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Health services for the aged

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COUNTRY REPORT

HEALTH SERVICES FOR THE ELDERLY IN INDIA

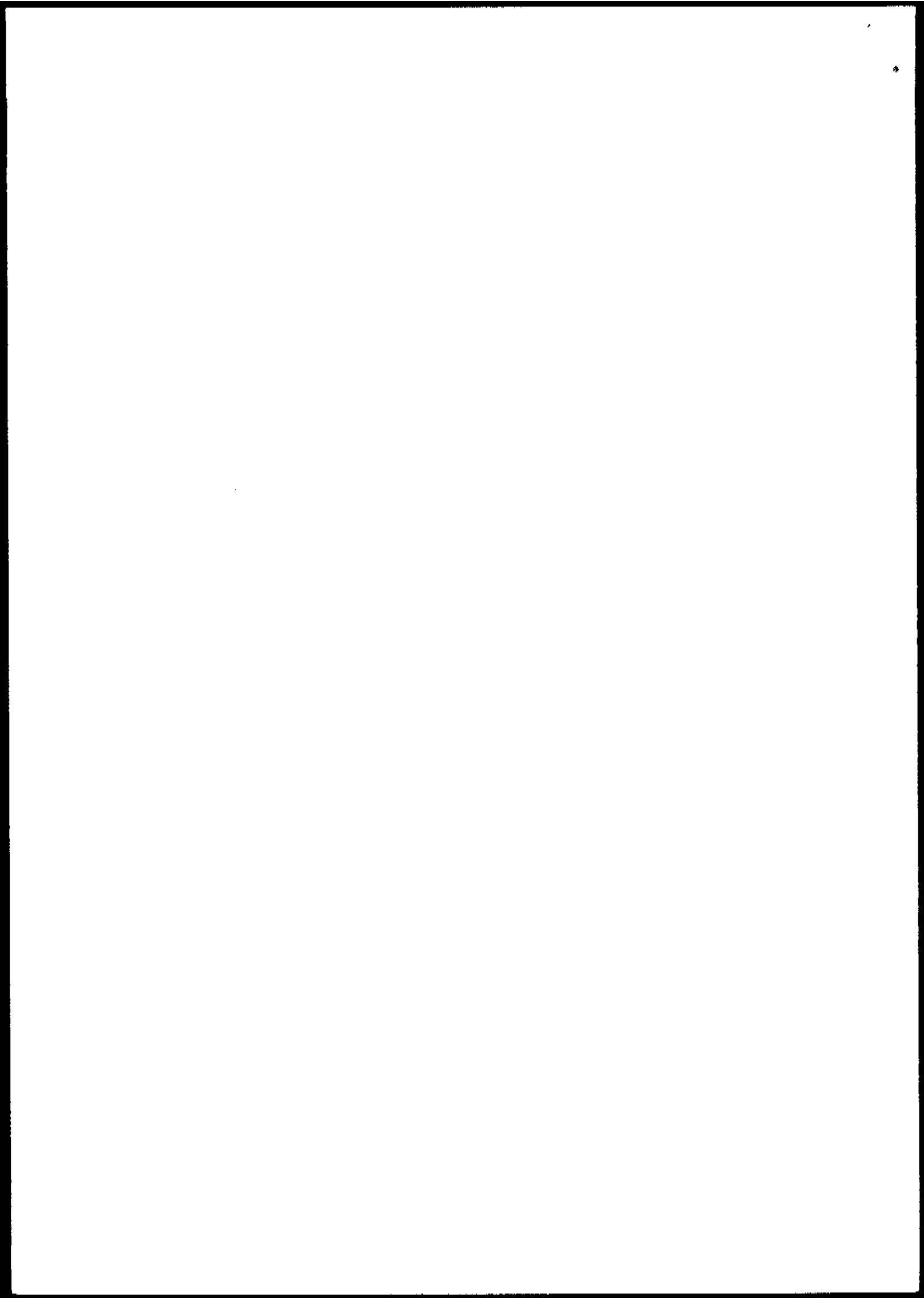
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Available Literature

The available literature on the problems of aging in India is very scanty. Most of it is in the form of articles written in popular journals. The aspects best covered are the demographic aspects where data at the national as well as state level are available. The rest of the literature, with the exception of half a dozen studies, is mostly in the nature of emphasising the need for services for the aged and how the existing services might be improved. We have no exact data on exact number of institutional and non-institutional facilities available in the country.

The Department of Social Welfare of the Government of India issued an Annotated Bibliography entitled "Aging in India" in the year 1979. This bibliography divides the total number of studies into 5 major categories: demographic aspects (15 entries), economic aspects (21 entries), health aspects (9 entries), social aspects (26 entries) and psychological aspects (8 entries).

Publications in the form of books and State reports are not more than 10 or 12. All the studies, except those based on demographic data, are of a local character limited to individual studies of towns, institutions or villages. They can give us some idea of the quality of the problem, but not of its dimensions. Further, very few of these studies give information on the health needs of the aged. The publications that have been found particularly useful so far as this paper is concerned are the studies by J.D.Pathak, K.G.Desai and R.D.Naik, and Kirpal Singh Soodan.

There is one journal called the Indian Journal of Gerontology which has been published over the last few years. I have not had the benefit of referring to this journal.

Size of the Aged Population

Different studies have used different definitions for defining old age. Some have taken the population group 55+ as the aged. Others have used 60+ as the cut-off point and one study has used 70+ as the cut-off point. In this paper, except otherwise stated, I have used 60+ as the dividing line between the aged population and the rest.

According to the 1971 census, 32.7 million persons in the total population of India were of the age group 60 and above. This number was approximately 5.9% of the total population. The 32.7 million persons were made up of 16.8 million males and 15.9 million females. The aged males as well as females were 6.0% of the respective total population of males and females. Eighty per cent of the aged lived in rural areas and 20 per cent in the urban areas.*

It is obvious that thinking purely in terms of percentages, the total percentage of the aged in India is small as compared with the populations of the developed countries. However, when one thinks of the absolute number of aged persons it makes a sizable population.

The size of the aging population in India is large and increasing. By 1988 if the total population increases to 760.5 million the population of the aged will be 45 million even without allowing for the rising level of life expectancy at birth and later ages.

The expectation of life at age 60+ years has increased from 9.25 in 1881 to 13.00 in 1971 for males and from 9.79 to 13.3 for females. This means that we will not only have more aged persons in the population but that they will expect to live longer than was previously the case.

It is in this context of the increasing size and life expectancy of the population that one has to look at the problems of the aged in the years to come.

Economic Status

About 56 per cent of the age group 60+ (i.e. approx. 18.3 million) are defined as non-workers in the census.

*Percentages calculated from data given in India: Pocket Book of Population Statistics, New Delhi: Registrar-General and Census Commissioner, 1972.

Of these 79 per cent live in the rural areas and the rest in the urban areas. About 0.94 per cent of the non-workers are reported to be beggars, vagrants, etc. The proportion of these elderly beggars and vagrants among the aged non-workers is slightly higher in the urban areas (1.13 per cent) than in the rural areas (0.89 per cent)*.

Health Status of the Aged

There are no data covering the whole country about the health condition of the aged. As explained earlier, most of the studies are local and limited to a single city or institution.

The Office of the Registrar-General of India had issued a publication called "Causes of Death" in 1973. This publication gives the causes of death of persons above the age of 55. The percentage breakdown of causes of death shows that 36 per cent of the deaths were attributed to senility; 23 per cent to coughs and other disorders of ^{the} respiratory system; 10 per cent to undifferentiated fevers; 7 per cent to disorders of the circulatory system, 7 per cent to digestive disorders, 3 per cent to disorders of the central nervous system and others due to a variety of factors not clearly identified.

All the groupings into which the various deaths have been divided are not ^{equally} useful from the medical point of view - particularly the groupings "senility" and "fevers" which between them account for 46 per cent of the deaths of persons above 55 years.

Another study undertaken by Dr.G.Ramanatha Rao and A.K.Anwikar in Nagpur city and based on the records maintained by the Municipal Corporation and by the Model Vital Health Statistics Unit in Nagpur gave the following causes of deaths of the aged.**

Of the total deaths in Nagpur city in 1972, the deaths of persons in the age-group 55+ accounted for 26 per cent though the proportion of the population in this age group was only 8 per cent. This is only to be expected since the death rates would normally be high at higher age levels. According to the paper, cardiovascular diseases accounted for 25 per cent of the

*Census of India 1971, Series 1, Paper 3, 1972, Economic Characteristics of the Population.

**Indian Journal of Public Health, Vol.20, No.2, April-June 1976, p.72.

deaths, infective and parasitic diseases accounted for 18 per cent, cancer for 10.1 per cent and digestive and respiratory ailments accounted for 8 per cent, senility and undefined causes accounted for 8.3 per cent of the deaths.

This study by Rao and Anwikar gives a further detail that tuberculosis is the major disease responsible for 55 per cent of the infectious disease deaths. Among diseases of the alimentary tract, cirrhosis accounted for 29 per cent. Of the respiratory diseases 68 per cent were due to bronchitis and asthma.

Most of the deaths reported upon in the study took place at home and not in a hospital or nursing home.

Apart from the above statistics about the causes of death, individual studies by Pathak (1974-75), Soodan (1975) and Desai and Naik (1972) report on types of illnesses prevalent among the aged population in particular cities or institutions. J.D.Pathak is the Director of the Medical Research Centre in the Bombay Hospital, Bombay. One of his papers is based specifically upon a study of upper middle class female patients admitted to the Bombay Hospital over a two-year period.* Among his cases 23.2 per cent suffered from complaints of the circulatory system, 16 per cent from complaints of urogenital and reproductive system, 12 per cent each of orthopaedic and ophthalmic system, 10 per cent suffered from diseases of the nervous system and the others were distributed between various other complaints.

Kirpal Singh Soodan made a study of a random sample of 390 persons of the age-group of 55+ in Lucknow. These were persons taken from the general population and not individuals admitted to hospitals or clinics.** He reports that 90 per cent of the persons interviewed complained of constipation, 58 per cent of indigestion, 37 per cent of back-aches, 26 per cent of urinary troubles, 22 per cent of head-aches, 16 per cent of blood pressure, 15 per cent of rheumatism and 14 per cent of asthma. But he mentions that these complaints were not serious except in the case of 3 to 5 per cent of the population for various diseases.

* J.D.Pathak in Scientific Contributions, Vol.2, p.85, 1974-75, Medical Research Centre, Bombay Hospital, Bombay.

** Kirpal Singh Soodan, Aging in India, Calcutta: Minerva Associates, 1975.

Soodan also mentions that among the population that he surveyed 85 per cent suffered some impairment of eye sight, 3 per cent were totally blind, 5 per cent were hard of hearing and 0.5 per cent were crippled.

K.G.Desai and Naik* whose study is restricted to middle and lower middle class respondents devote a whole chapter to health. According to this study while about 29 per cent of the respondents complained of different problems of health, only about 7 per cent had serious problems or were incapacitated. Most common complaints mentioned were impairment of vision (22 per cent), blood pressure (16 per cent), digestive complaints (16 per cent), pain in joints (16 per cent), diabetes (9 per cent), difficulties in hearing (9 per cent), heart trouble (8 per cent), sleeplessness (7 per cent). It will be noticed that complaints of sickness - mild and serious - are fewer in middle income group of Desai and Naik than in Soodan's randomly selected population of Lucknow.

Desai and Naik also give an interesting table summarising the history of ailments. They find that 30 per cent of the sample did not suffer from any ailments before retirement, but began to suffer from them after retirement and continue to do so now. There was also another 30 per cent who suffered minor ailments even prior to retirement and continued to suffer from them even at the point of the study. Of the total number of 600 cases about 50 per cent required varying degrees of medical treatment. 22 per cent received such occasional treatment at home. 7 per cent found it necessary to be hospitalised. 15 per cent needed regular treatment at home and 3 per cent received regular treatment at the out-patient departments of the hospitals.

Desai and Naik also report that the average medical expenses for those who needed medical treatment were a little less than Rs.30/- per month. This worked to about 10 per cent of their respondents' average income. However, in about 10 per cent of the cases the expenditure was as high as 25 to 50 per cent of the total income.

*K.G.Desai and P.D.Naik, Problems of Retired People in Greater Bombay, Bombay: Tata Institute of Social Sciences, 1972.

There are not many studies reporting on health conditions of the aged people in the rural areas. However, one study by Raj and Prasad* deals with some health aspects of the aged population in a rural area. The authors found that 45 per cent of the 300 odd persons surveyed by them were unwell at the time of the survey and 7 per cent referred to vague undiagnosed symptoms. Nine per cent of the respondents were disabled by blindness (5 per cent), deafness (3 per cent) and paraplegia (1 per cent). Additionally, 15.5 per cent suffered from partial loss of vision.

The five most common ailments reported upon by them were artheritis 7.1 per cent, chronic bronchitis 12.5 per cent, deficiency diseases 6.7 per cent, blood pressure 6.1 per cent and gastro-intestinal disease 4.2 per cent. Apart from physical health, Soodan and Desai & Naik report in their studies upon the mental conditions of the population surveyed by them. In his Lucknow study Soodan found that 44 per cent of his sample seemed to be "distressed" about the present conditions of their life. 34 per cent complained of loneliness, 27 per cent were partially disoriented and lost in their memories of the past and 15 per cent had a general sense of failure about their life.

Desai and Naik report that many of their respondents felt that they were better off before their retirement and were now pessimistic about their future. When they were specifically asked to indicate their problems, financial problems got top priority. The next set of problems mentioned were those relating to health and the third priority was given to problems about family and social relationships.

While we have no national data on problems of physical and mental health of the aged, it is clear from the data presented above that the 37 million persons above the age of 60 living in urban as well as rural areas must suffer from diverse problems of physical health and mental peace. We would need to review in this context the kinds of services that are available to care for them.

* B.Raj and B.G.Prasad, "A Study of Rural Aged Persons in Social Profile", Indian Journal of Social Work, Vol.XXXII, No.2, July 1971.

Health Services for the Aged

One would expect that since in a country like India the problem of poverty is all pervasive it affects the aged as much as the other age groups. It is of course possible to argue that the survival rate among the really poor beyond the age of 60 might be appreciably lower than among the middle and higher income groups. There are no specific age expectancy or actual survival figures by income levels readily available. But even if the possibility of a lower survival rate at an advanced age for the poor is accepted, no one would question the fact that in absolute numbers the aged poor would far exceed the aged middle or upper income individuals. It would, therefore, be fair to assume that the primary health problem among the aged of India would be one of adequate nutrition for survival. In the low income families the food needs of the aged are likely to receive lower priority than those of the adult and the very young population. There is also often a sex differentiation in terms of access to food within the family.

In India there is no universal social security or income maintenance service. The Employees State Insurance Scheme does provide certain health services. But these are not for the aged non-working population and not for those working in the rural or in the unorganised urban sectors of the economy. The aged population in most families is dependant for meeting its survival needs on the younger members, particularly sons. The joint family traditions are, therefore, still the first line of defense against deprivation.

In the case of the middle and upper income groups, however, there may be savings from earlier incomes and/or a continuing interest in family business or profession. In their case the health problem can be separated from the problem of poverty. But for the majority of the aged the economic problem is an important one and in its turn a direct as well as indirect cause of many health problems.

The only scheme of old age assistance in India that has now been in operation for the past 10 to 15 years is the scheme of old age pensions. According to the Handbook on Social Welfare Statistics published by the

Government of India, Department of Social Welfare (1976), 14 States and 4 Union Territories have limited programmes of such old age pensions. The eligibility requirements for these pensions almost universally specify that the person should be 60 or 65 years and above and should have no one to support him. This suggests that the scheme is meant primarily for the destitute. In 1974-75 the total beneficiaries in the country were 246,639. We saw earlier that the total population of the aged in the country is around 28 million. The total IVth ^{Five Year} Plan expenditure on this scheme was reported to be approximately Rs.1600 million for all the States and Union Territories together. The old age pension rate varied between Rs.20/- to Rs.50/- per person per month from State to State.

Apart from old age pensions which are restricted to those who are indigent and have no one to support them, there are some State supported and many privately supported residential institutions for the aged poor and infirm. The exact number of such institutions is not known. During the year 1979-80 a total number of 23 such institutions were aided through the Central and State Social Welfare Boards. Additionally, a new organisation called Help Age India lists about 38 different projects and institutions which were aided by them between 1978-79.

It is certain that the total number of institutions for the aged in the country may be at least 10 or 20 times the number that are being aided from public funds or from well established grant giving bodies. The exact number, however, is not known.

K.G.Desai and Rekha Bholle prepared a Social Situation Report on the Aged for the Department of Social Welfare in 1978. As part of their study they visited old age homes in different states run by voluntary organisations as well as by State Governments. They observed that the homes managed by governmental agencies had generally more resources available to them and yet were generally less well managed than the private ones. They also observed that neither in the governmental homes nor in the privately managed homes were there any special facilities for medical assistance. There is often a provision for stocking of medicines for minor illnesses. But otherwise the inmates have to be sent to public

hospitals. Most of the homes do not have a regular doctor. to visit them. There is no regular medical check-up of the inmates.

Most of the old age homes are run as institutions for the destitute and their emphasis is primarily on the provision of food and shelter. Some of the institutions are run almost with the sole purpose of providing to the indigent old a place to die in relative dignity.

In recent years a small number of residential institutions have come into existence which seem to meet the needs of those from the lower middle class groups and where the individual resident either pays fully or partially for his maintenance. More such institutions are needed especially in the urban areas where the joint family ties have not remained as strong as before and where inadequacies of housing space make it difficult for the family to provide any kind of privacy or quiet to the aging individual.

There are no health care facilities in the community specifically meant for the aged. The aged individuals attend the same general hospitals and dispensaries as are meant for the rest of the population. In a few hospitals there has been an effort to establish separate geriatric wards where aged hospitalised patients can be specially attended to. As far as one knows there are no special out-patient departments for the aged in general hospitals where old persons would not have to wait in long queues or hustle with others in order to get attention.

Self-supporting aged individuals from the upper middle and upper income groups generally obtain whatever services they need from private clinics and nursing homes: the lower middle classes and the poor go to public financed hospitals and the very poor go without any facilities.

A somewhat specialised but occasional health service from which the aged population derives the major benefit is an eye-camp. These 3-6 day camps are organised by voluntary agencies like the Rotary, the Lions and sometimes by groups of medical professionals on their own initiative. Most ophthalmic complaints - including glaucoma and cataracts - are attended to in such camps. The services are rendered free or at nominal

costs and organised in small towns so that persons from surrounding villages can benefit by them. While many such camps are organised in different parts of the country, there are no data about their exact number or about the large numbers of people who benefit by them.

It should be obvious that in poor countries health services in the form of residential institutions cannot possibly reach all those who are in need; such institutions usually involve large capital outlays. Increasingly emphasis must be given to the organising of community based and, where possible, domiciliary services for the aged. These may be offered as parts of the services in a primary health centre or a local government dispensary. But it would help the aged individuals a great deal if even in such general dispensaries a separate time could be set aside for the aged.

On the whole, the subject of care of the aged is not yet separated from the care of the poor, the disabled and the destitute. The problems of the aged as different from the problems of poverty or lack of material support have not yet been identified in India. In this context the problems of health care as different from the problems of maintenance are also not likely to receive special attention. The absence of special geriatric facilities in different hospitals and even of private practitioners specialising in geriatrics is a reflection of this generally undifferentiated situation.

The studies by Soodan and Desai & Naik have shown that apart from problems of physical health, the aged are also afflicted by problems of mental health. The most important of these latter problems is loneliness and the absence of a meaningful involvement in social relationships. These problems will become more and more acute as urbanisation increases and the proportion of the population above the age of superannuation increases. Recreational opportunity, opportunities for social usefulness (with or without monetary returns), opportunities for continuing intellectual stimulation in the case of those who have had education will need to be created. To-day very few such organised opportunities exist - except, of course, social clubs for the well-to-do. Recently, the Bombay Television Station presented an

interesting documentary based upon the effort of a group of middle-class, educated senior citizens in a Bombay suburb organising mutual aid as well as community service activities. These activities need to be made known and enabled to be multiplied several fold. They will prove useful in maintaining atleast the educated elders creatively engaged in the community. This can be an important programme of social and mental health promotion for the elders as well as ^{for} the beneficiaries of their services.

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