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Policy Shortfalls Leave India's Elderly to Fend for Themselves

Tulika Tripathi

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Photo Caption: An elderly man at a home for the aged in Kalpathy, Kerala. Rising population of the elderly, migration of youth to other countries, and an increase in the number of nuclear families have contributed to the phenomenon of increasing number of old-age homes in the State. File photo: K. K. Mustafah/The Hindu.

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ABSTRACT

One of independent India's successes, improving life expectancy at birth from about 30 years in the 1950s to the 70s in the 2000s, has also exposed a major flaw in the country's policymaking process: an abject neglect of state support for the elderly. Barring a few token measures, India's elders languish in the blind spot of its policymakers. A mix of factors are at play. For all practical purposes, the country's public healthcare facilities do not inspire the confidence of the people despite experienced professionals and the nearly free services that they deliver. At the other end of this spectrum of healthcare providers are expensive privately run hospitals that can push patients and their families into poverty. Societal changes, including the rising number of nuclear families, smaller family sizes, and migration for employment by the economically active population, have also had their effect on the provision of care for the elderly.

In this Policy Watch, **Tulika Tripathi, Economist, Centre for Studies in Economics and Planning, Central University of Gujarat**, analyses the causes behind the neglect of the elderly by the state. Drawing from studies in Gujarat and other parts of India, she proposes that India's public policy should be designed to cater to multiple levels, including correcting the rural-urban biases in health infrastructure, creating elderly friendly facilities, and providing support for caregivers.

I. INDIA'S DEMOGRAPHIC TRANSITION AND OLD-AGE DEPENDENCY

India is home to the second highest number of elders in the world. Its 144 million elders comprise about 13 per cent of global elderly population of 1.81 billion. As India's population grows, its increasing share of older adults is particularly notable. The growth rate of the elders (60 years and older) is three times higher than that of the population as a whole (Arunika et al 2016) and will be five times higher in 2031.

Table 1: Number of Persons aged 60 years and above
(in '000s) as on July 1, 2021

All WHO Regions	1081903.00
China	258372.00
India	144322.00

Source: WHO Data Platform

[**World Health Organization. 2022**. Maternal, Newborn, Child and Adolescent Health and Ageing: Indicators. URL: https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/indicator-explorer-new/MCA/percentage-of-total-population-aged-60-years-or-over].

The WHO's data portal projects that by 2051, an estimated 326 million Indians (19.90 per cent of the projected population) will be aged 60 years and above. This will transform the demographics of India as the current youth bulge grows into a nation of elders. The rise in elderly population is evident in both rural and urban areas (MoSPI 2020). Between 1991 and 2021, it went up from 44.3 million to 73.3 million in rural areas, and from 12.4 million to 30.6 million in urban areas. The absolute number doubled in rural India and almost quadrupled in urban India from 1981 to 2021. However, the growth of health care facilities in both rural and urban areas has not been commensurate with that of the ageing populations, at least not in public health (Tripathi 2014).

There are two grave underlying problems with India's public health policy. Firstly, it is tilted towards maternal and child health care and, secondly, it has an urban bias (ibid), which continues uncorrected. Therefore, with the high incidence of chronic ailments such as diabetes, hypertension, arthritis, and cancer, these patients would have to seek medical care in cities. To add to their woes, if such facilities are not available in the nearby cities, they would have to travel further to other

locations, depending on affordability and the extent of concern for the older family member shown by the earning members of the ailing elder's family (Tripathi 2021).

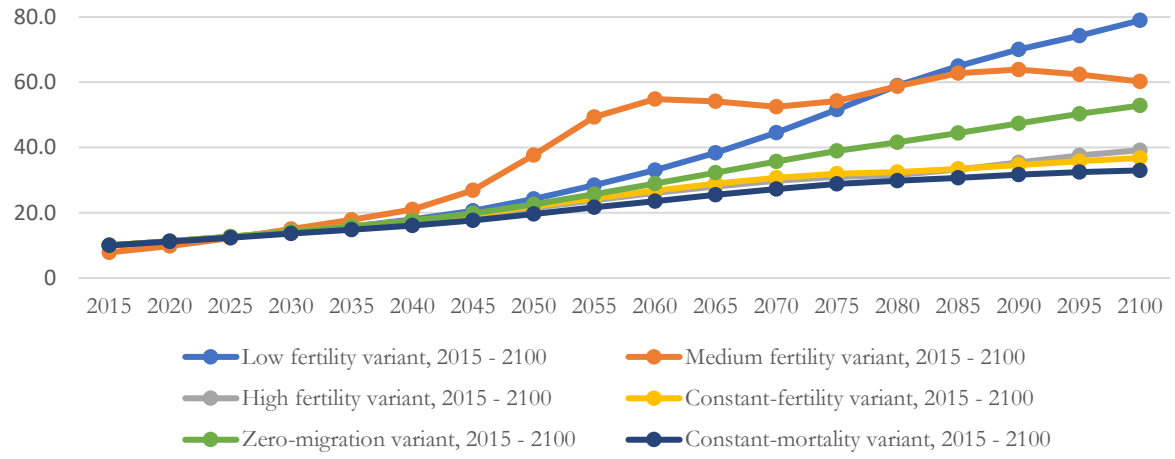
Although the share of elders in India's population has been steadily increasing after 1961 (when it was 5.6 per cent of the total population), the rise has been sharper since 1981. This trend is officially attributed to "various health interventions" since the 1981 census[1]. These include increasing use of antibiotics to fight infections, several disease-control programmes, the establishment of public health centres, new treatment technology, maternal and child health care, and vaccination and nutritional programmes.

The issue of old-age dependency

A direct economic consequence of an ageing population is old age dependency. Official statistics show this as a ratio of "the number of elderly people at an age of 60+ compared with the number of people in the age group 15-59".[2] It is also important to note that the rate of increase in female elders has been sharper than that of their male counterparts, and this is expected to go up in future (ibid). The sharp rate of increase started somewhere in the 1991-2001 intercensal period and manifested first in 2001. The same is reflected in the dependency ratio. Dependency ratio of females and males used to be quite stable till 1991 (around 12 per cent for both) but started rising secularly thereafter. Moreover, the female dependency ratio became higher than male dependency with this difference widening over time. However, even the stable dependency ratio observed until 1991, turns out to be incorrect when dissected across place of residence. In rural India, the old age dependency ratio has been consistently going up since 1961. Although the urban old age dependency ratio started rising only from 1991, the rural old age dependency ratio has always been higher. It is difficult to precisely predict how the observed old age dependency ratio will move as it depends on factors like fertility rate, migration, and mortality. However, a few scenarios can serve as guiding posts for policy making.

[1] **National Statistical Office. 2021**. *Elderly in India 2021,* Ministry of Statistics and Programme Implementation, Government of India.
[2] **Ibid**. p. 34.

Figure 1: Old-age dependency ratio
(ratio of population aged 65+ per 100 population 20-64)- India



Source: Extracted from OECD data.

Based on OECD (2017) data, Figure 1 plots six possible scenarios of old age dependency ratio until the year 2100. The ratio is expected to be the lowest in a "constant mortality scenario" and the highest in case of "low fertility scenario". Both "zero migration" and "low fertility" scenarios appear quite unlikely in India. The most likely scenarios are that of medium and constant fertility. In that case, the old age dependency ratio is projected to be between 40 per cent and 60 per cent by the year 2100. Although the year 2100 may now appear to be in the distant future, it is a short span in the life of a nation and, therefore, the old-age dependency projection should be cause for some alarm. Moreover, as early as 2050, this ratio is projected to be in the range of 20 per cent to 40 per cent, which calls for action by policy makers and the political leadership to bring in correctives to a healthcare delivery mechanism that is not catering to the requirement of the elderly.

Almost 30 per cent of the elderly across India either live alone or with an aged partner. This ratio is higher in villages than in cities (Table 2). An Indian household would have 1+ old-age person; 15 per cent households have at least two old age family members, and seven per cent households have more than two aged family members. One possible reason could be the migration of youth for employment followed by their family members for better amenities, leaving their old parents to either support each other or to live alone. Another factor is reverse migration of the retired labour force to villages.

A direct consequence of old age dependency and extended longevity on households is in terms of long-term care (LTC) requirements. The average family size in India is around 5.5. This would

mean that in seven per cent of households there are at least three elders dependent on two younger persons, and in 15 per cent households two old-age members of the household are dependent on three younger persons. These households will also have young children to be taken care of, resulting in huge care burden on the members of the household who are aged between 15 years and 59 years.

Almost 30 per cent of the elderly in India either live alone or with another older family member, without any younger member to provide care. Data show that there are 70 per cent household without any elders, and almost 30 per cent families comprise only elders. This reveals a mismatch in the availability of younger care givers. The common perception that elders will have informal caregivers available from the family is misplaced. Therefore, this group of lonely elders needs some formal arrangement of caregivers, be it through full-time care providers, nursing homes, care centres, or restricted living homes, to name a few. Further, this requirement will be greater in rural areas than in cities as the rural elders' population — both in absolute numbers and the number of elders either living alone or with another older person — is higher. The requirement of care givers will also vary across States. For instance, the average number of elderly members in a household is highest in Haryana, followed by Rajasthan and Gujarat.

All these point to a substantial number of the elderly who are in need of long-term care. Moreover, even those who live with families comprising younger adults are likely to suffer from inadequate/low quality of care that is provided to them. Studies by HelpAge India have thrown light on not only the inadequate care of the elderly but also the abuse inflicted upon them by their family members. Isolation and neglect are very frequent complaints by the elderly (Interviews with old age people, Tripathi 2021).

Table 2: Living arrangements of the elderly (60 years and above) by background characteristics in India (%)

Background Characteristics	**Living Alone**	**Living With Spouse**	**Living With Spouse And Children**	**Living With Children Without Spouse**	**Living With Others**
Place of Residence					
Rural	6.3	21.5	40.6	25.6	6
Urban	4.1	17.5	40.7	32.6	5
Total	**5.7**	**20.3**	**40.6**	**27.6**	**5.7**

Source: LASI WAVE-1 Report, 2017-2018

Families remain a predominant social unit in India. However, as the age of individual family members increases, the number of people living with many family members declines. This can be due to marriage of children or members of the family migrating for higher studies or work. This results in the elderly having to either live alone or with their ageing spouses. The number of those living alone is highest in rural areas and among females. Further, the old age people living with spouse is 20 per cent, where mostly both the partners will be old, and requirement of care givers will be higher. There are around 28 per cent of the elderly living with children. In the absence of any other public support system or actionable programmes, those living with children become entirely dependent on them. They often suffer loneliness with none to even converse with, as younger family members on whom they are dependent are also breadwinners who would have to work long and tiring hours. Our surveys and personal interviews revealed a similar situation.

Evidence from other countries[3] suggests that for working children it becomes very difficult to provide care to their elderly. In India, though less reported, there are high chances of maltreatment or lack of care to older people. Likewise, it is not uncommon that caregivers opt for early retirement, overlook career progression, and incur loss of income or take unpaid leave to care for their elders. The impact can be severe on working women, not to mention the low female labour force participation in India, which, according to data from the International Labour Organization, has registered a decline from 30.27 per cent in 1990 to 20.79 per cent in 2019[4]. One of the factors that explains this low level is the role of women in providing domestic care, with as high as about 62 per cent in the age group 15-59 years involved in domestic duty participation [which includes care for the elderly] in 2017-18.[5]

[3] **Butrica, B. A. and Karamcheva, N. S. 2014**. *The impact of informal caregiving on older adults' labor supply and economic resources*. Washington, DC: U.S. Department of Labor. [April 8, 2015].
[4] **The World Bank. 2021**. Labor force participation rate, female (% of female population ages 15+) (modelled ILO estimate) – India, June 15. [https://data.worldbank.org/indicator/SL.TLF.CACT.FE.ZS?locations=IN].
[5] **Kapoor, M and Kapoor, A. 2021**. No place for women: What drives India's ever-declining female labour force?, *The Economic Times*, June 13. [https://economictimes.indiatimes.com/news/economy/indicators/no-place-for-women-what-drives-indias-ever-declining-female-labour-force/articleshow/83480203.cms?from=mdr].

II. ADAPTIVE PREFERENCES: EXAMPLES FROM CASE STUDIES

Field studies by the author bring out the relationship between economic status and the manner in which elders live during their sunset years. The geographic setting – rural or urban – and the associated social networks that come with these is also another factor that has an impact on the quality of life of the elderly. The manner in which the elderly cope with ageing also varies across classes and locations. During a survey in Gujarat in June 2021 for a project for ICSSR-IMPRESS, enormous differences were noticed in the coping mechanism of the elders depending upon their location (rural or urban) and the class (rich or poor). The coping mechanism displayed by the elders in rural areas and the poor in both rural and urban areas in these case studies is reflective of 'adaptive preference'[6] rationalisation.

Case Study 1: Urban Upper Class

The couple in Photo A live independently in their own apartment and in close proximity to their two sons. This family is from the affluent class; they have hired a domestic help for domestic chores and a personal private transport (an autorickshaw) in which the elderly woman travels for her physiotherapy sessions.

Photo A

As she loves cooking, both partners watch cookery shows together. She makes note of the dishes she likes, cooks them and they share their sunset years without any economic strain. This is representative of the affluent Indian who can afford things for their care and independent living.

Although this does not imply that the elderly from the middle- and low-income classes cannot make similar arrangements, not all such elders have the benefit of independent living. Their economic circumstances would leave them with no option but to live with their children under the same roof, even if their relationship with other family members is not good. Such is the situation of the person in the next case study.

[6] The issue of adaptive preference formation was introduced by political theorist, Jon Elster, in 1982 and was subsequently examined by Nobel Laureate in Economics, Amartya Sen, philosopher, Martha Nussbaum, and others. Individuals or groups develop adaptive preferences "when society has put some things out of reach for the people, they typically learn not to want those things"

Case Study 2: Rural Poor Class

The person in the Photo B retired as a domestic guard and is a widower. His son's family lives in a nearby district. He lives with his son but during the day he is given an early lunch and sent to the village. He sits here and there under some tree or in his small parcel of farmland. Around evening, he takes a bus back to his son's home. In the picture, he is seen sitting on the roadside waiting for a bus. This is another face of the elderly in India: those who cannot afford care for themselves and are directly affected by the lack of good facilities. Despite his physical difficulty, he rose to greet us and took pictures with us. Our public systems owe to such dependent and vulnerable elderly to provide care in their twilight years. The government should create care institutions for such marginalised elderly, which can be means-tested and targeted.

Photo B

Case Study 3: Social life, God (Outside) and 'snuff' inside is cure to all their problems

Photo C

Photo D

India's social fabric is still vibrant in its villages. Men and women sit together to socialise. It reduces their loneliness and isolation to some extent, if not totally. However, when it comes to mobility, gender norms are applicable even at the advanced age of 70-75 years, with women confined to socialising with neighbours in front of their homes (Photo C), overseeing children, managing

homes or playing hosts to their guests. Men saunter to the entrance of the village to chit-chat with passers-by, smoke, drink tea, or engage in other forms of transient fellowship.

These women use a local powder mix (Photo D) to which they are addicted. They massage it over their gums at least thrice a day. They are told that it cures all the mouth and teeth related problems. However, all of them have lost their teeth. Most other diseases are "treated" in a similar manner until they turn fatal. Discussion with these groups of men and women suggest that they are waiting to die and all they have is the God's support and mercy. They want to be taken by God. They think it is their age that is reason for all their ailments, not dependency, vulnerability, nor the system or their families.

Photos B, C and D are in total contrast to Photo A. People from this affluent class wish to live happy and independent lives and are not fatalistic when it comes to their problems. While the rich want to live, and live happily, the manner in which the rural elderly poor in these case studies responded to the circumstances that they face reflects what scholars categorise as "adaptive preferences". This response mechanism, in turn, means lower expectations from families and the state resulting in inequalities being perpetuated.

As Noble Laureate Amartya Sen elaborates:

> "The most blatant forms of inequalities and exploitations survive in the world through making allies out of the deprived and the exploited. The underdog learns to bear the burden so well that he or she overlooks the burden itself. Discontent is replaced by acceptance, hopeless rebellion by conformist quiet, and — most relevantly in the present context — suffering and anger by cheerful endurance. As people learn to survive to adjust to the existing horrors by sheer necessity of uneventful survival, the horrors look less terrible in the metric of utilities."[7]

[7] **Sen, A. 1984.** *Resources, Values and Development*, p. 309. Oxford: Basil Blackwell. Cited in Teschl, M. and Comim, F. (op. cit.).

III. EXTENT AND TYPE OF CARE REQUIRED BY THE ELDERLY IN INDIA

India's present family structure has changed from what it was even a few decades ago. Previous generations had four or five siblings living in the same neighbourhood, if not in the same household, and shared responsibilities of caring for their elders (Tripathi 2020). Historically, informal care givers, particularly family members, were major care providers for the elderly. However, with changes in society, family composition, and the structure of the economy marked by varying employment and income policies, the ability and willingness to provide family-centric caregiving have begun to decline. The crisis is aggravated by higher life expectancy, declining fertility, increasing out-migration, changes in gender roles (for instance, women opting for employment), and the disintegration of the joint family system. The effect of these changes may mean that there will be lower family support for elderly Indians in the future.

Intergenerational living in South Asian countries like India have further intensified the care burden on the young people. Increased life expectancy also means longer years after retirement which adds pressure on the pensions and savings of the elders to meet their basic living expenses. A high incidence of informal employment leads to further stress on social and family support. India is witnessing more cases of families deserting parents in a situation of being incapable of taking care of them.[8] The incidence of chronic disease also increases with age and the impact is aggravated by the overall rise in the cost of health care in India. This puts further pressure on households with elderly members.

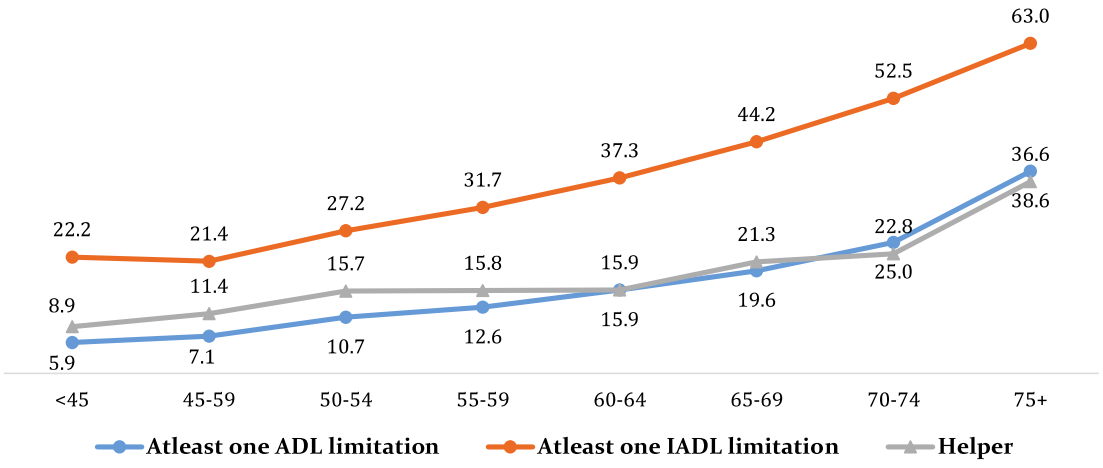
The author carried out an all-India analysis to measure the extent of care requirement. The current and projected dependency ratios of older people (65^+ population) to young people (20-24 age group) were calculated to understand the availability of informal caregivers. We analysed the living arrangements of the elderly (family size in which they are living) to understand the extent of the elderly with and without any family member. To understand physical and economic dependence, we estimated the Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) limitations of older people, incidence of disease among elderly, and levels of economic and physical dependence. (ADL are activities like bathing and dressing while IADL refer to activities like looking after finances, shopping and similar activities.)

[8] **HelpAge India (undated)**. *Home care of elderly in India*, (p.8). [https://tinyurl.com/32twbdvn].

To understand the nature and degree of dependency of the elderly, we looked at their physical and financial conditions that required support from others. Physical dependence can be categorised into ADL and IADL limitations. Here, we have taken the combined index of ADL and IADL limitations. Persons unable to do any activities of ADL and IADL are counted in the index. With age, ADL and IADL rise, with the increase in those suffering from IADL sharper than those with ADL (Figure 2). For persons with ADL, the limitations double with every passing decade from 45-years plus, and triples in the case of those with IADL. It is important to note that although almost everyone with ADL limitations is getting care, there is a shortfall in caregivers for those requiring IADL assistance. Moreover, as there is an increasing demand for such assistance, the widening gap between those seeking care and those who are able to provide such care should be a major policy concern.

Although the number of elders living in rural areas is high, it is in urban areas that the ADL/IADL limitations are marginally higher. Women have higher life-expectancy but are slightly more likely to have ADL/IADL limitations. The reasons could be the combined effects of the tough conditions of reproduction, higher levels of anaemia, low BMI since an early age, the heavy burden of work, be it domestic, economic, or both combined, and, above all a general neglect of personal and health care of women during their prime.

Figure 2: Percentage of elders (by age) with at least one ADL & IADL and need help



Notes
[1] Prevalence of ADL and IADL limitations were calculated based on all sample (n=71,943)
[2] Denominator for calculating the helper is those who reported ADL and/or IADL limitations (n=25,136)

Source: Longitudinal Ageing Survey in India (LASI) WAVE 1 Report, 2017-2018.

Regardless of caste and class, the incidence of ADL and IADL is almost uniform among older men and women. Surprisingly, there is no role for education, although literature suggest that the educated are healthier than those without education. Further, income levels, too, do not have any impact on the incidence of ADL and IADL. This also goes against the common understanding of better health outcomes among the rich. An important concern that emerged from the study was that about 10 per cent of the elders with any ADL or IADL are still working. This shows a lack of social protection and family support as these elders still have to work despite failing health and advancing age.

Physical dependence rises with age and its incidence is higher among women. In seven States, around eight per cent of the elderly require assistance to perform one of the activities (UNFPA 2012). Among activities of daily living, bathing was reported as the activity that caused the most difficulty to a large number of the elderly. This was followed by using the toilet, dressing and mobility (ibid). The problem of ADL is highest among women and rural elderly.

The elderly particularly require company and transportation during illness to reach health facilities and move around for diagnosis, check-ups, report and medicine collection, and related activities. It is important to understand who provides the desired support to the elderly. Results from a study, *Building a Knowledge Base on Population Ageing in India (BKPAI) 2011*, by the United Nations Population Fund show that around 50 per cent of the elderly are attended to by their children or grandchildren. However, around 25 per cent of the elderly reported that they had no one to turn to for assistance during medical treatment.

By 2030, nearly half of the total disease burden in India will be borne by the elders. They are more exposed to both non-communicable and chronic diseases, especially cardiovascular and chronic pulmonary diseases, diabetes, and cancer (Tripathi 2020). These will result in higher dependence levels to perform ADLs and IADLs, with specific requirements for long-term care. According to BKPAI data of seven States, around 3.7 per cent elderly suffer from any ADL limitations, 34.7 per cent each from any Chronic Morbidity and any Locomotor Disability, and 49.6 per cent from any IADL limitations requiring long term care (ibid).

However, changes in family composition, the trend towards nuclear rather than joint families, female employment outside the house, and very high youth migration have shrunk the space that was available for caring of the elderly. These have created serious challenges for the elderly, particularly in situations requiring long term physical support (Carmichael and Charles, 2003; Viitanen, 2005; Bravo &Puentes, 2012; He & McHenry, 2013).

The dependency ratio aggravates with economic dependence and failing health. Around 50-60 per cent of the old persons are economically dependent on some other family member. While almost 50 per cent of elderly men are dependent, this is higher for women, with 80-90 per cent of aged women economically dependent on other family members. Further, the economic dependence is higher among rural persons. A deeper analysis of the level of dependence shows similar patterns. A higher percentage of women (around 50-60 percent) and rural people are fully dependent. The important inference here is that social protection schemes and public institutions should be targeted for women and the rural population (Table 3).

Table 3: Percentage Distribution Elderly Population by State of Economic Independence

(% of elderly)

Population Subgroup	Survey (Year)	Not Dependent	Partially Dependent	Fully Dependent	Total
Rural Male	2017-2018	48	25	27	100
	2004	51	15	32	100
	1995-96	49	18	31	100
Rural Female	2017-18	10	24	66	100
	2004	14	12	72	100
	1995-96	12	15	71	100
Rural Person	2017-2018	28	25	47	100
	2004	33	14	52	100
	1995-96	30	16	51	100
Urban Male	2017-2018	57	19	24	100
	2004	56	13	30	100
	1995-96	52	17	30	100
Urban Female	2017-2018	11	21	68	100
	2004	17	10	72	100
	1995-96	12	11	76	100
Urban Person	2017-2018	33	20	47	100
	2004	36	11	52	100
	1995-96	31	14	53	100

Compiled by the author from: NSS 52th Round (July 1995-June 1996); The Aged In India - A Socio-Economic Profile; NSS 60th Round (January-June 2004); Morbidity, Health Care and Condition of the Aged; NSS 75th Round (July 2017-June 2018); and Key Indicators of Social Consumption in India: Health.

IV. PROVISIONING OF CARE IN INDIA

In India, the main primary care providers are family members, with approximately 90 per cent of the elderly receiving help from their family (Tables 4 and 5). Of the family members, it is mostly the daughter-in-law who provides care, followed by the spouse, the son and the daughter. It is mostly the children (approximately 70 per cent), and the spouse (14 per cent) who provide economic support to elders.

Table 4: Source of Financial Support for the Elderly (%)

	Rural	Urban
Spouse	14.8	18.0
Own Children	78.8	76.3
Grand Children	2.1	1.6
Others	4.3	4.2

Source: NSSO 75th Round 2017-2018

Table 5: Source of Physical Support for the Elderly (%)

	Rural	Urban
Household member	89.1	91.3
Other than household member	4.9	2.2
None	6.0	6.5

Source: NSSO 75th Round 2017-2018

The living arrangement is considered to be an important indicator to understand the quality of life, wellbeing, and the status of the elderly, as it signifies the availability of care for them in the absence of adequate social security and institutional setup (Rajan and Kumar, 2003). Sen and Noon (2007), using data from the IHDS (India Human Development Survey)-2004-2005, found that elders residing in a family setup were less likely to be affected by short-term diseases. They also examined the association between living arrangements and health care utilisation and found that living arrangement has no significant association with health care utilisation and medical expenditure after controlling socio-economic variables. Using the same data, Samanta et al. (2014) explained the association between health and living arrangement by contextual factors. They found that improved sanitation and access to health care services reduce the disease burden of the elderly, irrespective of their living arrangements.

Another study using data from NSSO 60th Round suggests that in south India, the elderly living with people other than their children or spouse, had to work for their livelihood and were more likely to be affected by diseases. Treatment seeking was highest among those living with spouses and children (Paul and Verma, 2016). Further, a study carried out using data from NFHS-2 based on 1998-99 data, found that elderly living alone are more vulnerable to poor health outcomes such as asthma, tuberculosis, and malaria (Agarwal, 2012). Elderly women living alone are at higher risk of diseases (Sarkar, Shekar and Modol, 2012) and are more likely to suffer from poor health outcomes. A recent cross-sectional study found that self-rated health was higher among the elderly living with adult children and other family members compared with those living alone (Rudra, 2017). Furthermore, health care utilisation is higher among those co-residing with their children across various socio-economic variables (Joe, 2017).

These studies highlight the important role of the family in the quality of life and health of the elderly. Evidence from western countries have also shown that elders living with their grandchildren in a multi-generational setup report higher self-rated health and experience better health status than those living only with their adult children or in nuclear families (Chen and Liu 2012, Silverstein et al. 2006). An epidemiological study highlighted that the elderly living alone are more prone to falls, functional limitations, poor diet, sedentary lifestyle, social isolation, and chronic conditions across various socio-economic variables. This shows greater support received in a multi-generational family, and a feeling of security and satisfaction among the elders.

Although family and society are assumed to be the primary providers of long-term care for the elderly, scant attention has been given on the extent and quality of LTC and structural factors. Elders in India are increasingly being dependent and insecure in health outcomes. They require long-term care given the type of disease burden. This long-term care, so far, is mainly provided by informal sources. This model is no longer sustainable as it puts another section of population — informal care givers — at the receiving end.

Need for research on caregivers

Research on caregivers in India is sparse, if not completely missing. Their perspectives, the burden they bear, and their requirements are all buried under the family tradition of providing care. Therefore, while it is no wonder that elders living with their families self-rate themselves in good health, the hardship faced by both care receivers and care givers go unnoticed. All sorts of care requisition are understood to be concealed under the single umbrella of the 'family'. A large

number of codes in large data sets would be classified under a family member, while 'others' are clubbed under non-household members or relatives.

Moreover, no information is available whether that person (care-giver) is paid or unpaid, trained or educated (Tripathi 2014). We expect that the major determinants of access to care are urban residence, affluent economic and social background and asset ownership of the elderly and, to some extent, income and employment status of children (ibid). Further, we hypothesise that the elderly who secured economic and social affluence during their working life or because of retirement from formal sector still have some entitlement over long-term formal care and have better access to those (refer Case Studies).

V. PUBLIC POLICY FOR THE ELDERLY IN INDIA

Despite the rising trend in ageing population, comprehensive geriatric care – which includes addressing the challenges faced by the elderly and their caregivers – has not been a priority in India. However, in recent times this issue is receiving the attention of policymakers. Some non-profit organisations and NGOs are also taking the initiative to safeguard the interest of the elderly and support them to live a life with dignity. HelpAge India is one such non-profit organisation contributing to enhancing the lives of the elderly. However, these are located in urban areas and lack adequate funding. Therefore, it is required to provide them with economic incentives through more effective measures to strengthen their role and allow them to render services to the elderly in a more effective way (Bharti and Singh, 2013).

Table 6 shows the list of programmes by the Union government to support the elderly, followed by those by State governments. We further analysed Longitudinal Aging Study in India – Wave 1 (LASI w-1) 2020 data to understand the awareness and utilisation of these programmes.

Table 6: Policies, Programmes, and Schemes sponsored by the Union Government

Social Security initiatives by government, Year	**Aim**	**Evaluation studies about the effectiveness of the scheme**
"National policy for older persons" (1999), by Ministry of Social Justice and Empowerment	Food, clothing and shelter, health care, to improve the quality of their lives.	
"Integrated Programme for Older Persons" (1992)	Basic necessities of life such as food, shelter and provision for heath. Providing support for capacity building of Government/ Non-Governmental Organizations (MOSPI 2020).	
"National Initiative on Care for Elderly" (NICE) (2002), National Institute of Social Defence	Provide training and skill to people for providing assistance to elders.	Limited initiative, low awareness regarding availability of such facilities
"Maintenance and Welfare of Parents and Senior Citizen's Act" (2007)	• Old Age Homes • Geriatric beds in government hospitals.	There is lack of awareness among the elderly both in rural and urban areas. Most of the parents hesitate to take action

	• Separate queues for senior citizens. • Protection of the life and property. • Punishment for the abandoning elderly parents.	against their children (Kumar and Vishwakarma, 2019).
"National Programme for the Health Care for the Elderly" (NPHCE), (2011), Ministry of Health and Family Welfare	Separate queues for older persons in government hospitals Promote research on geriatric diseases.	Improper infrastructure and the number of hospitals having separate geriatric care is negligible
"Indira Gandhi National Old Age Pension Scheme" (2007)	Elderly in age group 60-79 is given Rs. 200 per month and Rs 500 for those above 80.	The amount is too small and loopholes in the implementation leads to underutilisation of the scheme by those who are in need (Mutalik and Shah 2011, Biswas 2017, Tripathi 2014). The utilization of this scheme is lower among those having low level of education or belong to lower socio-economic group (BKPAI Report, 2011). Long waiting period and problems in producing documents (Nanda et al. 2011).
"Annapurna" Scheme, (2000)	Free food grain (10 kg) is provided to senior citizens to those who are not covered under IGNOAPS.	Only for economically deprived elderly.
"Rashtriya Vayoshri Yojana" (RVY) (2017)	Scheme for providing Physical Aids and Assisted-Living Devices for Senior Citizens who are below poverty line	
Other facilities and benefits for the elderly • Concession in railway tickets • Exemption in income tax • Higher rate of interest for senior citizen in post office saving schemes • Pension Portal has been set up by the Department, to enable senior citizens to get information regarding the status of their application, the amount of pension, documents required, if any, etc.		
Source: Ministry of Health and Family Welfare, Government of India, accessed in August 2020		

The first major step taken by the Union government was the introduction of a National Policy for Older Persons in 1999[9]. It aims to encourage families to take care of the elderly and to motivate people to make provisions for them and their spouse for old age. It also encouraged non-government organisations to supplement the care provided by families. There are three major schemes to support old people of which two are pension schemes. These two, the National Old Age Pension Scheme and the Widow Pension Scheme, are apparently the most known as more than 50 per cent of the people surveyed are aware about them and have benefited from them. It is important to mention that all Union or State government-provided support are targeted and applicable for poor and the 65-plus elderly. However, the Annapurna Yojana is hardly known to 12 per cent of the elderly of which less than one per cent are benefited (Table 7).

Table 7: Awareness of and Benefits from Union Government Programmes to Support the Elderly

Scheme	Freq.	Percent	Freq.	Percent
National Old Age Pension	**Awareness**		**Benefited**	
Yes	17,041.81	55.02	7,554.80	42.06
No	13,930.19	44.98	10,409.20	57.94
Widow Pension				
Yes	13,629.62	44.01	1,746.82	23.76
No	17,342.38	55.99	5,606.18	76.24
Annapurna				
Yes	3,708.16	11.97	410.44	11.4
No	27,263.84	88.03	3,190.56	88.6
Any Other State Scheme				
Yes	483.95	1.56	127.50	29.04
No	30,488.05	98.44	311.50	70.96

Source: LASI w1 2020

There are State-level schemes also, listed in Table 8, but they are not known to many potential beneficiaries; hardly 1.56 per cent of the elderly know about them. Social security schemes are there in southern States. Telangana, Andhra Pradesh, and Kerala have two types of social security programmes for the elderly while Tamil Nadu, Karnataka, Pondicherry, and Goa have one umbrella scheme each. All these schemes, however, are also those with meagre monetary benefits that amount to tokenism, given the large range of requirements of the elderly population.

[9] **Ministry of Social Justice and Empowerment, Government of India. 2009**. *National Policy for Older Persons Year 1999*.
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That said, northern States, which have the maximum number of elders, are those that lag the most in providing any social security to the elderly. Elders in these States are dependent only on pensions provided by the Union government, which are targeted and have a cap on the number of elders who can get the pension from an area. There is some coverage, albeit very small, in terms of employer-provided pensions (Table 8).

Table 8: Awareness about Miscellaneous and State-supported Schemes for the Elderly in India 2021

Scheme	Aware (%)	State
Abhaya Hastham pension	2.89	Telangana
Geetha Karmika Aasara Pension	1.05	Telangana
Agriculture Labour Pension	0.21	Kerala
Karunya Arogya Suraksha Padhathi	0.01	Kerala
NTR Bharosa Pension	6.76	Andhra Pradesh
Chandranna Bima (Insurance for accident and work loss for informal labourers)	0.90	Andhra Pradesh
Sandhya Suraksha Yojana	0.04	Karnataka
CMUPT – Old Age Pension (General)	1.83	Tamil Nadu
Ladli Social Security Allowance	0.49	Haryana
Dayanand Social Security Scheme (DSSS)	1.40	Goa
Nirashi pension	0.68	Chhattisgarh
OAPS Puducherry	5.18	Puducherry
Varishtha Pension Bima Yojana	0.01	LIC
Retirement Pension	4.07	Employer
Widow Pension	0.44	From Employer
Coal Mines pension scheme	0.29	GoI
Ordinary Family Pension	5.17	GoI
Deen Dayal Upadhyaya Social Security Scheme	1.46	GoI
Old age Penson	8.54	GoI & State
Army Pension	2.76	GoI
Divyang Pension	29.63	GoI
Kisan Maan-Dhan Yojana (PM-KMY)	2.80	GoI
Artistes Pension Scheme	0.19	National
Other	23.22	State & Local Gov
Total Beneficiaries (in number)	**483**	

Source: LASI w1 verified from State government websites

When it comes to the awareness among the elderly about their legal entitlements, surprisingly LASI data suggest that only about one-fourth of the elderly know about old age concessions and as less as 12 per cent know about the law on maintenance and welfare of parents and senior citizens. Beneficiaries from these entitlements are often very few; firstly due to the extent of paperwork required, which often would be elusive for the rural and the poor; and secondly there are very few government services provided anyway to be availed of to make a meaningful difference. In most cases, road transport and air transport are private services, and so are health providers and other such facilities, resulting in a lack of state-provided options. Similarly, the Maintenance and Welfare of Parents and Senior Citizens Act is hardly exercised, as discussed earlier, due to the social norms of sanctity of the family and a perceived sense of "shame" involved.

Table 9: Awareness about Concessions and Legal Rights

Aware about concession given by Government in old Age		
Freq.	**Sample size**	**Per cent**
Yes	8,905.11	28.37
No	22487.89	71.63
Maintenance and welfare of Parents & Senior Citizens		
Yes	3,737.02	12.33
No	26,577.98	87.67

Source: LASI w1 2020

VI. CONCLUSION

To sum up, families and communities remain the largest care destination and family members are normally the primary care providers. Elders are mostly reporting fine with the time and quality of care they are receiving, be it economic support or physical support. However, there seems to be a type of adaptiveness towards their misery and vulnerability (Case Studies). There is a common understanding about old age association with several health problems and dependency. One would often hear the elderly and, sometimes, health practitioners say that there is no cure for the old age.

The lack of social support, poverty, and social norms, and the lack of other care facilities add up to a situation in which the elderly remain solely dependent on family and relatives for their care needs. Due to this interdependent relationship, their reporting of abuse and neglect is lower than what is reported, though in some cases we noticed the misbehaviour or were told about it by the neighbours. There is sufficient fear and, particularly, shame among the elderly in reporting bad behaviour from their family members. It comes from the social stigma and fear of being abandoned. Therefore, even the low number of reporting should be taken as important policy concern.

However, there is no shame or guilt among the family member in reporting the problems and burden of providing care to elderly. The reasons can be real difficulties being faced by them, for instance, budgetary and time constraints on spending and transport, and the overall decline in care responsibility. Often the burden on the family member and the vulnerability of the poor comes from the lack of social security nets and publicly funded structures to provide care.

As discussed in the previous chapter, most of the social security programmes laid out by governments are targeted and means tested. The pension amount varies anywhere from Rs. 100 to Rs. 400 per month which is too less for a poor elderly suffering from chronic ailments, aggravated by the lack of good treatment facilities in government hospitals and high cost treatment in private sector. In the last five to ten years, health insurance has been advocated as a measure to reduce the cost burden on the state, which is increasingly adopting privatisation of healthcare as an important component of health policy.

Market failure in old-age health insurance

However, the historical problem of market failure, which is in full force in the case of old age health insurance, has not engaged the attention of policy makers. In other words, health insurance providers would not prefer to insure aged people and those suffering from chronic ailments, and we know that this is a difficult combination which would necessitate health insurance to save on a family's finances. Even if the issues of insurance availability and premia are addressed, other problems that remain include lack of awareness about insurance policies and their limitations, complicated system to get the reimbursement and hospitals' acceptance of health insurance. As a result, the coverage of health insurance remains very low, particularly for elders.

The role of the state as an intervenor in cases of market failure is distinctly absent of providing good quality and affordable health care. Therefore, geriatric wards and OPDs should be expanded in government hospitals along the lines once adopted for maternal and child health care. Moreover, as the elderly may require a higher frequency of visits to meet their healthcare requirements, mobile vans and e-health portals could be cost effective measures. They can also be used to provide health facilities in remote areas with connectivity to PHCs/Sub-centres. More health personnel for house visits to elder patient and nursing staff should be hired to avoid the crowd and burden on the public hospitals/centres. Given an overall vulnerable condition of the elderly in India – their economic and physical dependency, lack of infrastructural and institutional support (Tripathi 2021) – the architecture of public policies for the elderly must go beyond the façade of paltry pension schemes and effete laws.

Public policy should be designed to cater to multiple levels, including the creation of elderly friendly infrastructure to provide support for caregivers. While there is need to increase the coverage and amount of pension offered to the elderly, it is also important that caregivers are accommodated by their employers and supported by state infrastructure. In India, most of the caregiving for the elderly is by members of the family, and most of the time such caregivers suffer from fatigue, lack of personal, family and social time, and need assistance to provide care. Therefore, day-care centres, elderly hostels, support staff at every medical centre to relieve caregivers, nursing care and hospice care (end of life support) are much needed. Further, vigilant monitoring of the policies, providing economic incentives to the caregivers to cover for the man-day loss and leaves, and initiating flexible working hours for individuals who need to provide care, will also improve the quantum and quality of support for India's elderly.

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