Emerging Trends in Education [Vol. VI - No. 1. August 2015. pp 11-30]

An Approach Towards Healthy and Active Ageing

*Dr. Vandana Sinha**

General Concept of Ageing

WHO defines Health as a state of complete physical, mental and social being and not merely the absence of disease or infirmity. Ageing is not a disease but a natural and biological phenomenon associated with growing age and falling health. Defining ageing as a disease and then trying to cure is very unscientific. Ageing is different from deleterious process that decreases one's ability to fight disease. Ageing is a progressive process as years after years are added to life with passing of time. Faulty lifestyle results in premature ageing. Old age is viewed as an unavoidable, undesirable, problem-ridden phase of life that we all are compelled to live, marking time until our final exit from life itself. Ageing is normally characterized by a gradually decreasing ability to cope with stress, increased homeostatic imbalance and ageing difficulties.

There are many definitions of 'Healthy ageing', a term which is often used interchangeably with terms such as successful ageing, positive ageing and productive ageing. Although there is no universal definition, there is general acceptance that healthy ageing involves more than just physical or functional health. The term 'Active ageing' was adopted by the World Health Organization in the late 1990s. 'Active ageing' is defined by WHO as 'the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age allowing people to 'realize their potential for physical, social and mental well-being throughout the life course'

Active ageing allows people to realise their potential for physical, social and mental well being throughout their life course and participate in the society, while providing them with adequate protection, security and care they need. The word 'active' refers to continuing participation in social, economic, cultural and civic affairs and not just the ability to be physically active or to participate in the labour force. Older people who retire from their service or work, ill or live with disabilities can remain active contributors to their families, peers, communities

* Professor, Social Work Department, Mahatma Gandhi Kashi Vidyapith, Varanasi

and nation. Active ageing aims to extend healthy life expectancy and quality of life for all people as they age. It applies both to individuals and the population groups. Ageing takes place with context of friends, work associates, neighbours and family members. This is why interdependence and intergenerational solidarity are important trends of active ageing. As people age, their quality of life is largely determined by their ability to maintain autonomy and independence.

The active ageing approach is based on the recognition of the human rights of older people and the United Nations principles of independence, participation, dignity, care and self-fulfilment. It shifts strategic planning away from a 'needs-based' approach (which assumes that older people are passive targets) to a 'rights- based' approach that recognizes the rights of people to equality of opportunity and treatment in all aspects of life as they grow older.

Terminology associated with Old Age

Elderly or old age consists of ages nearing or surpassing the average life span of human beings. Government of India adopted 'National Policy on Older Persons' in January, 1999. The policy defines '*senior citizen*' or '*elderly*' or '*old persons*' as a person who is 60 years or above in age. The medical study of the ageing process is *Gerontology* and the study of diseases that afflict the elderly is *Geriatrics*. *Senescence* is defined as 'combination of deterioration processes after the development period of a living organism'. (Latin word *senex* means old age or old man). *Life Expectancy* is the expected (in the statistical sense) number of years of life remaining at a given age. *Healthy life expectancy* is commonly used as a synonym for *"disability-free life expectancy"*. *Mortality Rate* is a measure of the number of deaths in some population, scaled to the size of that population, per unit time. Mortality rate is typically expressed in units of deaths per 1000 individuals per year. *Crude Death Rate* is the total number of deaths per year per 1000 people. *Age –specific mortality rate* is defined as the number of deaths in specific age-group per thousand populations in the same age-group in a given year. *Dependency Ratio* is an age-population ratio of those typically not in the labour force (the *dependent* part) and those typically in the labour force (the *productive* part). In India, the *Old age dependency ratio* is defined as the number of persons in the age-group 60 or more per 100 persons in the age-group 15-59 years. *Quality of life* refers to "an individual's perception of his or her position in life in the context of the culture and value system where they live, and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept, incorporating in a complex way a person's physical health, psychological state,

level of independence, social relationships, personal beliefs and relationship to salient features in the environment."(WHO, 1994).

Trend of Ageing Across the Globe

Population ageing is taking place in nearly all the countries of the world. The global share of older people (aged 60 years or over) increased from 9.2 per cent in 1990 to 11.7 per cent in 2013 and will continue to grow as a proportion of the world population, reaching 21.1 per cent by 2050. Globally, the number of older persons (aged 60 years or over) is expected to more than double, from 841 million people in 2013 to more than 2 billion in 2050

Presently, about two thirds of the world's older persons live in developing countries because the older population in less developed regions is growing faster than in the more developed regions. This is a huge population that must receive attention from policymakers and social scientists across the world. The projections show that older persons will be increasingly concentrated in the less developed regions of the world. By 2050, nearly 8 in 10 of the world's older population will live in the less developed regions. India and China will contribute one third of this.

If the current projections are realized, ageing will become a virtually universal phenomenon during the present century, although it will progress with different intensity and speed across countries and regions. The oldest-old age segment (80 years and above) is the fastest-growing segment and by 2050, about 20 per cent of older persons will be 80 years and above. The coming decades therefore are characterised by ageing of the aged. This will have significant implications for the older persons themselves, as well as the families and societies they live in.

Table1: Global Scenario of Aged, 1995 – 2050

Year	Population (in Billion)	% aged 60+	% aged 65+	% aged 80+
1995	5.7	9.5	6.5	1.1
2000	6.1	9.9	6.8	1.1
2025	8.0	14.6	10.8	1.7
2050	9.4	20.7	15.1	3.4

Source: United Nations, 1998, World Population Projections, Department of Economic and Social Affairs, Population Division.

State of the Aged in India

India has more than 50% of its population below the age of 25 and more than 65% below the age of 35. The proportion of the population aged 60 years and above was 7 percent in 2009 (88 million) and is expected to increase to 20 per cent (315 million) by the year 2050. The United Nations Population Division projects that India's population aged 50 and older will reach 34 percent by 2050 (UN 2011). Between 2010 and 2050, the share of 65 and older is expected to increase from 5 percent to 14 percent, while the share of the oldest-old age group (80 and older) will triple from 1 percent to 3 percent. The projections suggest that the country is gradually but surely transitioning away from a young age structure with a steady increase in the current median age of about 23 years to 31 years by 2026. Currently 1 in 11 Indians is elderly, by 2050 this would be 1 in 5. Among the elderly, the no. of oldest old i.e. 80 yrs and above will increase more rapidly than the rest.

Table 2. gives a profile of the elderly classified by ages 60 and above in terms of size, proportions and gender dimensions. The number of elderly persons above 70 years of age (old-old) is likely to increase more sharply than those 60 years and above. The old-old are projected to increase five-fold during 2001-2051 (from 29 million in 2001 to 132 million in 2051). Their proportion is expected to rise from 2.9 to 7.6 percent. Although excess males are found in the age group 60 and above, the old-old sex ratio is favourable to females. The oldest old (80+) among the elderly in India is expected to grow faster than any other age group in the population. In absolute terms, it is likely to increase four-fold from 8 million in 2001 to 32 million in 2051.

Table 2: Number, Proportion and Sex Ratio of the Elderly, 2001-2051

	2001	*2011*	*2021*	*2031*	*2041*	*2051*
60 and Above						
Numbers (in millions)	77	96	133	179	236	301
Percentage to the total population	7.5	8.2	9.9	11.9	14.5	17.3
Sex Ratio (males per 1000 females)	1028	1034	1004	964	1008	1007
70 and Above						
Numbers (in millions)	29	36	51	73	98	132
Percentage to the total population	2.9	3.1	3.8	4.8	6.0	7.6
Sex Ratio (males per 1000 females)	991	966	970	930	891	954

80 and Above						
Numbers (in millions)	8	9	11	16	23	32
Percentage to the total population	0.5	0.7	0.8	1.0	1.4	1.8
Sex Ratio (males per 1000 females)	1051	884	866	843	774	732

Source: S.Irudaya Rajan: Population Ageing and Health in India; Centre for Enquiry into Health and Allied Themes; Mumbai.

The transition away from a young age structure is not uniform across the country. Some states, particularly in the southern region are at the forefront of this transition. The more developed states in the southern region and a few others like Punjab, Himachal Pradesh and Maharashtra have experienced demographic transition ahead of others and therefore are growing older faster than other states. Certain regions, primarily in the central and eastern parts of the country, still have high fertility and mortality levels, and therefore, younger population age structures.

Growing population of elderly persons result in a rise of dependency ratio that give birth to many socio cultural and economic issues. As India's population ages, the nation will face a shrinking pool of working-age people to support the elderly population. Arokiasamy and colleagues report that the old-age dependency ratio is expected to rise from 12 per 100 to 31 per 100 by 2050.

Problems of the Aged

Ageing is a natural stage of human life and it is associated with many problems for the people who have grown old. A detailed analysis of the major problems of the aged in the light of the findings from various studies is explained below:

Physiological problems

With growing age, older persons experience various anatomical and physiological changes. These changes bring many psychological, behavioural and attitudinal changes in them. Consequently, they have to suffer varied sorts of physiological problems such as loss of physical strength and stamina, which become more acute as a person grows older. During the process of ageing, the physical functions of the body slowly deteriorate demanding greater coping skills on the part of the ageing persons to adjust to the environment. In addition, there are problems caused by others in the society because of the unfavourable attitudes against them. Physiological problems can be grouped into following sub heads:

Physical Health

Besides chronic diseases health problems in aged result in, physical weakness and deterioration, lessened hearing and diminished eyesight, slower reaction times and agility, reduced ability to think clearly, difficulty in recalling memories, lessening or cessation of sex, sometimes because of physical symptoms such as erectile wrinkles and liver spots on the skin, dysfunction in men, but often simply a decline in libido, greater susceptibility to bone diseases such as osteoarthritis, embarrassment to life from the viewpoint of success standards, lack of self-confidence , lack of ability to concentrate, forgetfulness, inability to speak, to hear, to see etc. Health problems are supposed to be the major concern of a society as older people are more prone to suffer from ill health than younger age groups. There is a gradual degradation of health with ageing and the elderly persons suffer with one or many diseases often chronic diseases.

Economic development and urbanization have brought lifestyle changes that have led to unhealthy nutrition, physical inactivity, and obesity contributing to the prevalence of diabetes. Chatterji and colleagues (2008) report a high rate of smoking (26 percent) and inadequate physical activity (18 percent) among Indians. These behaviours will likely translate into future ill health. Almost one-half (47 percent) of older Indians have at least one chronic disease such as asthma, angina, arthritis, depression, or diabetes (Chatterji et al. 2008).

Various independent and NSSO surveys carried out in India suggest that aged persons, in general and rural aged in particular, suffer from multiple health problems. Nandal, Khatri and Kadian (1987) in their study found a majority of the elderly suffering from diseases like cough, poor eyesight, anaemia and dental problems. Among the eight chronic diseases canvassed in the 52nd round of National Sample Survey, close to one-third of the elderly reported suffering from pain in joints, followed by cough (about 20 percent) and blood pressure (about 10 percent). Less than five percent of the elderly reported as suffering from piles, heart diseases, urinary problems, diabetics and cancer. Findings of 60th round of NSSO 2004, on the basis of hospitalization, indicate that aged persons suffer most from heart diseases, diseases of kidney/urinary system, ulcer, respiratory problems, joint pains and cancer.

Table 3: Per 1000 distribution of persons hospitalised by type of ailment

Type of ailment*	Rural	Urban
Diarrhoea/ dysentery	76	62
Gastritis/ gastric or peptic ulcer	48	39
Hepatitis/Jaundice	15	22
Heart disease	43	80
Hypertension	18	32
Respiratory incl. ear/nose/throat ailments	35	30
Tuberculosis	30	17
Disorders of joints and bones	25	26
Bronchial asthma	34	30
Diseases of kidney/urinary system	37	49
Gynaecological disorders	52	50
Neurological disorders	32	32
Psychiatric disorders	10	06
Cataract	29	24
Diabetes mellitus	18	24
Malaria	32	36
Fever of unknown origin	79	67
Locomotor disability	13	9
Accidents/injuries/Burns/etc.	101	88
Cancer and other tumours	28	32
Other diagnosed ailments	164	166
Other undiagnosed ailments	19	15
All ailments	1000	1000
* Ailments with at least 1 % share are only listed separately.		

Source: Morbidity, Health Care, and the Condition of the Aged, NSS 60th round (survey in 2004), NSSO, March 2006

Mental Health

Beside the physical health problems there are mental health aspects also. Major psychiatric illnesses associated with the old age are Dementia, Alzheimer's, Parkinson etc.

Dementia is the most common mental health problem among aged. *Aetiology* is the most common cause of dementia and it includes many forms of dementia. This group of illness is characterized by such a degree of dementia that full recovery to normal life is not possible, but the specific features associated with the other senile conditions are not present. Consequently, the patient can often be enabled to live a fuller life. The symptoms include a total personality disintegration starting with a progressive loss of memory, loss of intelligence and a loss of emotion. The patient loses her/his energy, initiative and interest, and finally there is total deterioration of one's personal habits including bladder and anal control. Depression is the most common feature and there may be either hypochondriacal preoccupations or a preoccupation amounting to an obsession with some specific matter such as witnessing a legal document. Some cases seem to run in families, but many cases occur sporadically in the community. Patient of this type cannot be nursed in a general hospital. If the disease is untreated then it became irreversible and terminal. It normally occurs after 65 years, affects 1in 6 of all people over 65 and is, therefore, one of the greatest problems in modern medicine.

Alzheimer is a neurological disorder in which the death of brain cells causes memory loss and cognitive decline. The disease starts mild and gets progressively worse. It is the commonest form of percentile dementia and normally occurs between the age of 50 and 65 yrs. The essential lesion is in the cerebral cortex, but typical forms do occur with specific paraplegia, extra pyramidal and cerebral signs.

Parkinson's disease is a degenerative disorder of the central nervous system. The major symptoms of Parkinson's disease are shaking, rigidity, slowness of movement and difficulty with walking. Later, thinking and behavioral problems may arise. The four primary symptoms of PD are tremor, or trembling in hands, arms, legs, jaw, and face; rigidity, or stiffness of the limbs and trunk; bradykinesia, or slowness of movement; and postural instability, or impaired balance and coordination. Other symptoms include sensory, sleep and emotional problems and may include depression and other emotional changes; difficulty in swallowing, chewing, and speaking; urinary problems or constipation; skin problems; and sleep disruptions. Parkinson's disease is more

common in older people, with most cases occurring after the age of 60. The disease can be difficult to diagnose accurately. There is an increased risk of Parkinson's disease in people exposed to certain pesticides and a reduced risk in tobacco smokers. Some atypical cases have genetic origin.

Social Problems

Indian society is undergoing rapid transformation under the impact of industrialization, urbanization, technical and technological change, education and globalization. Consequently, the traditional values and institutions are in the process of erosion and adaptation, resulting breaking of the traditional families. Industrialization has replaced the simple family production units by the mass production and the factory. Economic transactions are now between individuals. Individual jobs and earnings give rise to income differentials within the family.

Under the changing circumstances the care of elderly has emerged as an important issue in India. Providing care for the aged has never been a problem in India where a value based joint family system was dominant. However, with a growing trend towards nuclear family set-up, and increasing education, urbanization and industrialization, the vulnerability of elderly is rapidly increasing. The coping capacities of the younger and elder family members are now being challenged under various circumstances resulting in neglect and abuse of elderly in many ways, both within the family and outside. Sociologically, ageing marks a form of transition from one set of social roles to another, and such roles are difficult. Among all role transformation in the course of ageing, the shift into the new role of the 'old' is one of the most complex and complicated. In traditional society, where children followed their parent's occupation, it was natural that the expertise and knowledge of each generation were passed on to the next, thus affording older persons a useful role in society. However, this is no longer true in modern society, in which improved education, rapid technical change and new forms of organization have often rendered obsolete the knowledge, experience and wisdom of older persons. Once they retire, elderly people find that their children are not seeking advice from them anymore, and society has not much use for them. This realization often results in feeling of loss of status, worthlessness and loneliness. Neither having authority in the family, nor being needed, they feel frustrated and depressed. These things further leads to psychological problems.

Another development impacting negatively on the status of older people is the increasing occurrence of dual career families. Female participation in economic activity sometimes refers to the lack to time for care of elderly member of the family. Hence the changing factors in the family in its structure and

function are undermining the capacity of the family to provide support to elderly and the weakening of the traditional norms underlying such support leading to neglect and abuse of older people in family.

Economic Problems

Economic factors definitely play a major role in generating care for elderly people. The economic status, of the family, as well as that of the care-receiver besides the functional ability status of the care receiver and care giver are additional factors that appears to contribute to the burden. Economic dependence is one of the major factors that very often affect the wellbeing of older persons. Economic dependence is manifested in two ways. First, the status of economic dependence may be caused by retirement for a person employed in the formal sector. Secondly, for a person in the rural or urban informal sectors, it may result from their declining ability to work because of decreased physical and mental abilities. Sometimes older persons are also faced with economic dependence when management responsibilities for matters relating to finances, property or business are shifted to children, pushing the older person into a new status of economic dependence. Economic problems are felt more in case of persons retiring with no provision of pension or no other source of income to back up.

Factors Affecting Healthy and Active Ageing

Activities of Daily Living

While life expectancy at birth remains an important measure of population ageing, how long people can expect to live without disabilities is especially important to an ageing population. This may be elaborated by attempts to measure the degree of difficulty an older person has in performing *activities related to daily living* (ADLs) and *instrumental activities of daily living* (IADLs). ADLs include, for example, bathing, eating, using the toilet and walking across the room. IADLs include activities such as shopping, housework and meal preparation. Elderly persons capable of doing activities covered under ADL and IADL are said to be leading healthy and active ageing. Falling health affects this and in that case aged persons require physical and emotional support of the family members. Those who are lucky to get that lead a better life than the others who have no family members to back up. In 2010, the LASI pilot phase surveyed a representative sample of nearly 1,700 Indians ages 45 and older in four states (Karnataka, Kerala, Punjab, and Rajasthan), chosen to reflect the nation's regional, cultural, and socio-economic variation. Early results from the LASI pilot offer a variety of findings that illustrate the health risks faced by older Indians (Arokiasamy et al.). Thirteen percent of older Indians sampled have some

type of disability that affects at least one activity of daily living. More than one-quarter are underweight and nearly one-third have undiagnosed hypertension.

Functional Capacity

Functional capacity (such as ventilatory capacity, muscular strength, and cardiovascular output) increases in childhood and speaks in early adulthood, eventually followed by a decline. The rate of decline, however, is largely determined by factors related to adult lifestyle – such as smoking, alcohol consumption, levels of physical activity and diet – as well as external and environmental factors. The gradient of decline may become so steep as to result in premature disability. However, the acceleration in decline can be influenced and may be reversible at any age through individual and public policy measures.

Resource Sharing within the family

Children and the elderly consume more than they produce through their labour. Analysis of the way resources are shared, consumed, saved, and produced in India yields some surprising results. Ladusingh and Narayana (2011) document the role of public funding for education (mainly consumed by the young) and of private funding for health care (mainly consumed by the elderly). They find that the lion's share of family support goes to those below age 20, with little, if any, going to family members ages 60 and older.

Health Care

Fewer than 10 percent of Indians have health insurance from private or public sources, and about 72 percent of health care spending is paid out-of-pocket, according to national surveys (Bhattacharjya and Sapra 2008). India's health insurance scheme for the poor only covers those ages 65 and younger, leaving India's elderly population particularly vulnerable. Within the older Indian population, women face additional risks, they tend to have poorer health and less access to health care than men of similar backgrounds (Roy and Chaudhuri 2008).

Rising numbers of older people will put new and increasing demands on the health care system. Chatterji and colleagues (2008) suggest that the "health care services will need to shift resources and services to respond to an aging population." An analysis by Farahani, Subramanian, and Canning (2010) linked public health spending in India to increased survival of the elderly and other vulnerable groups. They found that a 10 percent increase in public health spending decreases deaths by about 3 percent among the elderly, women, and children. An analysis by Yip and Mahal (2008) documented wide disparity in access to health care for aging Indians who are poor or live in rural areas. They

suggest health care reforms should not just increase funding but also address inequality of access and include regulations to limit cost inflation, writing: "Money alone, channelled through insurance and infrastructure strengthening, is inadequate to address the current problems of unaffordable health care and the future challenges posed by aging populations that are increasingly affected by non communicable diseases."

Institutional factors

Strong institutional concern about the aged helps the elderly indirectly in leading a healthy and active life. This includes Pro aged policies and their effective implementation, a friendly media, social security system related to old age pension and other social security measures

Other factors

Other factors include Autonomy, Keeping positive attitude, Cheerful mood, Taking responsibility, Involvement in decision making, Participation in actual work of household or society, Inquisitive about something new and happening around, Physical exercise, Spiritual input etc. Absence of one or more factors is detrimental to healthy and active ageing. These factors are often ignored and the policy makers as well as the family members are more concerned with the health and minimum needs of the aged viz, food, shelter, clothing etc. One should be equally careful about the other factors.

Emerging Issues of Ageing

While the shift from a young to an older age structure reflects a successful record in health improvements in the country, the fact that individuals are reaching the older ages in unprecedented numbers and with varying needs and resources is likely to pose many policy challenges arising out of increasing proportions of elderly and decreasing proportions of children. This trend leads to a decreasing support base combined with higher levels of old age dependency. The shift to an older age structure has important implications for the country as well as for elders and their families. There is therefore a need to promote harmony between development and demographic change by increasing the economic and social sources of support for the elderly, among others.

Earlier, when life was simpler and values counted for more, those who reached a ripe old age held an enviable place in society where they could really relax and enjoy their twilight years, secure in the knowledge that they still commanded attention, respect and affection, and that though they were well past their prime, all that they had given their best for was still important- and so were

they. Now a day, old age brings about future shock. Senior citizen finds herself /himself out of phase with the younger generations of children and grandchildren. The children's future plans do not include them. Therefore a hazardous trend is growing rapidly towards hypercriticism of the children by the elderly and children's apathy towards the elderly. This causes a serious problem in the family, in particular and the society, in general.

United Nation's Initiative for the Aged

The United Nations adopted the 1st International Plan of Action on Ageing in Vienna in 1982, and it took until 1991 for the General Assembly to adopt the UN Principles for Older Persons Resolution 46/91) and its 4 main themes - independence, participation, care, self-fulfillment and dignity. The Committee on Economic, Social and Culture Rights adopted the General comment on the Economic and Social, and Cultural Rights of Older Persons.

In 1999, with the International Year of Older Persons, came the Conceptual Framework based on the Plan and Principles with 4 priority areas (i) the situation of older persons, (ii) individual life long development, (iii) the relationship between generations, (iv) the inter-relationship of population, aging and development. Finally, in Madrid in 2002, the 2nd World Assembly on Ageing (WAA) had adopted unanimously a Political Declaration and an International Strategic Plan of Action on Ageing. The 2004 report of the Secretary-General to the General Assembly recommends 'to assign full-time focal points on ageing and provide them with adequate resources to further implementation' The International day of older persons is celebrated every year on 1st October.

Need for Active Ageing Policy

Population ageing raises many fundamental questions for policy-makers. How do we help people remain independent and active as they age? How can we strengthen health promotion and prevention policies, especially those directed to older people? As people are living longer, how can the quality of life in old age be improved? Will large numbers of older people bankrupt our health care and social security systems? How do we best balance the role of the family and the state when it comes to caring for people who need assistance, as they grow older? How do we acknowledge and support the major role that people play as they age in caring for others? It approaches health from a broad perspective and acknowledges the fact that health can only be created and sustained through the participation of multiple sectors. It suggests that health providers and professionals must take a lead if we are to achieve the goal that *healthy older persons remain a resource to their families, communities and economies*, as

stated in the WHO Brasilia Declaration on Ageing and Health in 1996.

Population ageing is one of humanity's greatest triumphs as it is a result of longer life expectancy, at the same time it is also one of our greatest challenges. The World Health Organization argues that countries can afford to get old if governments, international organizations and civil society enact 'active ageing' policies and programmes that enhance the health, participation and security of older citizens. The time to plan and to act is now. In all countries and in developing countries in particular, measures to help older people remain healthy and active are a necessity, not a luxury. These policies and programmes should be based on the rights, needs, preferences and capacities of older people. They also need to embrace a life course perspective that recognizes the important influence of earlier life experiences on the way individuals age.

Most of the older people in all countries continue to be a vital resource to their families and communities. Many continue to work in both the formal and informal labour sectors. Thus, as an indicator for forecasting population needs, the dependency ratio is of limited use. More sophisticated indices are needed to more accurately reflect "dependency", rather than falsely categorizing individuals that continue to be fully able and independent. At the same time, active ageing policies and programmes are needed to enable people to continue to work according to their capacities and preferences as they grow older, and to prevent or delay disabilities and chronic diseases that are costly to individuals, families and the health care system.

Policy for Aged in India: Provisions and Suggestions

Constitutional Provisions

Article 41 of the Constitution provides that the State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want. Article 47 provides that the State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties.

Legislative Provisions

National Council for Older Persons

The National Council for Older Persons (NCOP) was constituted in 1999 under the Chairpersonship of the Minister for Social Justice and Empowerment. The NCOP is the highest body to advise the Government in the formulation and

implementation of policy and programmes for the aged.

Inter-ministerial Committee on Older Persons

An Inter-Ministerial Committee on Older Persons comprising twenty-two Ministries/ Departments, and headed by the Secretary, Ministry of Social Justice & Empowerment is another coordination mechanism in implementation of the National Policy on Older Persons (NPOP).

Maintenance and Welfare of Parents and Senior Citizens Act, 2007

The Maintenance and Welfare of Parents and Senior Citizens Act, 2007 was enacted in December 2007 to ensure need based maintenance for parents and senior citizens and their welfare. The Act has made maintenance of parents/ senior citizens by children/ relatives obligatory. It has penal provision for abandonment of senior citizens. Establishment of Old Age Homes for Indigent Senior Citizens and making adequate medical facilities and security for Senior Citizens are the other provisions.

Policies/schemes/ Programmes for Welfare of the Elderly

(i) National Policy on Older Persons

The National Policy on Older Persons was announced by the Government in January 1999 which envisages State support to ensure financial and food security, health care, shelter and other needs of older persons to improve the quality of their lives. The policy encourage individuals to make provision for their own as well as their spouse`s old age and promotes voluntary and non-governmental organizations to supplement the care provided by the family.

(ii) Central Sector Scheme of Integrated Programme for Older Persons (IPOP)

An 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 entertainment opportunities and by encouraging productive and active ageing through providing support for capacity building of the stake holders. Under the Scheme, financial assistance up to 90% of the project cost is provided to non-governmental organizations for establishing and maintaining old age homes, day care centres and mobile medicare units.

(iii) National Programme for Health Care for Elderly (NPHCE)

NPHCE was implemented by the Ministry of Health and Family Welfare from the year 2010-11. The Ministry has made provisions of separate queues for

older persons and establishment of Geriatric clinic in government hospitals .

(iv) Indira Gandhi National Old Age Pension Scheme (IGNOAPS)

IGNOAPS was implemented by the Ministry of Rural Development under which Central assistance is given towards pension @ Rs. 200/- per month to persons above 60 years and @ Rs.500/- per month for senior citizens of 80 years and above belonging to a household below poverty line, which is meant to be supplemented by at least an equal contribution by the States.

(v) Separate Ticket Counters

Separate ticket counters have been provided by the Ministry of Railways for senior citizens of age 60 years and above at various Passenger Reservation System centers. The Ministry also provides 30% and 50% concession respectively in rail fare for male and female senior citizen respectively of 60 years and above respectively.

(vi) Income Tax Exemptions

Income tax is exempted for Senior Citizens of 60 years and above up to Rs. 3.00 lakh per annum. The limit is Rs 5.0 lakh per annum for Senior Citizens of 80 years and above. Deduction of Rs 25,000 under Section 80D is allowed to an individual who pays medical insurance premium for his/ her parent or parents, who is a senior citizen. Besides this, an individual is eligible for a deduction of the amount spent or Rs 60,000, whichever is less for medical treatment of a dependent senior citizen.

(vii) Insurance Regulatory Development Authority (IRDA)

IRDA has issued instructions on health insurance for senior citizens to CEOs of all General Health Insurance Companies like allowing entry into health insurance scheme till 65 years of age, transparency in the premium charged, reasons to be recorded for denial of any proposals etc. on all health insurance products catering to the needs of senior citizens. It also calls for design the products in such a way that various options are available to policy holders so that those who are unable to pay can go for reduced premium with reduced sum assured.

(viii) Pensions Portal

A Pensions Portal has been set up by the Department of Pensions, Government of India, to enable senior citizens to get information regarding the status of their application, the amount of pension, documents required, if any, etc.

The Portal also provides for lodging of grievances. As per recommendation of the Sixth Pay Commission, additional pension will be provided to elders as per their age group ranging from 20% addition for 80+ to 100% for 100+ elderly persons.

Institutional Provisions

The National Institute on Aging (NIA) supports research on the health, social support, and economic security of India's elderly population. Age Well Foundation and Help Age India are the leading NGOs working for elders including organising sensitization trainings for the stake holders including children, police etc.

Suggestions

Based on the above provisions and the health status of India's elderly, some definite health intervention measures are felt necessary to cater to specific diseases associated with old age. This calls for the establishment of special geriatric wards within public sector health facilities and concessions in private hospitals through identity cards for the poor elderly. This vulnerable section of society like any other economically backward section of the population needs to be provided with subsidised or concessional health care facilities. There should also be separate counters for elderly patients so that they do not have to stand or wait in long lines along with other patients. Our earlier studies, group discussions and case studies clearly indicate that the elderly in India mainly face three types of handicaps relating to hearing, vision and mobility. The majority among them suffer from ailments relating to vision and hearing. These handicaps can be rectified through the use of spectacles and hearing aids. For instance, Arvind Eye hospital in Tamil Nadu and Sri Sadguru Sewa Sangh Trust (SSSST), Chitrakoot (MP) provides free eye check up for the elderly, performs free surgery and gives them with eye glasses.

Most of India's elderly being economically dependent; the cost of treatment is often a burden on the household. Therefore, many of the elderly ignore their ailments unless they become too acute. Thus, there is a great need for an appropriate insurance scheme for enabling the elderly to meet their medical expenses. Evidently such schemes should be made compulsory for all workers gainfully employed during their economically active years of life. Besides this, some mechanism of Professional Geriatric Care Management System should be evolved in India on the pattern of Western countries.

Advance Planning for Healthy and Active Ageing

Every youth is marching towards old age, hence advance planning is a must for all. Very little care is paid presently on this aspect, that's why most of the persons are ill prepared to greet old age. Living with grace and dignity till death should be a fundamental right, for this planning is a must. The planning is essential both at individual's level as well as the family level besides the policy initiative at the government level. Although immortality and eternal youth is not possible, yet achieving a healthy old age without major disease is a possibility and this can be achieved by collective effort of all the stake holders. Individuals and families need to plan and prepare for older age, and make personal efforts to adopt positive personal health practices at all stages of life. At the same time supportive environments are required to 'make the healthy choices the easy choices.'

Global demographic shift in ageing entails fundamental social, economic and development challenges and opportunities. Maximum attention is needed in paying increasing priority to satisfy the needs of older persons while enabling them to have longer, healthier and more productive lives. Increasing number and proportion will have a direct impact for health services, pension and other social security payments. We must be well geared to face the situation - it is like now or never.

Conclusion

While the shift from a young to an older age structure reflects a successful and desirable outcome of health improvement, the pace of ageing and the size of the older population with varying needs and resources pose many challenges for policy. Unprecedented growth in the elderly population raises many pointers for policy makers, researchers and civil society and their partnership for a more effective and sustainable care and support for senior citizens. A growing older population implies the need for a higher quantity and quality of geriatric services, arrangements of income security and improved quality of life in general. The need for social pension payments and resulting financial outlays to meet the increasing old age dependency and decreasing support base are more important for policy consideration now and in the future. Further, older persons and their families will have to deal with challenges arising out of increased longevity. There is a need for analysing further details of health, workforce participation and living arrangements using existing data sources to build a knowledge base for policy and programme support on population ageing in India.

An active ageing approach to policy and programme development has the

potential to address many of the challenges of both individual and population ageing. When health, labour market, employment, education and social policies support active ageing there will potentially be fewer premature deaths in the highly productive stages of life, fewer disabilities associated with chronic diseases in older age, more people enjoying a positive quality of life as they grow older, more people participating actively as they age in the social, cultural, economic and political aspects of society, in paid and unpaid roles and in domestic, family and community life, lower costs related to medical treatment and care services. One should realise that the greatest medicine for old age is 'love and affection shown by kiths and kin' and this is to be realized in the family itself. One should not forget that every child as well as youth is marching towards old age and if they respect the elderly persons in the family they can expect the same in future when they themselves become old.

References:

- Active Ageing: A Policy Framework (2012), WHO/NMH/NPH/02.8
- Anil, R. & Pradhan, K.; (1996) Exercise and the Quality of Life: Physical Activity Programming for the Aged; Ageing & Society (The Indian Journal of Gerontology), Vol. VI, No. I & II.
- Annual Report (2011-12), Ministry of Social Justice and Empowerment, Government of India.
- Chattopadhyay, Aparajita (2004); Population Policy for the Aged in India; Economic and Political Weekly, Oct. 23.
- Healthy Ageing Literature Review (2012), Department of Health, State of Victoria
- Ibid – Bill to care for senior citizens dated 21.03.2007
- Kumar, R. (2008); Anti – Ageing, Let the silver sparkle; Deep & Deep Pub. New Delhi.
- Lekha, S. & Dhananjay W. (2011); Demographics of Population Ageing in India; UNFPA.
- Liebig, S. Phoebe & Rajan, S. Irudaya (2005); An aging India- perspective, prospects and policies, Rawat Publications.
- Mahajan, A. & Ray, A. (2013) ; The Indian elder : factors affecting geriatric care in India; Global Journal of Medicine and Public Health, Vol. 2, issue 4

- Mathew Grace et. al. (1997); Towards Enriching Years; A programme for the elderly by the family welfare agency; pub. rep.
- Mishra, A.K. (2007); Psychology of Ageing Sublime Publisher, Jaipur.
- Raju, S.S. & Anand, S.C. (2000); Physical Health of Older Persons: Differentials and Determinants; Gerentological Social Work in India – Some issues and perspectives (Ed); Desai. M. & Raju.S.S.; B.R. Pub. Corporations, Delhi.
- Sharma, M.L. & Dak T. M. (1987) (Ed) Aging in India, Ajanta Publication, New Delhi.
- Situation Analysis of the elderly in India (June 2011), Central Statistics Office, Ministry of Statistics and Programme Implementation, Government of India
- Twelfth Five Year Plan (2012-17), Planning Commission, Government of India, Vol. 3.
- Verma. M.M. (2004), Participation of Senior Citizens in the development process; Contemporary Social Work (Journal), Vol. xxi, Dept. Of social work, Lucknow University, Lucknow.
- Woodruff, S. Diana & Birren, E. James (1975); Aging- Scientific Perspectives and Social Issues, D. Van Nostrand Co. New York