October 2014 as a collaborative initiative between an NGO (the NMT) and a corporate entity (the Bagchi group). This activity-based centre adopted an approach outlined in the "ThinkingFit Study". The centre offers wide range of activities including physical (gym and non-gym-based), cognitive (iPad and paper pencil-based) and social cognitive (fun and non-fun-based) in a group. Over 100 senior citizens avail of the services every day. An initial individual assessment reveals the activities appropriate for the individual and mechanisms for improvement tracking. These tests are repeated quarterly to analyse the improvements. Every month subjective and objective feedback is taken for quality improvement purposes. In addition, the participants also maintain progress reports to track the number of activities, assessment schedule and comments about their health status. Periodic feedback is also sought from their regular physicians and family members. All results are shared with the technical experts from the ThinkingFit Team.

Analysis of the above data shows considerable enhancement of cognitive and social well-being among the elderly participants. The activity schedule has also shown good potential to bring about lifestyle changes, enhance the sense of overall well-being and promote better quality of life among the elderly. To replicate this experience, NMT has started a new Centre for Active Ageing in a village targeting lower-middle class elderly to keep them active and healthy through a combination of social engagement, mental stimulation and fitness programmes.

Future plans include extending active ageing facilities to old-age homes and reach out to elderly from different socio-economic strata.

## 5.5 Food Security and Quality of Life in Old Age

Food security in old age is particularly important for those vulnerable to malnutrition due to age-related financial constraints as well as inadequate access to food. Nutritional supplementation can help in the prevention of degenerative conditions of the elderly. The Government of India has various schemes in place that support household food security, such as the targeted public distribution system (PDS), Antyodaya Anna Yojana, Annapurna Scheme, and the Midday Meals scheme. The National Food Security Act, 2013 and Right to Food Act play an important role in providing policy and legislative support to food security for the poor.

Supplementary feeding programmes have a long history in Tamil Nadu. In 1956 a school midday meals programme was instituted in the then Madras State, initially funded by local contributions. The scheme was later partly funded by the government. Centralized kitchens were also introduced later. On 1 July 1982 the nutritious Noon Meal Programme (NMP) was introduced, expanding the coverage of the previously existing schemes. In addition to the NMP, Amma Canteens (detailed in Section 5.5.2) form part of a very popular scheme that provides cooked food to the urban poor, including the elderly at significantly subsidized rates. The third initiative to ensure food security is through the PDS. Food security schemes in Tamil Nadu are discussed below to provide insights into possible strategies to improve the quality of life of vulnerable elderly amongst the poor.

## 5.5.1 Noon Meal Programme

The nutritious NMP has evolved considerably since inception. It has gradually increased from its initial coverage of only pre-school children, to include children up to 15 years of age in rural areas. In 1983, old-age pensioners were also included in the NMP. It was expanded to cover children in urban areas in 1984. The Integrated Child Development Services (ICDS) Scheme and the Tamil Nadu Integrated Nutrition Project have been brought together and implemented by the Tamil Nadu government under the NMP. The Civil Supplies Corporation in the state provides necessary supplies for the NMP.

The NMP was introduced to reduce malnutrition and to alleviate nutritional insecurity among the poor elderly living in the state. NMP also aimed to complement the existing social security schemes for old-age pensioners in the state i.e., cash pension, provision of free rice (2 kilograms per month) and a saree/dhoti once every year. Elderly people who have no source of income; are not beggars, but are not supported by their adult children or grand children and do not possess assets exceeding 5,000 in value are eligible for such benefits. To avoid double-counting, a beneficiary of this scheme is not entitled to receive benefits under the PDS.

This programme is designed to build on the available infrastructure as well as manpower provided by ICDS and hence does not entail additional implementation costs. Free supply of rice in conjunction with the Old Age Pensioners Scheme reduces dependence of the elderly on family members. Further, bringing the elderly to the anganwadi centres of ICDS to have meals with children allows for the strengthening of inter generational bonds. As elderly get together out side of their own homes and socialize with their peers and children it promotes active ageing through physical, psychological and social well-being.

## 5.5.2 Amma Unavagam / Amma Canteens

Amma Unavagam is an initiative of the erstwhile Chief Minister of Tamil Nadu, Late J. Jayalalitha, who was respectfully referred as Amma (mother) all over the state[64]. Amma Canteens, started in February 2013 in Chennai and later spread to other areas, provide subsidized cooked food thrice a day to the urban poor including migrants, the elderly, daily wage labourers, drivers and others of limited means from the working population. With over 200 eateries in Chennai, these canteens are estimated to benefit about 20 percent of Chennai's BPL population of 650,000. The scheme is implemented by the Department of Social Services and Chennai Municipal Corporation. Besides improving nutrition of the urban poor the scheme also generates employment for women as many women SHGs are involved in the preparation and provision of food. The scheme also educates and promotes hygienic practices like washing hands. Billboards at the entry of the food courts advise the customers to leave their footwear outside the canteen in the interest of cleanliness and hygiene. With regular quality assurance systems in place, all the canteens are certified under Food Safety & Standards Authority of India.

The success and popularity of Amma Canteens prompted the state to set up branches in nine towns in other districts of Tamil Nadu catering to about 50,000 persons every day.

## 5.5.3 Public Distribution System

The PDS serves triple objectives of a food safety net for the poor, enhancing nutritional status and generating a moderate influence on market prices. Besides rice, the government also supplies other essential commodities such as sugar, wheat,

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64 We record with deep regret that Amma, the Chief Minister passed away before the publication of this report. The project team pays homage to her memory and hopes that Amma Canteen initiative will continue in the state with the same energy as it did in her life time.

kerosene, and iodized salt through fair price shops. It is a poverty alleviation programme that aims to promote social welfare. Universal PDS which makes no exclusion based on income is implemented by the Tamil Nadu Civil Supplies Corporation and cooperative societies.

In conclusion, it may be said that Tamil Nadu has reaped the benefits of its strong and sustained focus on food security for the poor. The NMP directly benefits the elderly while Amma Canteens and PDS benefit everyone, with indirect benefits accruing to the poor elderly. The combined impact of these three schemes is evident in Tamil Nadu and may be replicated in other states to enhance food security and reduce malnutrition in the entire population in general and the elderly in particular.

# 6

## Voices and Concerns of the Elderly

# Voices and Concerns of the Elderly

## 6.1 Introduction

One-third of the Indian population lives below the poverty line and about one-third just above it belongs to the lower income group, therefore, the financial situation of two-thirds of the 60-plus population can be said to be fragile[65]. This essentially implies that this segment is becoming larger and poorer.

Starting with a policy perspective, this chapter makes heard the collective and individual voices of the elderly in India from diverse social and economic contexts so that discerning policy can address these specific needs. The chapter is based on both secondary and microlevel studies initiated by the BKPAI team during 2013–2016[66].

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### Box 6.1: Concerns of the Elderly

Concerns of the elderly from across the globe may be classified into four clusters:

1. Participation and contribution: Older persons place great emphasis on reciprocity within the family and community. They want to support others as well as themselves. They value both caring and being cared for by others including neighbours, friends, children and grandchildren.

2. Income security: They encounter many difficulties in finding productive employment and when they actually find one, they are unable to match the performance of youngsters when asked to do similar work. They strongly feel that social pensions, however small, are important means of reducing vulnerability and increasing income security.

3. Health: Many older persons acknowledge improvements in health care services but flag the high costs as a challenge. They want more home-based care and better capacity of service providers in handling age-related illnesses.

4. Enabling and supportive environment: In general, the aged often feel underappreciated in social contexts and feel that if their contributions were given more public recognition they would be accorded greater respect by their family and community. The priority given to senior citizens in public service delivery such as banking and railways is much appreciated by them. However, the absence of a safe and secure, disabled access friendly public transport system combined with poor quality of roads reduces the mobility and independence of the elderly.

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65  MOSJE (1999), National Policy on Older Persons, 1999, Ministry of Social Justice and Empowerment, Government of India, New Delhi. Available online at:http://socialjustice.nic.in/writereaddata/UploadFile/National%20Policy%20for%20Older%20Persons%20Year%201999.pdf
66  The United Nations Population Fund (UNFPA), India in collaboration with the Institute for Social and Economic Change (ISEC), Bangalore, the Institute for Economic Growth (IEG), New Delhi and the Tata Institute of Social Sciences (TISS), Mumbai launched a research project, Building Knowledge-base on Population Ageing in India (BKPAI) in 2011.

At the global level, though, there are many situational differences amongst elderly, there are distinct concerns common to all elderly which are yet to be addressed. A UNFPA–HelpAge International Study (2012)[67] categorizes the main concerns of elderly across the world into four clusters: participation and contribution, income and security, health, and an enabling and supportive environment. These have been elaborated upon in Box 6.1 in the previous page.

## 6.2 Policy Perspectives

The National Policy for Older Persons (1999)[68] viewed the elderly as equal partners in the development process and sought to empower them by encouraging volunteerism and peer-to-peer organizations, supporting initiatives, trusts and other organizations in elder services, encouraging dialogue and networking with NGOs on ageing issues and the training of personnel and provision of services for the elderly. Panchayati Raj institutions were designated to address local issues.

The Draft National Policy for Senior Citizens (2011)[69], developed on the basis of a review of the 1999 policy similarly emphasized special needs of elderly women and their vulnerabilities. To ensure that the elderly are heard, it calls for mainstreaming of senior citizen issues in the national development debate and supports existing mechanisms for that purpose, including promotion and establishment of senior citizens' associations. The draft policy also proposes to appoint officers at designated Block Development Offices to serve elders, easing access to pensions, handling documentation and for other requirements. Role of Panchayati Raj Institutions in addressing local issues and implementing the plan has also been acknowledged, as was done in the 1999 policy.

## 6.3 Listening to the Elderly: Collective Voices

In India, the National Council for Older Persons (constituted in 1999 by the Ministry of Social Justice and Empowerment) and the autonomous National Association of Older Persons (part of the implementation strategy of the NPOP) were meant to promote the concerns of the elderly and coordinate policy response to them while Panchayati Raj institutions were encouraged to address local issues and needs of the elderly.

However, more organized senior citizens movements in India started in 2010 to ensure that senior citizens understood their entitlements under the NPOP and were able to flag and work around the impediments to accessing the intended benefits. A national level collective representing more than 70 senior citizens' associations called the All India Senior Citizens Confederation (AISCCON) emerged with the mandate of lobbying for policy attention to elderly issues at district/state/local levels. The efforts of the AISCCON were then documented in the book, Voice of Elderly in India based on letters, pamphlets and reports that emerged from elderly voices across the country[70]. The senior citizens' collective also interfaced with state and central governments for redressal of grievances.

The voices of senior citizens provided a reality check and an opportunity to incorporate mid-course corrections. The issues that emerged included a variety of health, financial, social and other concerns. Often highlighted was the inadequacy of the old-age pension in terms of both amount and reach and poor access to the Old Age Social and Income Security (OASIS) scheme[71].

67   UNFPA–HelpAge International 2012, Ageing in the Twenty-first Century: A Celebration and A Challenge, United Nations Population Fund and HelpAge International, http://www.unfpa.org/sites/default/files/pub-pdf/Ageing%20report.pdf
68  MOSJE (1999), National Policy on Older Persons, 1999, Ministry of Social Justice and Empowerment, Government of India, New Delhi. Available online at:http://socialjustice.nic.in/writereaddata/Upload-File/National%20Policy%20for%20Older%20Persons%20Year%201999.pdf
69  MOSJE (2011), Draft National Policy for Senior Citizens, 2011, Ministry of Social Justice and Empowerment, Government of India, New Delhi. Available online at: http://socialjustice.nic.in/writereaddata/UploadFile/dnpsc.pdf
70  Siva Raju (ed.) (2011), Voice of the Elderly in India. B.R. Publications Co. &  All India Senior Citizens' Confederation (AISCCON), New Delhi.
71  Ibid. p. 103.

The key issues highlighted by the elderly via the AISCCON were as follows[72]:

- Maintenance Act 2007: A more uniform implementation of the Act is needed across states.
- Old-age homes: Care and facilities in old-age homes across the country need to be standardized and regulated.
- Health care: Subsidized health insurance for BPL senior citizens with better implementation of an integrated health care system for elderly would be desirable.
- Social pension: There is a need for easier access to social pension with increased pension amounts and better disbursement.
- Socialization with peers: Senior citizen clubs could be established for better socialization, reduced sense of isolation and loneliness, particularly amongst those who have lost their spouses, and more productive use of time.
- Assistive devices: Greater state support was required to promote research in and to encourage production and distribution of affordable geriatric assistive devices and strengthening, geriatric health and medical care.
- Public representation: Senior citizens should find representation in Rajya Sabha and state level Vidhan Parishads and with adequate representation in official committees so that issues and concerns that are of relevance to them are not routinely over looked or deprioritized.

In 2015, Pension Parishad and the Tata Institute of Social Sciences conducted a study in eight states of the country reaching out to senior citizens across diverse socio-economic and age categories and administrators regarding the implementation of the National Social Assistance Programme[73]. Focus group discussions and in-depth interviews were carried out between May–June 2014 covering low literacy districts (as per the Census of India 2011) of Andhra Pradesh, Telangana, Kerala, Assam, West Bengal, Gujarat, Rajasthan and Haryana[74].

During the study, many elderly reported difficulty in determination of eligibility criteria of social pensions and dealing with the opacity in procedures as the applicant transitions from applying for the pension to approval and disbursal. This lack of transparency compels the prospective pensioner to be beholden to the mercies of the postman who often pockets a cut for delivering the pension. Equally, there were cases where the postman identified people eligible for pensions and prompted them to apply. This information asymmetry creates space for unequal power relations and corruption. Many pensioners also raised concerns regarding the actual delivery and payment processes; disbursal seldom adheres to a predetermined schedule and is highly irregular and inconvenient.

The study made the following recommendations:

- Pension coverage of the poor should be expanded and social pensions should be universalized.
- A single window system should be put in place where applicants can obtain all the necessary supporting documents for their pension application as well as submit their pension application for processing.

**Many elderly reported difficulty in determination of eligibility criteria of social pensions and dealing with the opacity in procedures as the applicant transitions from applying for the pension to approval and disbursal. This lack of transparency compels the prospective pensioner to be beholden to the mercies of the postman who often pockets a cut for delivering the pension.**

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72 Ibid.

73 Pension Parishad and Tata Institute of Social Sciences (2015), Summary Report of Eight State Study on Implementation of National Social Assistance Program. Available online at: http://pensionparishad.org/1350-2/

74 ORGI (2011), Census of India, 2011, Office of the Registrar General and the Census Commissioner of India, Ministry of Home Affairs, Government of India, New Delhi. www.censusindia.gov.in.

- Processing times for sanctioning of pensions must be specified.
- Pension amounts should be rationalized, indexed to inflation and revised annually like the wages disbursed under the National Rural Employment Guarantee Scheme and salaries of government staff.
- Regular payments should be made on a fixed date every month
- There should be special focus on highly vulnerable groups with social audits and other transparency and accountability measures in place.

## 6.4 Listening to the Elderly: Individual Voices

The elderly in India represent a very diverse and heterogeneous group with perhaps only one aspect in common; everyone is more than 60 years old. The diversity arises from place of residence (rural or urban, state), regional or cultural affiliation (the state to which they belong, the language they speak, habits related to food, clothing, social mores and expectations etc), economic status (financially independent or fully dependent), sex (man or woman), marital status (single, married, divorced, separated, abandoned, or widowed) and living arrangements (living alone, with family or in an institution). Unsurprisingly therefore, the challenges that the elderly face and the possible solutions and coping strategies are also a reflection of this diversity.

Below are a few selected situations of old-age vulnerability derived from many discussions carried out to listen to and understand tough situations faced by the elderly. These discussions were conducted in various socio-economic contexts in Maharashtra around 2014. These situations represent challenges related to external support systems, with family support and relationships, challenges related to caring for the elderly and the lack of security in old age, besides understanding the multiple dimensions of their vulnerability.

## 6.4.1 Challenges Related to External Support Systems

Vulnerability relating to the support systems for elderly can range from financial insecurity to lack of access to old-age benefits and complete dependence on others for survival. Support system can range from immediate family to the larger society and local governance arrangements.

### Situation 1: Income insecurity and challenges in accessing benefits

The respondent was a 70-year-old road construction worker, with no land, money or family support. Age-related health issues did not allow him to work and earn as before. His three daughters were married, and neither supported nor visited him. He worked intermittently depending on health and work availability to earn about ₹50 – ₹60 per day which was woefully inadequate for food, medication and other basic needs for survival. Although he had a BPL card, the village mukhiya had cancelled it for some reason, and now he was left with no pension or ration card. A social pension, however small was critical for his sustenance but without the mukhiya's help, enrolling under the pension scheme and putting together relevant documents to complete the formalities was impossible for him. In the absence of a ready and easy support system, the respondent was excluded from the government old-age pension scheme though he was eligible and deserving.

The respondent was a 61-year-old vegetable vendor staying with her three children, her 78-year-old mother, and a husband who had been paralysed by an accident at the flour mill where he worked. In the absence of any legal or policy binding, the mill had not offered any compensation to him after he was laid off due to the accident. The respondent described her situation as follows: "My earnings from selling vegetables are barely ₹ 50 – ₹ 60 per day, hardly enough for so many dependents in the family. My mother is very old and care-giving for her is particularly difficult and burdensome. My eldest son is unemployed but looking for some work as an agricultural labourer. My daughter has never been to school and has been taking care of the household instead but I must get her married now. My youngest son is still going to school which provides him a midday meal and a uniform." Besides the daily expenses, the respondent was also paying a small fee to the school. She had a BPL card and got registered for the old-age pension by bribing the village chief with ₹ 500 so that he would help her with the application. She was yet to receive any pension and she had been told that the approval process would take time. In case of health issues, neither she nor her family could afford public transport to cover the 15 km to the nearest government hospital. As a result they were denied the benefits of government health care services as well. The respondent was in dire need of old-age pension and felt, "It is my right to live life with dignity and peacefully during my old age".

Absence of personal security and support systems, high dependence on daily wage earnings and difficulties in accessing government schemes or health care institutions represent extreme vulnerabilities that could be addressed to some extent by existing welfare schemes for the elderly, were they to be implemented with a human face. When the elderly have to support and care for dependents who are older still, the situation becomes even more complex and challenging.

In India, family still remains the first social institution for care of the elderly. Yet, with changing economic compulsions and the need to migrate out for employment, the ability of children to take care of older parents on a co-residence basis is fast declining. Public institutions and the larger society therefore need to shoulder a greater responsibility. Quality of care for the elderly in terms of social, economic and health security needs much improvement. The government schemes such as old-age pension schemes, widow pension schemes and others must be made more accessible to eligible and deserving elderly by removing the administrative obstacles to both reach and utilization.

## 6.4.2 Challenges with Family Support and Relationships

Since the family plays a key role in the care of the elderly, the extent of family support and quality of relationships are key determinants of the quality of life of the elderly. Decline in status of the elderly due to lack of income, disagreement amongst family members regarding responsibility for parents' care, limited income of children and mistreatment are examples of issues that beset the lives of the aged. Migration of children seeking jobs, changing societal values and certain negative stereotypes further affect the elderly.

## Situation 3: Complete dependence reduces respect received within the family in old age

The respondent was a 73-year-old farmer, who still owned a piece of productive land. However, he felt that his efforts were not valued and his married children did not care for him or his wife. Their relationship with their married son had soured due to adjustment issues between his wife and their daughter-in-law and hence they stayed apart. He was convinced that his value and respect in the society depended on his earning capacity and with decline in agricultural income as well as physical strength to do hard work, he was being treated badly not just by his children but by his wife as well. He felt that his children had forgotten the many sacrifices he made in bringing them up and they showed no interest in supporting their aged parents or having them co-reside.

Yet, he did recognize that his children had limited means which made it difficult for them to provide shelter, food and health care to the old parents. They would perhaps have been more willing to consider the option of co-residence, had the parents been able to contribute to household expenses and chores. "Financial assistance from government in the form of old-age pension could pave the way for us to live peacefully with our children during old age", concluded the respondent.

## Situation 4: Excessive emotional dependence on children can wreck peace in old age

The respondent was a 62-year-old rural daily wage earner who had lived with his wife, two married sons and a daughter until about a year ago when the sons migrated with jobs to the city about 250 km away. Around the same time, the daughter got married and moved to a village about 100 km away. The sons had not visited the parents even once since, and the parents were lonely and distraught. The parents would have liked them visit for at least 15 days at a time but that was just not possible given the compulsions of their work lives. Both the respondent and hiswife were so emotionally dependent on their sons that they felt crippled by their absence and only succeeded in winding each other up over the shared trauma of separation. Over time, the sons and their families grew more distant from the old couple as they got busy with their lives. Even when the couple incurred significant costs to visit their daughter (at her insistence) to take care of their grandchild they received no financial assistance from the sons. The respondent mentioned: "We long for emotional support from the children, but they are not concerned as we are not part of their lives. I was a different kind of son to my parents but times have changed with this new generation".The couple eventually found fresh perspective under the guidance of an NGO working in the area of active ageing. They were encouraged to look for productive engagements suited to their physical health so that they could earn some money, find a purpose in life and grow beyond the constant feeling of having been abandoned by their children. Both of them came to acknowledge the value to active ageing and recognize the need to stay active, productive and healthy as long as possible. Instead of being emotionally dependent and complaining about their lot, they were prepared to make the attitudinal change necessary to be peaceful and wish their children well.

Typical perceptions of decline in status of the elderly within the family can be ameliorated to an extent by encouraging increased participation of the elderly both in family and social activities. Intergenerational bonding could be strengthened with the participation of senior citizens in family decisions, volunteerism or income generating opportunities. NGOs, CSO, and faith-based organizations could play a significant role in inculcating values in the younger generations of respect, regard and love for the elderly. Old-age pensions or tax breaks for children taking care of old parents could provide the right incentives for an ecosystem of increased awareness and practice of active ageing.

## 6.4.3 Challenges Related to Caring for the Elderly

The second pillar of the Madrid International Plan of Action on Ageing (MIPAA) refers to "advancing health and well-being into old age", thereby acknowledging the fact that taking care of personal health in the younger years is important to ensure transition into healthy old age. The elderly experience difficulties in accessing caregivers and family members are often unable to provide such care. The elderly, in particular women often find themselves supporting other dependents including care-giving to other elderly. Challenges are more serious when they also face financial difficulties.

### Situation 5: An old caregiver for her very old mother

The 65-year-old respondent providing home-based care to her 90-year-old mother was faced with both medical and financial problems. An NGO specializing in old age care had been providing much-needed medical assistance to the mother (along with other aged persons in her community) but she had heard that the NGO was likely to move out of her village due to the lack for funds. The respondent felt that government should support the NGO so that it could continue its good work. "My mother was unable to cope with my father's passing away eight years ago. She felt lonely and helpless because she could not travel alone. She had been completely dependent on my father", explained the respondent. "I was earning some money as a domestic help but could not set aside any savings for my mother or myself as there was too much pressure on me to contribute to the family expenditure", lamented the respondent. But she constantly remembered that her mother is getting very old and needed her support. About a couple of years ago she decided leave her marital home and move in with her mother. She continued her job but found it increasingly difficult to cope with the situation financially and physically as her mother now needed constant care. In this situation, the support provided by the NGO was invaluable. The respondent articulated that the societal perception towards caregivers was not very helpful. Care-giving was seen as the job of a woman, however old she may be, "irrespective of whether the family members expecting such care are young and able or old and disabled", she lamented. At the same time she was also bitterly aware of the fact that there would be no one to take care of her in her old age when she needed help and support.

## Situation 6: Save for later years

The 67-year-old respondent retired after nearly 40 years of service as a clerk in the district water supply and sanitation office. As a state government employee, he received a corpus of `1million as retirement benefits, considered a decent sum in his circle. He headed a joint family including his wife, their two sons, their wives and children. His only daughter lived in a nearby town with her family. A while ago, both his sons moved cities for employment, although their families continued to live with the respondent. Initially thought to be a temporary arrangement, it continued in the mid-long term with the sons showing no signs of taking their families with them. Instead, they would come home during festivals and other social occasions, to spend time with their parents, spouse and children. Those short holidays were indeed enjoyable, although financially burdensome. During one such trip, his daughter's husband pressurized the respondent to part with a substantial part of his post-retirement corpus to support a new business venture of his, money that sank quickly and unceremoniously with the failed initiative. The two sons came to know of this fact and laid claim of their "portion of the cash" as their rightful inheritance, leaving the old man with a paltry share of his retirement benefits. Though one of the sons invited the respondent and his wife to co-reside with him in the city, he felt the move would be unwise. "As long as I have some strength left in my body, we would like to stay in our native place. We have many friends and acquaintances here. The city will be a new place for us to live in and adjust to." They have also been advised by neighbours not to give away more of their savings to their children but to set aside the funds for their older years.

## Situation 7 : A widowed mother is harassed by her own children

The 68-year-old respondent had a nursing career during her working years in a hospital. She invested part of her earnings into acquiring a property in her town. With advancing age, she developed multiple health concerns with blood pressure, diabetes and gradual vision loss. She had no post-retirement income and was constantly harassed by her married but separated daughter who lived with her. In these adverse circumstances, the respondent was eventually forced to sell the property which she had purchased with her hard earned money.In a rather sinister turn of events, the estranged son-in-law came to know of the sale of property and began visiting and living with them to claim a portion of the sale proceeds. The daughter also now ganged up with the husband to intimidate and pressurize the respondent. "I was forced to sign some documents under duress as well as due to emotional blackmail by the grand children. I have lost peace of mind", she sobbed. Gradually she began losing access to the money obtained from sale of property. Since she had been a nurse and affiliated with a hospital in her working years, she was aware of the Maintenance Act 2007 under which children were obliged to take care of old parents and relatives. Yet she was unable to confide in any outsider who could invoke the Act in her favour. Nor did she have any faith in the enforcement and police system to help her. She hoped that her situation would change for the better and that she would get back what rightfully belonged to her but she was not sure how that could happen.

### 6.4.4 Lack of Security in Old Age

Elderly face issues of security in their old age, relating to both property and person. These issues may arise from within the family or in larger society. Elderly experience difficulties in obtaining both security and redress, and the lack of security in old age leads to mental distress. Dependency on external sources is high during old age, and the family, police, social organizations and other institutions play an important role in safeguarding and enhancing the quality of life of the elderly in this regard.

## 6.5 Some Concluding Remarks

This chapter narrates the stories of the elderly in various socio-economic and cultural contexts, both as individuals as well as through senior citizens organizations.

These experiences are closely linked to the financial status, dependency, occupation and education of the elderly as also the social relations, support networks and place of residence. These situations only show that further work is necessary to continue to hear the voices from the field so that public, NGO and private initiatives can be regularly and incrementally made more user-friendly in enabling a better quality of life for the elderly. Networked senior citizens' collectives such those developed in 2010, built on the efforts of many such organizations and informal groups working at the microlevel; the outcomes of these efforts have demonstrated amply their significance.

**Elderly face issues of security in their old age, relating to both property and person. These issues may arise from within the family or in larger society. Elderly experience difficulties in obtaining both security and redress, and the lack of security in old age leads to mental distress.**

# 7

# Meeting the Demand for Elder Care in India

# Meeting the Demand for Elder Care in India

## 7.1 Estimating the Demand for Elder Care Services in India

Increasing elderly population in India together with enhanced awareness on health issues is expected to put considerable pressure on the health care system in general and geriatric care in particular.

The UNFPA conducted a survey across seven states in India in 2011 to build a knowledge base on the socio-economic and health implications of ageing and the ability of the elderly to access and use various welfare initiatives of the government. The seven states are: Himachal Pradesh, Kerala, Maharashtra, Odisha, Punjab, Tamil Nadu and West Bengal. These states have higher proportion of elderly (60 years and above) as a percentage of population than the national average. The sample for each state was fixed at 1,280 elderly households having at least one elderly member. The survey showed that in 2011 around 7.6 percent of the elderly in India (approximately 7.9 million persons) had difficulty in accomplishing activities of daily living (ADLs) and were in need of assistance. This number is expected to go up substantially with advancing age[75].

According to the study, over 5 percent of the elderly in the country had functionality issues necessitating regular care and support. Around 8 percent of the elderly require assistance to perform at least one ADL. Approximately 18 percent of elderly rate their health as poor. In general, older women have greater difficulty in performing ADLs than men. Performing instrumental ADLs (IADLs) including the ability to telephone, shopping, food preparation, housekeeping, doing laundry, travelling, responsibility for own medication and ability to handle finances requires more skill, judgement and independence than performing ADLs. The survey covering the eight domains of IADL found that about 66 percent of the elderly have difficulty in preparing food and 60 percent in going shopping. A quarter

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75 The United Nations Population Fund (UNFPA), India in collaboration with the Institute for Social and Economic Change (ISEC), Bangalore, the Institute for Economic Growth (IEG), New Delhi and the Tata Institute of Social Sciences (TISS), Mumbai launched a research project, Building Knowledge-base on Population Ageing in India (BKPAI) in 2011.

of the elderly reported problems with using the telephone and 40 percent with doing the laundry. Based on the findings of the study, future demand for ADL services could be estimated in two scenarios: (I) in future years, the percentage of elderly with ADL difficulties remains same as in 2011; and (II) in future years, the percentage of elderly with ADL difficulties increases with population ageing (as observed in some developed countries). In Scenario II, the increase in the proportion of elderly and life expectancy increase at age 60 (as observed in developed countries) contribute to ADL service demand. As per author analysis, these two factors explained around 81 percent of change in ADL over a period of time in the select developed countries.

Scenario II projections based on the 2011 survey data show that by 2020 (just four years from now), there will be around 12 million elderly requiring ADL

assistance, a number that will expand to 17.8 million by 2030 and 37.9 million by 2050 (Table 7.1).

In addition to ADL difficulties, the elderly also suffer from chronic diseases that need continuous care in the longer term. The BKPAI 2012 survey pegged the percentage of elderly in India with one or more chronic conditions at 65 percent. If it is assumed that in future years, the percentage of elderly with specific chronic diseases will remain at the same rates as 2011, the number of elderly with at least one chronic disease will go up from 67.3 million in 2011 to 213.9 million in 2050 (Table 7.2).

Clearly, to meet the future demand for ADL services and chronic disease management, a multipronged strategy is needed and different models of care need to be tried out.

Table 7.1. Number of Elderly Persons with Difficulties in Performing at least One ADL (India, 2015–2050)

| Year | Scenario I (assuming % of elderly with ADL issues remains constant 2011 onward) | Scenario II (% of elderly with ADL issues increases with population ageing as observed in select developed countries) | |
|---|---|---|---|
| | No. of elderly (million) | Projected percentage | No. of elderly (million) |
| 2011 | 7.9 | 7.6 | 7.9 |
| 2015 | 8.9 | 8.3 | 9.7 |
| 2020 | 10.6 | 8.6 | 12.0 |
| 2030 | 14.5 | 9.4 | 17.8 |
| 2050 | 25.1 | 11.5 | 37.9 |

**Table 7.2. Incidence of Chronic Diseases amongst the Elderly (India, 2011–2050)**

| Major chronic diseases | Prevalence% (2011) | Incidence in million cases | | | | |
|---|---|---|---|---|---|---|
| | | 2011 | 2015 | 2020 | 2030 | 2050 |
| Arthritis | 29.3 | 30.4 | 34.1 | 40.8 | 55.9 | 96.7 |
| Hypertension | 21.0 | 21.8 | 24.5 | 29.3 | 40.1 | 69.3 |
| Diabetes | 10.1 | 10.5 | 11.8 | 14.1 | 19.3 | 33.3 |
| Asthma | 7.7 | 8.0 | 9.0 | 10.7 | 14.7 | 25.4 |
| Heart disease | 5.8 | 6.0 | 6.8 | 8.1 | 11.1 | 19.1 |
| Depression | 1.5 | 1.6 | 1.7 | 2.1 | 2.9 | 5.0 |
| Alzheimer's disease | 1.4 | 1.5 | 1.6 | 2.0 | 2.7 | 4.6 |
| Cerebral stroke | 1.0 | 1.0 | 1.2 | 1.4 | 1.9 | 3.3 |
| Dementia | 0.9 | 0.9 | 1.0 | 1.3 | 1.7 | 3.0 |
| Cancer | 0.4 | 0.4 | 0.5 | 0.6 | 0.8 | 1.3 |
| One or more chronic ailments | 64.8 | 67.3 | 75.5 | 90.3 | 123.6 | 213.9 |

## 7.2 Elderly Care Services that Need Special Attention

The survey showed that about half the elderly feel that the government should provide support during old age. In particular there is a need to have community-based day-care centres for the elderly providing services such as skill building, financial and legal advice, entertainment, exercise and other ways of active ageing, with effective linkages with the public health system. Specific attention is needed to build capacity in home-based and community-based care for the elderly. At the family level, stronger intergenerational bonding is a priority while at the community level, greater participation and involvement of the elderly is important[76]. The other priority areas include:

- elderly living in poor urban dwellings who need more age-friendly facilities;
- access to social security schemes, including old-age pensions without errors of inclusion or exclusion;
- community mobilization and engagement in social and cultural activities;
- appropriate avenues of gainful employment for the elderly who are still willing and able to work;

76  Sumati Kulkarni, Siva Raju and Smita Bammidi (2015), "Social Security for the Elderly in India", Thematic Paper 1, United Nations Population Fund, New Delhi, india.unfpa.org/sites/asiapacific/files/pub-pdf/ThematicPaper1_2.pdf

- greater involvement of corporate entities in enhancing the quality of life of the elderly by linking with corporate social responsibility (CSR) activities;
- food security for the elderly;
- routine screening for age-related diseases followed by proper medical attention; and
- addressing depression caused by high level of chronic morbidities through activities to keep the elderly socially engaged and mentally fit.

## 7.3 Models of Elder Care to Bridge the Need Gap

### 7.3.1 The Village-level Convergence Approach

**Introduction**

Chapter 3 of this report highlights the comprehensiveness of the National Policy on Older Persons (1999) and refers to two ways of increasing the scope of development initiatives to benefit the elderly: (i) by mainstreaming elderly issues in relevant sector-specific plans; and (ii) by ensuring synergistic convergence of different sector-specific activities in communities, thus increasing efficiency by avoiding duplication of effort and promoting rationalization of sector plans and implementation strategies.

The concept of village level convergence is not new in India though the recognition of its potential to benefit the rural elderly is. The Pradhan Mantri Adarsh Gram Yojana (PMAGY) was launched in 2009/10 as a development initiative for backward villages through the convergence of central and state rural development schemes in roads, water supply and sanitation, employment schemes, and education programmes including the Integrated Child Development Services (ICDS). Implemented by the Ministry of Social Justice and Empowerment (MOSJE), the Yojana envisaged the development of a model village through programme convergence for others

to emulate. The Yojana was expected to be implemented in 44,000 villages across the country which had a scheduled caste population of over 50 percent.

On 11 October 2014, PMAGY was rationalized and re-launched in a new avatar as the Sansad Adarsh Gram Yojana (SAGY), a demand-driven programme based on community participation. It mandated all Members of Parliament (MPs) to adopt one village each from their constituency (besides their own village or their in-law's village), and transform it into a model village by 2016 based on a set of predetermined parameters. Thereafter, they were expected to transform 2–3 more villages by 2019. While no new funds were allocated to SAGY, funds could be raised through existing schemes and sources such as the MP development fund, Panchayat revenues and corporate social responsibility (CSR) sources. On the one hand, SAGY fixes the onus of village development on the MP thereby leveraging central leadership, and on the other, it aims to instil amongst villagers, a sense of pride and ownership over the development process as they are transformed into models for others to emulate. Each MP is mandated to develop at least five Adarsh Grams (model villages) by 2024. It may be hoped that as the villages transform under SAGY, they will witness greater participation in local self-governance, gender equality, volunteerism, and social justice. As model villages pursuing the path of environmentally sustainable development they may promote a culture of cleanliness, mutual cooperation, and self-reliance[77]. Convergence of central and state initiatives, as well as private and voluntary initiatives to achieve comprehensive development in tune with people's aspirations and local potential is one of key approaches of the model village. As the majority of the elderly in our country still reside in rural areas, development of villages along these lines may indeed enhance their quality of life. The key aspects of SAGY that are relevant to older people include

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77  MORD (2014), Sansad Adarsh Gram Yojana (SAGY) Guidelines, Department of Rural Development, Ministry of Rural Development, Government of India, New Delhi.

poverty eradication, development of SHGs for income security, promotion of gender equality and empowerment especially of elderly women, protection against illness, and community empowerment. There is need to prepare a shelf of project ideas under SAGY to attract CSR funding; these could include mobile medical units (MMUs), health awareness and promotion camps, nutrition programmes, and promotion of elderly self-help groups (ESHGs) and health insurance. Effective implementation of SAGY would lead to capacity development of Gram Panchayats, a key pillar for the implementation of the NPOP.

## Making Basantwadi an Adarsh Gram for the Aged

The Tata Institute of Social Sciences, Mumbai recently undertook to empirically test the feasibility and effectiveness of model villages in improving the quality of life of all age groups. The study focused specifically on the elderly in Baswantwadi village in Osmanabad district of Maharashtra to assess the needs of elderly, awareness and utilization of ongoing programmes and barriers there of Information was collected from the villagers as well as from multiple stakeholders like different departments of the Tehsil office, child development project officers (CDPOs), anganwadi centres, Gram Sevak etc.

More than 15 percent of the total population in Basantwadi was over 60 years old with older women outnumbering the men. About half the elderly were below 70 years and about 10 percent above 80 years. About two out of five older women were widowed, while less 10 percent elderly men were widowers. Illiteracy among elderly was very high (over 90 percent) and over 75 percent of elderly were currently working (majority as wage labourers). About two fifth of the elderly lived below the poverty line (BPL). Many asset-poor elderly with intermittent wage income lived in unsafe housing and faced multiple vulnerabilities including the economic compulsion to work in old age.

Most of the elderly were aware of old-age pension and widow pension schemes though less than 50 percent applied for the benefits. Of the applicants about only one third were beneficiaries of either scheme. Most of the aged villagers felt that the paltry pension amount simply did not leave enough on the table to make the bribing for approvals and repeated expenditure on travelling to the bank worth the trouble.

The study included an elderly needs assessment survey as well which threw up the following findings: financial needs (87.2 percent), food security (79 percent), employment needs (45.3 percent), caregiver needs (38 percent), and housing needs (27 percent). The financial needs were clearly unmet even with the ongoing schemes and programmes. Almost all the older women have unmet financial needs, and about 90 percent had food and nutrition needs as well (Table 7.3).
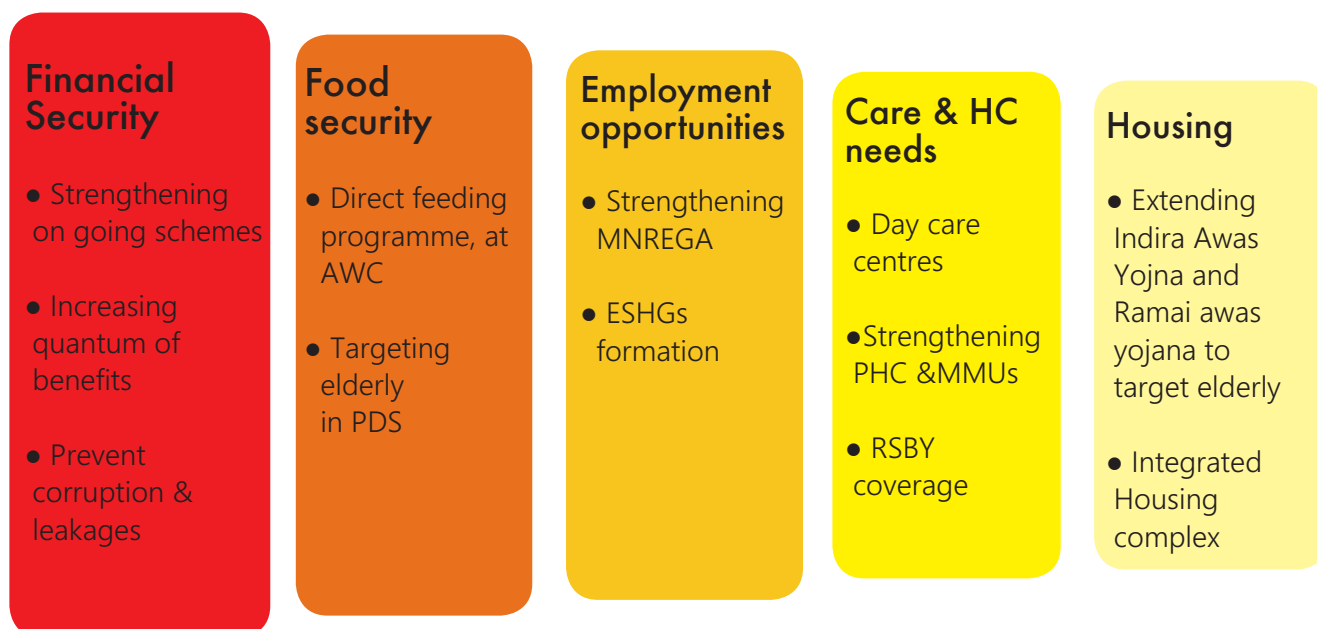
Convergence of central and state initiatives, as well as private and voluntary initiatives to achieve comprehensive development in tune with people's aspirations and local potential is one of key approaches of the model village. As majority of the elderly in our country reside in rural areas, development of villages along these lines may indeed enhance their quality of life.

## Table 7.3. All the Elderly have Needs but the Women are More Deprived

| Needs of the elderly | Men (%) | Women (%) | Total (%) |
|---|---|---|---|
| Financial | 80.7 | 93.3 | 87.2 |
| Food/ nutrition-related | 72.8 | 86.7 | 79.0 |
| Employment | 45.6 | 45.0 | 45.3 |
| Caregiver | 29.8 | 45.8 | 38.0 |
| Health | 14.0 | 20.0 | 17.1 |
| Housing | 23.8 | 30.0 | 26.9 |
| Social engagement | 11.4 | 21.7 | 16.7 |
| Participation in family affairs | 21.9 | 30.0 | 26.1 |
| Safety and security | 7.9 | 18.3 | 13.2 |

The research yielded some important insights on how elder care in Baswantwadi Village could be aligned better to the needs of the people (Figure 7.1).

## Figure 7.1. Interventions for Elder Care in Basantwadi



**Financial Security**

- Strengthening on going schemes
- Increasing quantum of benefits
- Prevent corruption & leakages

**Food security**

- Direct feeding programme, at AWC
- Targeting elderly in PDS

**Employment opportunities**

- Strengthening MNREGA
- ESHGs formation

**Care & HC needs**

- Day care centres
- Strengthening PHC &MMUs
- RSBY coverage

**Housing**

- Extending Indira Awas Yojna and Ramai awas yojana to target elderly
- Integrated Housing complex

**Financial security:** There are still a number of elderly who are eligible to receive old-age or widow pensions or benefits under other schemes but are left out. Some enablers of greater inclusion could be: (i) removal of administrative bottlenecks and simplification of required documentation; (ii) enhancement in the pension amount and adoption of a transparent disbursal mechanism. The MORD, working in collaboration with other ministries should aim at increasing financial security for senior citizens in the village by strengthening other ongoing schemes and programmes. The Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA) implemented by the MORD, can also help in providing employment opportunities to the active elderly of the village.

**Food security:** The ICDS could be extended to those elderly who have no financial support or those who are unable to cook due to age-related functional limitations. The public distribution system should also prioritize food supplies to the elderly of the village. Income earning opportunities: MNREGA which specifies no upper age limit for employment should engage active, willing and eligible elderly in paid work. Further, the definition of employment under MNREGA should be extended to include home-based care-giving to the elderly suffering from functional disabilities and other age-related problems due to which they are unable to do work. Development of ESHGs can enable the elderly to organize themselves, generate income as well as socialize with peers and help in active ageing.

**Health care needs:** All elderly and more particularly the women emphasized the need for a good care-giving mechanism in the village and a system for meeting unmet needs for health care of the elderly. Although the National Programme for the Health Care of the Elderly (NPHCE) addresses the need exclusively, a community-based day care centre with volunteers would be very useful. Strengthening the primary health care system in the community, organizing MMUs, and extending the ongoing Rashtriya Swasthya Bima Yojana (RSBY) to include the elderly would be needed. CSR support should be enlisted in MMU initiatives, health promotion and wellness initiatives for the elderly in the village.

**Housing needs:** In Baswantwadi village, about 40 percent of elderly live in unsafe kuchcha houses and are in need of financial assistance from the ongoing Indira Awas Yojana and Ramai Awas Yojana. For the few elderly who live alone, an integrated housing complex could be developed to form a sustainable support system. Meeting the above needs requires strong intersectoral coordination in planning, implementation and monitoring of ongoing programmes of various ministries and departments. To achieve greater and more effective convergence, private sector participation must be enlisted in strengthening the service delivery to improve the lives of the elderly. These are some additional features to be considered while selecting and creating model villages under SAGY.

In summary, the process of achieving convergence has the following steps:

- situational analysis of elderly;
- mapping the needs of elderly;
- prioritizing the needs;
- review of ongoing programmes in relation to priority needs;
- developing an action plan to improve access, making services elderly-friendly, and enabling elderly participation;
- executing the action plan;
- monitoring and evaluation;
- reviewing the progress; and
- taking necessary actions to respond to the findings.

## 7.3.2 Aligning Service Package with Needs: A Segmentation Approach

Senior citizens in India belong to diverse groups although majority of them live in rural areas, are illiterate, dependent, poor and carry significant morbidity burden. Consequently, the ageing issues are also different and a lot depends on the family support system the elderly enjoy. The heterogeneity among the elderly population must be factored into framing appropriate models of care for them. As the steady shift away from care-giving in a traditional joint family continues, there is likely be a decrease in elder care by adult children in the future, which will create more demand for old-age homes. Public policy in India has to decide on an appropriate combination of family care and institutional/community care for our elderly. Some scholars believe that due to high cost we cannot fully depend on institutional care as a priority but should develop models of home or family care supplemented by a variety of respite services suitable for our cultural context[78]. Such models would be influenced by factors such as rural–urban residence, social class differences and gender dynamics. Below are a few considerations upon which different combinations of care of the elderly can be developed. Needs for care of elderly differ across five overlapping segments—rural, urban poor, urban upper and middle income elderly, elderly women, and those living alone.

### Rural elderly

The traditional support systems of family, kinship and community were once considered strong enough to provide social security to older people, particularly in rural areas. But today these traditional values and norms have become weak as joint family arrangements and value systems are being eroded partly due to migration for work and increasing participation of women in workforce. The elderly who are left behind often depend on money sent by children who do not live with them, flows which may be intermittent and in some cases entirely absent. To supplement, the rural parents are often forced to find work in the informal sector with its attendant insecurities. In addition they also lack access to good health care services and do not get adequate support from old-age pension schemes. For this group of rural elderly, support for increased access and use of dedicated income and health security provisions is a priority. They also need to be better aware of active ageing principles and taking care of one's own heath to the extent possible. This is a priority for the government and NGO partners as well as for Panchayati Raj institutions (PRIs) to meet the needs of rural elderly.

For this segment, a package of care addressing health security, food security and financial security appears to be the felt need. Strengthening the primary health care system in ways anticipated under the NPHCE is a priority for health security. To increase accessibility, mobile medical clinics of HelpAge India provide a good model to scale up. Food insecurity of the rural poor elderly is a result of lack of income or asset ownership and hence dependence on doles and transfers. To address the issue without creating additional services and structures, it is suggested that anganwadis expand the direct feeding programmes of ICDS to cover the elderly. Financial security can be addressed through (i) ESHGs initiated by HelpAge India, (ii) leveraging provisions under MNREGA to increase the scope of work for the able elderly, and (iii) increasing the amount and coverage of national old-age pension schemes.

### Urban poor elderly

When the elderly decide to move to urban areas, they face the consequences of transition from rural living to urban slums and settlements which are congested and unsanitary as also beset with crime and alcoholism. To this group of elderly, more secure living arrangements and health care would be the priority. The National Urban Health Programme as well as the NPHCE should focus on

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78  Liebig, Phoebe S. and S. Irudaya Rajan (2005), An Ageing India: Perspectives, Prospects and Policies, Rawat Publications, New Delhi.

such marginalized urban elderly population more strongly. Strengthening of municipal health systems particularly in geriatric care with a focus on chronic conditions and non-communicable diseases (NCDs) is essential. There is a need to design models of social and community-based care for the urban poor elderly. Networking between organizations working for senior citizens, old-age homes as well as day care centres is necessary for greater community participation and socialization of the elderly who may otherwise experience loneliness.

## Urban upper and middle income elderly

In this group the elderly are generally healthy and active and are often able to lead productive and purposeful post retirement lives. While rural India continues to be family-dependent in old age, the urban upper and middle income elderly benefit from the migration of their children to better employment opportunities. Many are well-off precisely because of their prosperous children but are left alone to take care of themselves; more often than not, they are quite capable of doing so. Strengthening systems of formal and reliable care-giving is essential for this segment of elderly. Promoting age-friendly community-based initiatives for socialization as well as for active ageing can fulfil the felt needs of this segment.

## Elderly women

As discussed in Chapter 2, there are significant gender differentials in longevity, loss of spouse, income and asset ownership, living arrangements and health. Care-giving responsibilities are largely expected to be borne by women both young and old. Traditional gender roles often restrict women within their home without much decision-making power. The engendering of roles experienced by women throughout their life course becomes particularly explicit in later years and often exposes elderly women to greater risk of ill-health. It therefore appears that ageing poses more challenges for women than for men. As most women outlive their husbands, they are more likely to be saddled with care-giving tasks in the family, leading to deteriorating health and mental stress. This restricts their ability to be employed even if they are qualified and makes them economically dependent on others. In case they are employed, they are often expected to carry responsibility of both home and work front, especially if they belong to rural and urban poor families.

It is necessary to review the existing social support programmes for elderly through a gender lens and focus on problems of older women who pull the drag of not just by their age, but also widow hood and continued gender bias throughout their life course. Counselling services for elderly women as well as their family members to combat social isolation, lack of awareness and knowledge and elder abuse is essential. Special health care services for older women with a focus on NCDs will address the multiple morbidities.

## Elderly living alone

Of central importance to the elderly living alone (particularly women), is community-based care involving other senior citizens, children and youth. Some attempts like, "Adopt a Granny" by school children to strengthen intergenerational bonds are known to show positive outcomes. Protection by law and police for elderly living alone is essential.

## 7.4 Estimating Resource Requirements

The financial implications of the Universal Old Age Pension Scheme (UOAPS) for Maharashtra were worked out by a study published in 2014 under two scenarios: I: 100 percent coverage of all elderly; and II: coverage of only economically dependent elderly[79].

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79 Ramkumar, R. (2014),"Financing of Old Age Pensions in Maharashtra: A Note", Tata Institute of Social Sciences, Mumbai.

For both alternatives, the total and net burden was calculated for three monthly pension scenarios:

- Monthly pension remains ₹ 600
- Monthly pension rises to ₹ 2000, where ₹ 1800 is provided by the Government of Maharashtra and ₹ 200 by the Government of India; and
- Monthly pension rises to ₹ 2000, where ₹ 1000 is provided by the Government of Maharashtra and ₹ 1000 by the Government of India.

It was estimated that across all scenarios the total burden would range from ₹ 26.7 billion to ₹ 240 billion and the net additional burden over and above that of the existing two schemes, Shravanbal Rajya Seva Nivrutti Yojana (SSNY) and Sanjay Gandhi Niradhar Anudan Yojna (SGNAY), would range from ₹ 17.2 billion to ₹ 231 billion.

If the universal pension scheme of ₹ 2000 per month, as suggested by the Pension Parishad is made applicable to all the elderly in India above 60 (instead of 55-plus, as suggested by the Pension Parishad), which numbers to 103.8 million elderly, the total annual burden on the Government of India will be ₹ 2,492 billion. The burden would be much less if the scheme were to be restricted to non-income tax payers, and those not receiving a regular pension.  Since income tax payers and pensioners are on government records, such applicants are easy to verify and exclude. These exclusion criteria are likely to work well for urban areas but to exclude the rural rich, it will be necessary to find a suitable exclusion criterion. BKPAI survey for seven states shows that about a third of the elderly belongs to the two top wealth quintiles. If the pension of ₹ 2000 per month is given to the remaining 66 percent elderly (60-plus), that is, to 68.5 million elderly, the annual burden on the government will be ₹ 1,644 billion. The net burden will be much less as the expenditure on existing pension schemes will not be required.

Another study examined the fiscal sustainability of the Universal Age Pension Scheme (UOAPS) using the National Transfer Accounts Methodology[80]. It took into account, ageing of the population over the years as well as the alternative scenarios regarding productivity growth, discount rates and alternative income elasticity (0.5, 1.0, 1.5) of public expenditure on cash transfers, including UOAPS. According to the study, the expected increase in expenditure due to UOAPS will be fiscally sustainable if the policy makers restrain the income elasticity of cash transfers, including UOAPS, to less than 0.5. Assuming 0.5 income elasticity, the required expenditure on UOAPS increases from ₹ 1,947 billion in 2005/06 to ₹ 2279 billion in 2010/11. The corresponding percentage annual increase in the required expenditure in these two years will be 4.38 percent and 6.66 percent. The corresponding required expenditure as  percent of GDP will be 6 percent in 2005/06 and 3.52 percent in 2010/11. As against this, if income elasticity is 1.5, the increase in expenditure will increase from ₹ 2,206 billion in 2005/06 to ₹ 2,713 billion in 2010/11. The corresponding figures for required expenditure as a percentage of GDP will be 6.8 percent in 2005/06 and 4.19 percent in 2010/11.

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80  Narayana, M.R. (2014), "Universal Old Age Pension in India: Estimates of Public Cost and Fiscal Sustainability", a presentation at the UNFPA–TISS–ISEC conference on India's Elderly: Dignity, Health and Security held in New Delhi on 3–4 December 2014. The presentation was based on Narayana, M.R.,(2014), "Impact of Population Ageing on Sustainability of India's Current Fiscal Policies: A Generational Accounting Approach", Journal of the Economics of Ageing, No.3, pp. 71–83.

# The Way Forward

## Enhancing Policy and Programme Relevance

### Feedback from the field

At present there is no formal and regular mechanism of receiving and incorporating user feedback for making mid-course corrections. The feedback is often in the form of reports on physical targets achieved, expenditures and some aspects of human resources such as recruitment, training etc. But generally the demand side information (related to how the older persons feel about the quality and access to services, their suggestions to increase relevance of services to their needs etc.) in the form of feedback from PRIs and community is lacking. This formal mechanism of seeking feedback from the field is an important element of empowerment, a word that is now a part of the MOSJE's title. This formal and regular feedback from the field (say, three times in a year) would help top policy makers and managers in making mid-course corrections and increasing the policy and programme relevance to respond to the real and emerging needs of the elderly.

### Policy and programme audit

Setting up of a community participatory task force, including PRIs and older persons would be very useful to identify and remove negative stereotypes in policies and programmes that might have crept in. This should also include identification and removal of administrative and procedural bottlenecks for easier access to social welfare schemes by the older persons. A periodic critical review of select social welfare schemes for the elderly by this task force will help to assess if the expected results or positive changes are being actually achieved, moving beyond just activities and budgets.

### Adoption by the states

State governments should adopt the NPOP and develop action plans for implementation in their own states, with technical assistance from MOSJE. Specific budgetary provision and increased allocations for the elderly are needed in the state budgets.

## Creating a Supportive Environment

### Advocacy

To stand up against ageism and to change mindsets towards creating a more supportive environment, it is necessary to establish formal linkages with media, elected representatives and faith-based organizations so that: (i) media can publish positive stories about the contributions of the elderly to the family and society, aimed at removing negative stereotypes that view the elderly as burdensome; (ii) a group of champion parliamentarians/legislators can be identified who can bring up the issues on the floor of the House as well as in their respective constituencies; and (iii) faith-based organizations can inculcate values, respect and regard for the elderly.

### Better bonding between generations

There is a need to work with the in-school and out-of-school children and young people to develop better intergenerational bonding with a focus on reciprocity. Contributions and achievements of the elderly should be publicly recognized in the community in the same way as the MOSJE does annually at the national level.

### Ensure that benefits are better availed

The reach of old-age pension schemes and widow pension schemes is very limited even among BPL families and widowed women who have no other source of income. Increased pension amount and coverage, including an easy and transparent

disbursement system is essential. The active role of PRIs will be particularly important for better availing of social welfare schemes by both older men and older women.

## Safety and security of older persons

This should begin with the preparation of a comprehensive plan for safety and security starting with stringent punishment for abuse of and crimes against older persons. Informal community vigil as well as formal support from the police to keep a regular watch on safety and security of the elderly would be needed. Age-friendly, barrier-free access in all public places would be required. Age-friendly housing complexes without segregation of the elderly would be needed. Loans for the elderly for the purchase of new property or repairs of existing housing property should be available with low interest rates and easy repayment schedules.

# Capacity Development

## Capacity of mid-level managers

It is necessary to develop the capacity of state level managers and institutions for better coordinated implementation of both central and state sponsored schemes. For this purpose, civil service officials need to undertake systematic efforts to sensitize mid-level managers through state training institutions.

## The PRIs

NPOP lays strong emphasis on the role of PRIs for effective community-level changes. It is therefore necessary to educate the PRIs on how they can facilitate and encourage better care of the elderly in the community. The convergence of development initiatives in villages through the SAGY requires increased capacity of PRIs.

## Capacity of health professionals and service providers

The NPHCE envisages efforts both in terms of infrastructure and human resource development for which adequate training capacity needs to be

created along with well-designed and delivered geriatric training courses for health workers. A cadre of caregivers for home-based care for disabled older persons needs to be developed. Those pursuing this career need to be recognized with professional growth opportunities. Also, affordable and appropriate assistive devices need to be researched, developed and made easily available. Regional Resource and Training Centres (RRTCs) must be more actively involved in structuring both short duration and long-term health care needs for dementia and other geriatric illnesses, including training of personnel and education of families.

## National Institute of Social Defence

In 2015, UNFPA completed a management study of the National Institute of Social Defence (NISD) for upgrading it to a centre of excellence. The report was formally accepted by MOSJE which was interested in implementing the recommendations. Specifically, the report highlighted the need for competent staff recruitment and motivation; a fresh approach to planning, progress monitoring and impact assessment systems and quality assurance of all NISD functions. Over the next Country Programme cycle, UNFPA could carry this initiative forward and help NISD develop capacity towards becoming a centre of excellence.

## Strengthening partnership with CSR

UNFPA held a few meetings with corporate entities (largely Mumbai-based) under the auspices of the TISS-based CSR hub. Such engagement needs to be strengthened further over the next few years. A shelf of project ideas for CSR funding should be developed and linkages established with interested corporate firms.

# Policy and Programme Relevant Research

### Research Advisory Committee at NISD

The governments, private sector and relevant UN agencies can work together to encourage research and knowledge building on emerging areas such as economic aspects and its implications on ageing, health insurance, longitudinal study on health parameters, demand for and supply of variety of services and products needed for older persons etc. The government can think of setting up a Research Advisory Committee for this purpose.

### Expand the research base

There is a need to encourage research on ageing in government institutions such as the National Council of Applied Economic Research, National Institute of Public Finance and Policy, and the Indian Council of Social Science Research so that the younger pool of multidisciplinary researchers takes interest in various aspects of ageing relevant to national policy.

### Collaboration with national data collection efforts

Partnerships with National Sample Survey Office and other large data collection agencies should be established to include questions on older persons. Collaboration with agencies like UNFPA will add significant value by converting data into information and creating a knowledge base on ageing.

### Learning from others

Networking of all stakeholders on to a common platform may be facilitated so that they may learn from each other. Further, there is a need to visit and learn from relevant international experiences and adapt them to the Indian context. Specific dedicated funds for this purpose need to be allocated.

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