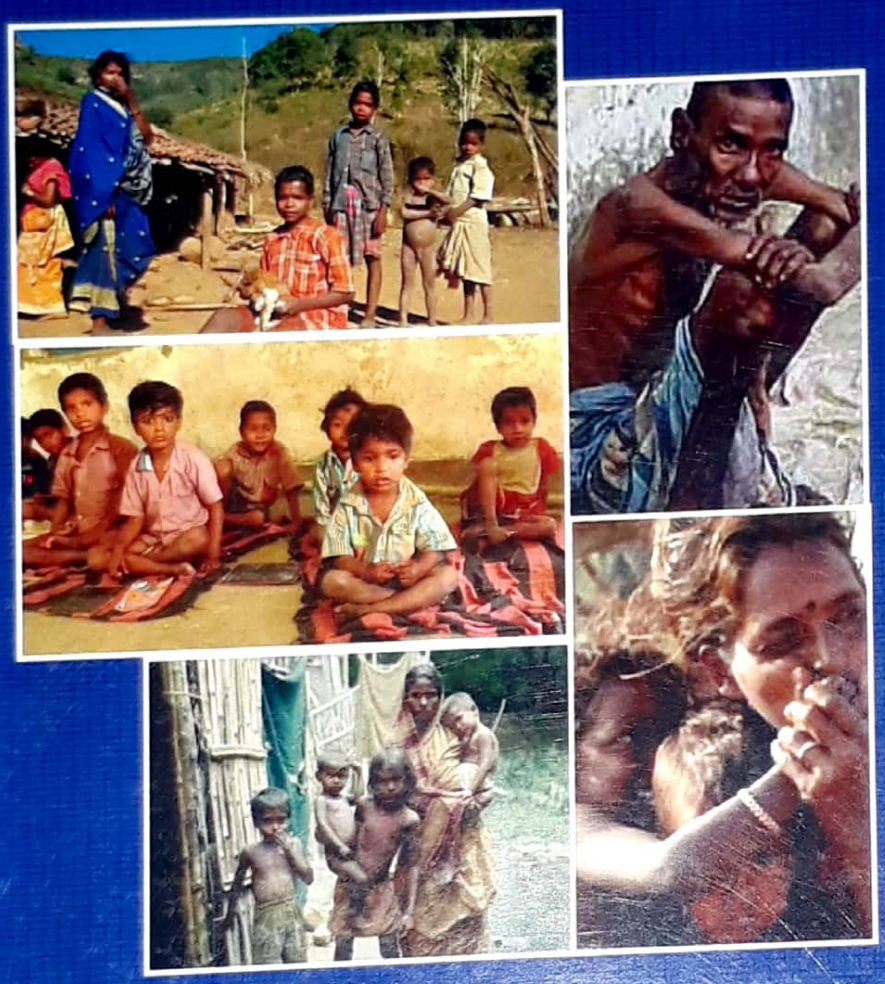
THE HEALTH STATUS OF MARGINALISED GROUPS IN INDIA: ISSUES AND CONCERNS



Editor
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ISSUES AND CHALLENGES OF AGED

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Introduction

Over the past century, life expectancy has increased dramatically and the world will soon have more old people than children. This social transformation represents both challenges and opportunities. The theme of World Health Day 2012, April 7, 2012, was "Ageing and Health." Many people develop disabilities in later life related to the wear and tear of ageing (e.g., arthritis) or the onset of a chronic disease, (e.g., lung cancer, diabetes and peripheral vascular disease) or a degenerative illness (e.g., dementia). But disabilities associated with ageing and the onset of chronic disease can be prevented or delayed. The traditional Indian society and the age-old joint family system have been instrumental in safeguarding the social and economic security of the elderly people. However, with rapid changes in society and the emergence of nuclear families in India in recent years, the elderly are likely to be exposed to emotional, physical and financial insecurity in the years to come.

Countries and health care systems will need to find innovative and sustainable ways to cope with the demographic shift. John Beard, director of the WHO Department of Ageing and Life Course, says that "with the rapid ageing of populations, finding the right model for long-term care becomes more and more urgent." anniversary of the adoption of the Madrid International Plan of Action on Ageing (MIPAA). The plan is a resource for policy-makers, suggesting ways for governments, non-governmental organisations and other stakeholders to reorient the ways in which their societies perceive, interact with and care for their older citizens, as two billion people will be aged 60 and above by 2050.

Demographic View

India, the world's second most populous country, has experienced a dramatic demographic transition in the past 50 years, entailing almost a tripling of the population over the age of 60 years (i.e., the elderly). This pattern is poised to continue. It is projected that the proportion of Indians aged 60 and older will rise from 7.5% in 2010 to 11.1% in 2025 (United Nations Department of Economic and Social Affairs). This is a small percentage point increase, but a remarkable figure in absolute terms. According to UNDESA data on projected age structure of the population, India had more than 91.6 million elderly in 2010 with an annual addition of 2.5 million elderly between 2005 and 2010. The number of elderly in India is projected to reach 158.7 million in 2025, and is expected, by 2050, to surpass the population of children below 14 years .

A few important characteristics of the elderly population in India are noteworthy. Of the 7.5% of the population who are elderly, two-thirds live in villages and nearly half are of poor socioeconomic status (SES).Half of the Indian elderly are dependents, often due to

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widowhood, divorce, or separation, and a majority of the elderly are women (70%). Of the minority (2.4%) of the elderly living alone, more are women (3.49%) than men (1.42%)..Thus, the majority of elderly reside in rural areas, belong to low SES, and are dependent upon their families.

National Policy on Aging

In view of the increasing need for intervention in area of old age welfare, the Ministry of Social Justice and Empowerment, Government of India, adopted a 'National Policy on Older Persons' in January 1999. The policy provides broad guidelines to the State governments for taking action for the welfare of older persons in a proactive manner. It defines 'senior citizen' as a person who is 60 years or above and strives to ensure their well-being and improve the quality of their lives by providing specific facilities, concessions, relief and services and helping them cope with problems associated with old age. It proposes affirmative action on the part of government departments for ensuring that the existing public services for senior citizens are user-friendly and sensitive to their needs.

While systematic studies are rare, there have been increasing reports of material exploitation, financial deprivation, property grabbing, abandonment, verbal humiliation, and emotional and psychological torment in India, all of which compromise the mental and physical health of the elderly, the Maintenance and Welfare of Parents and Senior Citizens Bill raised the profile of such practices, issuing penalties for abuse and neglect of elders exacted by members of their extended/joint family. Some laws are enacted to solve this problem. According to the mentality of people here, they do not bother to follow moral duties but they have to follow legal duties because of fear of punishment. The maintenance of parents is included in section 125 of CrPC, The Hindu Adoption and Maintenance Act 1956. But the procedures under these laws are time consuming and expensive. Under these acts parents can claim maintenance from their children

National Old Age Pension Scheme (NOAP) was introduced by the Indian government to provide Rupees 200 per month to the old and destitute people. But money cannot take place of emotional support, care etc. In 2007, The Maintenance and Welfare of Parents and senior Citizen Act (Senior Citizen Act) has enacted to provide some speedy and inexpensive remedy to get maintenance. The bill provides for—

a) Appropriate mechanism to be set-up to provide need-based maintenance to the parents and senior citizens

b) Providing better medical facilities to them

c) For institutionalization of a suitable, mechanism for protection of life and property of older persons

d) Setting-up of old age homes in every district

Family life is very necessary for senior citizens and for parents to lead a life of security, care and dignity. So the act will really help senior citizens, and they will be able to live a normal life. This will be a great relief to the parents and senior citizens. This act is also made applicable to senior citizens who are childless. The High Court of Delhi in one case appreciated the efforts of Parliament in enacting the Maintenance and Welfare of Parents and Senior Citizens Act, 2007. Also there is need of creating awareness among the people regarding this act and the rights which are given to senior citizens under this act.

Active Aging

If ageing is to be a positive experience, longer life must be accompanied by continuing opportunities for health, participation and security. The World Health Organisation (WHO) has adopted the term "active ageing" to express the process for achieving this vision. During the International Year of Older Persons in 1999, WHO launched a new campaign, Active Ageing, which highlights the importance of social integration and health throughout the life course. Active ageing aims to extend healthy life expectancy and the quality of life for all people as they age, including those who are frail, disabled and in need of care.

Active ageing depends on a variety of influences or "determinants" that surround individuals, families and nations. These apply to the health of all age groups, although the emphasis is on the health and quality of life of older persons. Attaining the goal of active ageing will require action in a variety of sectors, including education, employment and labour, finance, social security, housing, transportation, justice and rural and urban development.

WHO has recognised the need to develop a global strategy for the prevention of the abuse of older people. This strategy is being developed within the framework of a working partnership between the WHO Ageing and Life Course unit of the Department of Chronic Diseases and Health Promotion, the WHO Department of Injuries and Violence Prevention, the International Network for the Prevention of Elder Abuse (INPEA), Help Age International and partners from academic institutions in a range of countries.

Dr. Gro Harlem Brundtland, Director General of WHO, says that "there is much the individual can do to remain active and healthy in later life. The right lifestyle, involvement in family and society and a supportive environment for old age — all preserve well-being. Policies that reduce social inequalities and poverty are essential to complement individual efforts towards Active Aging.

The elderly most frequently suffer from cardiovascular illness, circulatory diseases, and cancers, while the non-elderly face a higher risk of mortality from infectious and parasitic diseases. In developed countries advancing through demographic transition, there have been emerging epidemics of chronic non-communicable diseases (NCDs), most of which are lifestyle-based diseases and disabilities . In contrast, India's accelerated

demographic transition has not been accompanied by a corresponding epidemiological transition from communicable diseases to NCDs. It is noted that the Indian elderly are more likely to suffer from chronic than acute illness. There is a rise in NCDs, particularly cardiovascular, metabolic, and degenerative disorders, as well as communicable diseases While cardiovascular disease is the leading cause of death among the elderly, multiple chronic diseases afflict them: chronic bronchitis, anaemia, high blood pressure, chest pain, kidney problems, digestive disorders, vision problems, diabetes, rheumatism, and depression. Concurrently, the prevalence of morbidity among the elderly due to re-emerging infectious diseases is quite high, with considerable variations across genders, areas of residence, and socioeconomic status. It is projected that NCD-related disability will increase and contribute to a higher proportion of overall national disability, in step with the greying of the population.

Social Factors

A closer look at the literature on access to healthcare reveals variation across an age gradient. Older Indians have reported higher rates of out-patient and inpatient visits. The age gradient in elderly health access is overlaid by social determinants of health. For one, there is a feminization of the elderly population; according to the 2001 census, the gender ratio among the Indian elderly aged 60 years and older is 1,028 females for 1,000 males. It is expected that by 2016, 51% of India's elderly will be women (in rural areas, this proportion will be much higher. More women report poor health status as compared to males, and yet a far greater proportion of men are hospitalized as compared to females (87 versus 67 per 1,000 aged persons.

Unmet health needs are more pronounced among the 33.1% of the elderly in India who in 2001 were reported to have lost their spouses, of whom a larger relative proportion is female (50% of female elderly are widows versus only 15% of male elderly who are widowers). Studies have shown that widows are disproportionately vulnerable to disability, illness, and poor healthcare utilization due to a number of mobility, employment, property, and financial constraints. Although broader trends of economic dependence are changing, kinship systems and social support still have strong bearing on access to healthcare among the elderly. A strong link can be established between ownership of property and kin-based care giving arrangements.

Traditional arrangements structured shared domicile of the elderly in their ancestral homes along with younger generations, who would later inherit this property. While strong cultural emphasis was and continues to be placed upon respect for the elderly, kin conflict and such other broader considerations as caste order have historically hampered access to health. Property less elders have a relatively higher likelihood of residence in old-age homes, living alone, and being looked after by relations other than their children when widowed. More recently, arrangements of "living apart but together" are increasingly

common, where joint family co-residence is discontinued but strong social support is immediately available, particularly in times of health crises. Given this variable provision of support, "discourses of neglect" may emerge, where in their everyday lives, the needs and problems of the elderly are invisible to those who offer them support in times of acute ill health. Moreover, research in India has shown that it is not the quantity but rather the quality of particular ties that relate to health. In some cases, having a continuous engagement or strong tie with a neighbour or child may have a more health-protective impact than having many (weak) ties to a host of family and community members.

India has no population-wide mechanisms of social security. Given this scenario, Indians have to work as long as possible in order to support themselves. Employer insurance and pension schemes are available only to as low as 9% of rural males and 41.9% of urban males who are in the formal sector; among females, the figures are lower still (3.9% rural, 38.5% urban).The rest of the workforce comprises casual and self-employed workers who are not entitled to formal retirement benefits and, in order to afford healthcare in their early years, face the paradoxical challenges of remaining both healthy and employed in old age. Those in the formal sector may experience a halving of their incomes, which, in the face of rising inflation, leaves smaller proportions of income that may be allocated to health. As a result, a considerable proportion of the elderly are employed. An analysis of the Worker Population Ratios (WPRs) depicts that 56.79% of elderly males and 16.32% of elderly females were engaged in employment (proportions are higher in rural areas). Among the elderly participating in the workforce, a majority (nearly 95%) is either self-employed or involved in casual labour with a maximum number of elderly being self-employed (79%). Such employment arrangements may offer limited remuneration and require the elderly to keep working: NSS data suggest that almost one-fourth of males and one-sixth of females are employed even in the 80–84 age group.

In view of increasing the financial security of the elderly, higher tax exemption has been provided for the elderly, and the exemption age has also been reduced from 65 to 60 in the 2011 budget. Also, a new category called "very senior citizen" for elderly above 80 years of age has been introduced for greater tax exemption (Highlights of Union Budget 2011–2012). Notwithstanding these most recent developments, the overall pattern of employment in old age has required the pursuit of financial security up to later periods in life. The declining health and energy of the elderly discourages employers from hiring them in the regular workforce, forcing the elderly to opt for self-employment and casual labor, particularly in rural areas, where employment opportunities are generally low .In the absence of state-level measures of providing social security, security in old age may be assured through movable or immovable property assets. In India, which is largely patriarchal, the ownership of land, house, or property is mostly owned and devolved among men with exceptions on the southwest coast and in the northeast (where matrilineal societies have existed. Thus, ownership of property and assets is strongly affected by prevailing social

norms related to gender and socioeconomic status. In the case of women, the basis of property rights not only is generally weak but also seems to be eroding. Ownership rights vary for women depending on their status as daughters or widows. NSS data show that more than twice the number of male elderly own property or assets compared to female elderly in both urban and rural areas, a difference that is moderated by socioeconomic status (i.e., lower strata have greater gender disparities in property ownership). Transfer of property to children results in propertylessness, a phenomenon more common among rural elderly men and urban widowed women with sons. Lack of property means lack of assets or a safety net to rely on as health costs escalate through old age.

Paying for Healthcare

Apart from individual-level socioeconomic issues that adversely affect affordability, a number of systemic factors underpin the reduced ability of people, particularly the elderly, to pay for healthcare. Although all forms of healthcare payments are available in India, 83% of healthcare expenses are private out-of-pocket (OOP) expenditures. India's relatively unaccountable and inefficient public system of healthcare has led to the evolution of a highly varied, unregulated, and mostly expensive private sector that provides most healthcare, rendering Indians increasingly vulnerable to catastrophic health expenditures and poverty .

According to 2005 estimates, per capita expenditure on health is 125 Indian Rupees (INR), of which per capita OOP expenditure is 100 INR. The largest proportion of this OOP expenditure is spent on outpatient expenditures (74 INR), which overlaps to a great extent with the purchase of drugs (72 INR). The elderly, due to increased morbidity from chronic diseases, have long-term healthcare needs and a large likelihood of having health expenditures in general and OOP expenditures in particular. The need for healthcare increases with age. Those above 65 years spend on average 1.5 times on healthcare compared to those in the 60–64 year age category. The elderly have little recourse as insurance does not cover outpatient or drug purchase. Moreover, insurance plans only cover inpatient hospital expenses, and, thus, even insured elderly have a higher chance of falling into poverty, given that catastrophic expenditure occurs due to outpatient and drug expenses. In fact, the probability of catastrophic OOP expenses in households with elderly is much higher as compared to households without elderly members. Evidence suggests that if OOP payments for either medicines or outpatient care were removed, only 0.5% of people would fall into poverty due to health spending.

Financial protection for health spending in India is largely in the form of savings and insurance. However, insurance in India is limited not only by its low coverage of conditions, but also by low coverage of populations. The National Family Health Survey of 2004–2005 indicates that only 10% of households in India had at least one member of the family covered by any form of health insurance. Overall, the insurance market in India remains

limited and fragmented in its presence. Benefits are accessed by only a few privileged sections of the population, such as those in the formal and civil service sectors like defence, civil services, and the railways, even after retirement long into old age. Lack of employment and income affect elderly utilization of medical insurance, as these populations are often incapable of paying regular insurance premiums. Finally, insurance companies often explicitly exclude the elderly due to age limits or eligibility restrictions for those with pre-existing conditions. This results in heightening the estrangement of the aged from a healthcare system and policy environment that has historically lagged in supporting the financially weak.

CONCLUSION

According to NGOs incidences of elderly couples being forced to sell their houses are very high. Some elderly people have also complained that in case of a property dispute they feel more helpless when their wives side with their children. Many of them suffer in silence as they fear humiliation or are too scared to speak up. According to them a phenomenon called 'grand dumping' is becoming common in urban areas these days as children are being increasingly intolerant of their parents' health problems. The number of people in old age homes is constantly increasing and also most of the parents are now deciding to live in old age homes rather than living with their children. Nowadays these people are facing the problems like lack of care, emotional support and economic support from the family etc. Our culture recognizes the status of the parents as that of God. A moral duty is put on the children to take care of their parents. But nowadays what we are observing in our society is that the children are not willing to take care of their parents, they do not want to spend money on them, they are treating their parents as aliens, they do not want to share an emotional bond with parents. These children are forgetting that the foundation of their life is built up by the parents. They are forgetting their moral and ethical duties towards their parents. This is because of fast life, industrialization, money oriented minds, inflation etc. Children have no time to look after their parents because of their busy schedule and as a consequence of this situation, the elders are getting neglected. At this age almost all the people need some kind of support.

The growth of the elderly population in the coming decades will bring with it unprecedented burdens of morbidity and mortality across the country. As we have outlined, key challenges to access to health for the Indian elderly include social barriers shaped by gender and other axes of social inequality (religion, caste, socioeconomic status, and stigma). Physical barriers include reduced mobility, declining social engagement, and the limited reach of the health system. Health affordability constraints include limitations in income, employment, and assets, as well as the limitations of financial protection offered for health expenditures in the Indian health system.

Recommendations under the Universal Health Coverage (UHC) framework have prioritized primary and secondary prevention and health promotion, with the goal of creating enabling environments for healthy lifestyles, early detection, and routine screening among the aged and avoiding institutionalization. In order to ensure these needs are met, a concomitant program of dedicated research is required on how various UHC elements affect and may cater more appropriately to the growing demographic of Indian elderly.

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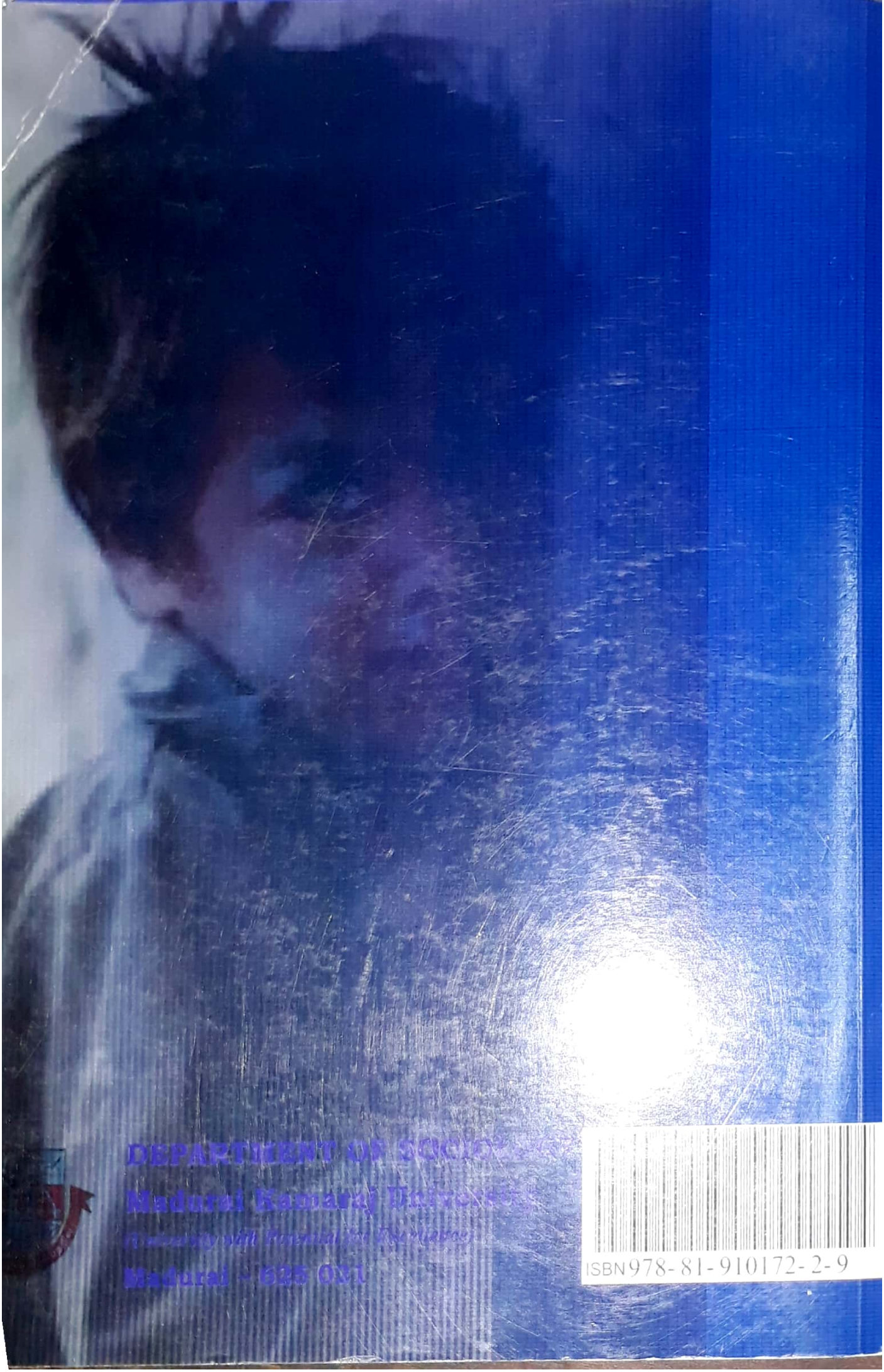

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