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SUBJECTIVE AND OBJECTIVE ENVIRONMENT AND HEALTH STATUS OF OLDER PEOPLE IN INDIA: A CRITICAL ANALYSIS

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ABSTRACT

Population ageing has profound, major consequences and implications for all facets of human life. Its effect is determined by the subjective and objective environment and health status particularly the older person. This paper examines the subjective and objective environment, health status and different aspects of human deprivation in the old age and how it varies across gender, sector and state. Secondary data from the National Sample Survey Organization (NSSO) collected during it 42nd, 50th, 52nd & 60th round were utilized for the analysis of variables identified for the present paper. The analysis shows variation in the old age dependence ratio among rural (119) and urban (125) areas and these differences appeared to be nil for the older having surviving children. 65% of the aged had to depend on others for their day to day maintenance and the situation was worse for the older females. Majority (76-78%) had to depend on their children and spouses. Among the economically independent aged about 85-88% were have one or more dependents. The proportion of older persons reporting confinement to their home or bed found to increase with the age, among women and persons aged 80 and above. Majority of the aged felt that they were in a good or fair condition of health and their sickness as a problem of ageing. Among those who had sickness during the past 12 months 83 percent were hospitalized.

INTRODUCTION

Population ageing is a global phenomenon resulting from demographic transition with decline in both natality and mortality rates and subsequent increase in the life expectancy at birth. The increasing trend of older aged is demanding world attention especially for the developing countries like India. The aged population in India is the second largest in the world next to china. Currently it enumerates to 103 million of the aged which will be nearly to the total population of Mexico and it is predicted that the shares of population ages 60 and above years are expected to reach 137 million by 2021 which will be near to current population of Japan. Rapid population ageing has profound, major consequences and implications for all facets of human life. In the economic sphere, population ageing will have an impact on economic growth, savings, investment and consumption, labor markets, pensions, taxation and inter-generational transfers. In the socio-culture sphere, population ageing affects family composition, individual as well as family income, living arrangements, housing and migration. On the health aspects it has great impact on the health and healthcare, family income and consumption pattern, institutional care, health care facilities, health care expenditure by individual, family and the country, development of human resources for special health care of older etc. Majority of studies associated with older in the developing world attributed to the increasing numbers and deteriorating conditions. The lives of many older people are often affected by the social and economic insecurity which accompany with demographic and development process (World Bank 1994). The growth of individualism, desire of the independence and autonomy of the young generation, urbanization, nuclearisation of family, migration and dual career families (Serow William 1995 & Jamuna 2003) affect the status of the older people and making care of older more and more of a personal and social problem in India. The studies on the socio economic condition of older women showed more vulnerability within the framework of the

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demographic and the socio cultural change. The situation of older poverty has been a consistent phenomenon in the third world as they are deprived of their basic needs (Keyfitz , Nathan and Wilhelm Flieger 1990). From these studies, it is evident that people in the old age suffer from different kinds of eventualities in their old age. It can cause a condition where older are prone to the deteriorating life condition in their later life. Health care of the older is a major concern for the society as ageing is often accompanied by multiple illnesses and physical ailments. One out of two older persons in India suffers from at least one chronic disease which requires life-long medications. Providing healthcare to older is a burden especially for poor households (Rajan 2006). Among the older, the widows, poor and disabled constitute those who are more disadvantaged. Recent study on older people of Indian suggests growing prevalence of morbidity, poor health status along with significant increases in longevity among them (Elizabeth & Khan 2010). Thus, for the country where maternal and child health care indicators are still far from goals, ageing has emerged as another long term burden over the country's health care system. Like many other developing countries, the health system of India is inadequate to promote, support, and protect health and social well-being of the older due to lack of human and financial resources.

The prevailing situation stands as a major concern among policy makers to extend socio-economic security and proper health care for their ageing population specifically to the poor section of the society. Therefore, the necessity of analyzing the current health status, disease profile, morbidity pattern and demand for healthcare services target towards older is utmost importance. Moreover, very few studies have shown the pattern of health status and physical mobility of older in India (Mini 2008, Agrawal, Keshri, and Gaur 2009 & Dhak 2009). Most of the existing literature had not focused much on social determinants and pattern of living condition, economic status and self-reporting health status, morbidity and immobility among older in the country. Hence, this paper mainly focuses on the subjective and objective environment and health status of older people in India. To elaborate the subjective and objective environment and health status of older the present paper focuses extensively on the current pattern of socio-culture, economic status, living condition and self-reported health status, morbidity and diseases profile, mobility and hospitalization among older in India and does its critical analysis in order to explain the magnitude of population ageing in the country.

MATERIALS AND METHODS

The study utilized the secondary data collected from the reports published by National Sample Survey Organization (NSSO) in India. The reports of NSSO during its 42nd round (1986-87), 50th round (1993-94), 52nd round (1995-96) and 60th round (2004) were utilized for identifying and making comparison of the variables selected to support socio-culture, economic and health status of the older and the change that took place during these periods with reference to the variables chosen. Variable selected for the present paper to understand socio-culture, economic and health status are the following:

Socio-cultural Status: Number of Surviving children, living arrangement, economic independence, category of persons supporting, number of dependents and by location of residence.

Economic status: Work participation, employment status, old age dependency ratio.

Health Status: Physical mobility that is those not confined to bed or confined to home are consider as physical mobile. Self-perceived health status i.e. excellent/very good, good/ fair, and poor which is a subjective assessment about their own health status which is recognized by WHO as an instrument for monitoring health. Perception of aged persons about their state of health, rate of hospitalization during the last 12 months, average duration of ailment in days and average loss of household income due to ailment. Number of older persons who were not employed preceding the date of survey due to illness. The type of disabilities and nature of ailments among older people.

Since this paper utilized the data of National Sample Survey the older people are also addressed as elderly or aged people in the paper as mentioned in the survey reports.

RESULTS

Socio-cultural status: In India the socio-cultural status of the older person is often judged by appreciating the number of Surviving children, living arrangement, economic independence, categories of persons supporting the older person, number of dependents and location of residence. The aged persons per 1000 for each sex and sector at all India level for the above mentioned variables were presented in the table no. 1. In India joint family system is the dominant form of family under which many of the aged, particularly the older women those who lost their spouse were taken care by their children. In India during 2004 about 94.5 percent of the aged had at least one surviving child while about 5.5 percent of the aged had no surviving children. The rural- urban as well as male and female difference appeared to be nil with respect to proportion of older who had surviving children (Table No.-1**)** indicating provision for sufficient social support in old age as traditional culture conditioned that children will look after their aged parents.

Traditionally the older persons use to live with their spouse and children. In the year 2004 out of 1000 aged person 320 (rural) to 322 (urban) older person lives with their children. Further, majority of the older people both in rural (442) and urban (468) areas live with their spouse and other members like children and other relatives. The majority of older male seems to living with their spouse and other members compare to the older female. There is a gradual decrease in the number of older persons living alone from 1986-87 to 2004. On the other side the proportion of the older female living alone in rural and urban areas shows increasing trends from 1986-87 to 2004 (Table 1). This indicates higher incidence of widowhood among the older females than males. The incidence of widowhood is higher among women because they live longer and got marry to men much older than themselves which is a general customary practice in the country. The number of older persons living with children shows a declining trend from 1986-87 to 2004. It shows the decreasing trend of the support being provided by the children towards their parents

Table 1. Distribution of socio-cultural status of the older person (per1000) for each sex and sector in India

Social status Indicators	Period	Rural			Urban			All
		Male	Female	Person	Male	Female	Person	
Aged persons per 1000 by number of their surviving children for each sex								
no children	1986-87	74	56	67	83	69	77	71
	1995-96	55	62	58	53	65	59	58
	2004	53	56	55	49	66	58	55
1 or more children	1986-87	926	944	933	917	931	923	929
	1995-96	945	938	942	947	935	941	942
	2004	947	944	945	951	934	945	945
Aged persons per 1000 by type of Living arrangement for each sex								
Alone	1986-87	124	14	80	95	8	59	
	1995-96	25	61	43	30	60	45	
	2004	28	76	53	21	65	43	
With spouse only	1986-87	na	na	na	na	na	na	
	1995-96	137	77	107	103	57	80	
	2004	162	87	125	133	75	104	
With spouse & other members	1986-87							
	1995-96	613	313	462	648	297	469	
	2004	597	284	442	649	294	468	
With children	1986-87	368	660	486	396	673	510	
	1995-96	179	481	331	178	512	349	
	2004	168	475	320	154	482	322	
With other relations & non relations	1986-87	57	74	62	56	100	74	
	1995-96	38	59	48	35	65	51	
	2004	27	56	42	29	67	49	
State of economic independence per 1000 aged persons for each sex								
Not dependent on others	1986-87	511	88	340	457	48	289	
	1995-96	485	121	301	515	115	311	
	2004	513	139	327	555	170	359	
Partially dependent on others	1986-87	162	137	152	169	91	137	
	1995-96	180	146	163	169	110	139	
	2004	152	124	138	134	95	114	
Fully dependent on others	1986-87	327	775	508	374	861	574	
	1995-96	313	706	511	297	757	532	
	2004	320	720	519	301	721	516	
Category of persons economically supporting the aged person (per 1000)								
Spouse	1986-87	70	115	95	62	113	90	
	1995-96	113	159	142	105	182	156	
	2004	70	159	127	60	192	148	
Own children	1986-87	750	738	744	780	723	749	
	1995-96	766	717	735	792	695	728	
	2004	850	746	784	865	710	762	
Grand children	1986-87	62	64	63	61	65	63	
	1995-96	50	52	52	54	30	55	
	2004	22	31	28	18	56	26	
others	1986-87	118	83	98	97	99	98	
	1995-96	71	72	71	49	67	61	
	2004	57	63	61	57	68	64	
Number of dependents per 1000 economically independent aged persons for each sex								
Nil	1995-96	35	157	52	32	175	51	
	2004	69	320	122	83	341	146	
1	1995-96	348	242	332	434	303	416	
	2004	321	175	290	396	146	335	
2	1995-96	150	102	144	181	101	170	
	2004	234	370	262	256	417	295	
3-5	1995-96	266	162	251	218	91	201	
	2004	247	95	215	206	79	176	
6 or more	1995-96	201	337	221	135	330	162	
	2004	130	40	111	59	17	49	
Aged person by location of residence (per 1000)	2004							
Within the same building		205	169	188	169	177	173	185
Within the village/ town		372	398	384	275	348	310	369
Outside village/ town		272	289	280	384	312	349	294

Source: Report of NSSO 42nd round (1986-87), NSSO 52nd round (1995-96) and NSSO 60th round (2004)

Table 2. Distribution of Economic and employment statuses of older based on sex and sector in India

Economic and employment status of Older people	Period	Rural			Urban			All
		Male	Female	Person	Male	Female	Person	
Work Participation								
WPR (per 1000)	1993-94	683	173	433	429	92	255	
	1995-96	603	173	386	353	79	92	
	2004							
Self- employed in Agriculture (per 1000)	1993-94	657	503	626	177	174	176	
	1995-96	662	509	627	176	203	182	
	2004							
Self-employed in Non-Agriculture (per 1000)	1993-94	116	104	113	575	370	522	
	1995-96	111	92	106	567	354	523	
	2004							
Regular employees (per 1000)	1993-94	20	12	18	140	185	149	
	1995-96	12	29	16	147	152	150	
	2004							
Causal labour (per 1000)	1993-94	207	381	243	128	271	153	
	1995-96	215	370	251	110	291	145	
	2004							
Employment status								
Economically active	2004	59.3	16.7	38.2	33.0	8.0	20.2	33.8
Non – active	2004	40.7	83.3	61.8	67.0	92.0	79.8	66.2
aged persons per 1000 who were employed but were not employed		412	400	407	201	278	219	
preceding the date of survey due to Bad health	1995-96							
Old age dependence ratio								
NSS 50th round	1993-94			108			90	104
NSS 52nd round	1995-96			92			74	87
NSS 60th round	2004			125			103	119

Source: Report of NSSO 50th round (1993-94), NSSO 52nd round (1995-96) and NSSO 60th round (2004)

both in rural and urban areas. Economic independence discloses information about the self- supporting and maintenance of livelihood of the older people by themselves. In the year 2004 about 1/3rd of the older persons both in rural and urban areas were not dependent on others. Further, slightly more than 50 percent of the male do not dependent on others. Contrary to this older female compare to older male largely dependent on other for economic support for livelihood. However, it shows marginal declining trends among the urban older female from 1986-87 to 2004 (Table 1). It shows the tradition of confinement of women in household activities which are generally considered as non- economic contribution to the family. Further, women's involvement and contribution in economic activities like farming and other business in which the family is involved is often combined and considered as economic activities of men rather than that of women.

It has been observed that large proportions of the older persons were economically dependent on others for their livelihood. It is therefore necessary to know who the persons are providing economic support to these older persons. From the table 1 it was found that of the economically dependent aged, majority (784 in rural and 762 in urban per 1000 aged persons) had to depend on their children and a sizable proportion (12 percent in rural and 14 percent in urban) on their spouse for their economic support. Only 3 per cent were supported by their grandchildren and rest 6 percent had to depend on others including non-relation. In the inter survey period, the proportion of the aged males and females depending on their children for economic support has increased in both rural and urban areas and more so in the rural areas. Further, the proportion of those depending on their spouse decreased in general among the aged male but marginally increased among the aged females in both rural and urban areas. The information on the number of dependents for the aged who were economically independent was presented in the table no.1. It has been observed that about 12 to 15 percent had no dependent. In other words 85 to 88 percent were reported to be living with one or more dependents. Older females living in both rural and urban areas had less dependent compare to male. This implies that on an average an aged male had more dependents compared to an aged female and appears to be same for both rural and urban areas. Location of residence of the aged person is very important for assessing the quality of social support and care the older person would receive from their children and other relatives. The information on these aspects was collected and presented in the table no. 1. It has been observed that only 18 percent of the aged person in both rural and urban areas lives with their children and other relatives in the same building. Slightly more than 1/3rd that is 36 to 38 percent aged person's lives in the same village or town where their children and other relatives reside. Further around 28 percent stay outside their village or town. Thus majority of the older person showed the lack of receiving social support and care from their children and other relatives as the distance of residential location changes.

Economic status: The economic status of older Indians is more varied than any other age groups. Economic status of the older people is assessed not only by considering their income but also by their level of work participation, employment status particularly involvement in income generation activities, old age dependency ratio and were presented in the Table 2 and Figure 1 and Figure 2.

Income and economic security in the old age is very important for leading a healthy qualitative life during old age. The work participation among elder's would show their economic independency which were presented in the Table 2. Examination of the table showed that in the rural areas 66 percent of male and 50 percent of female among the older persons were self-employed in agricultural sector. On the contrary in the urban areas 56 percent of male and 35 percent of female were self-employed in non-agricultural activities.

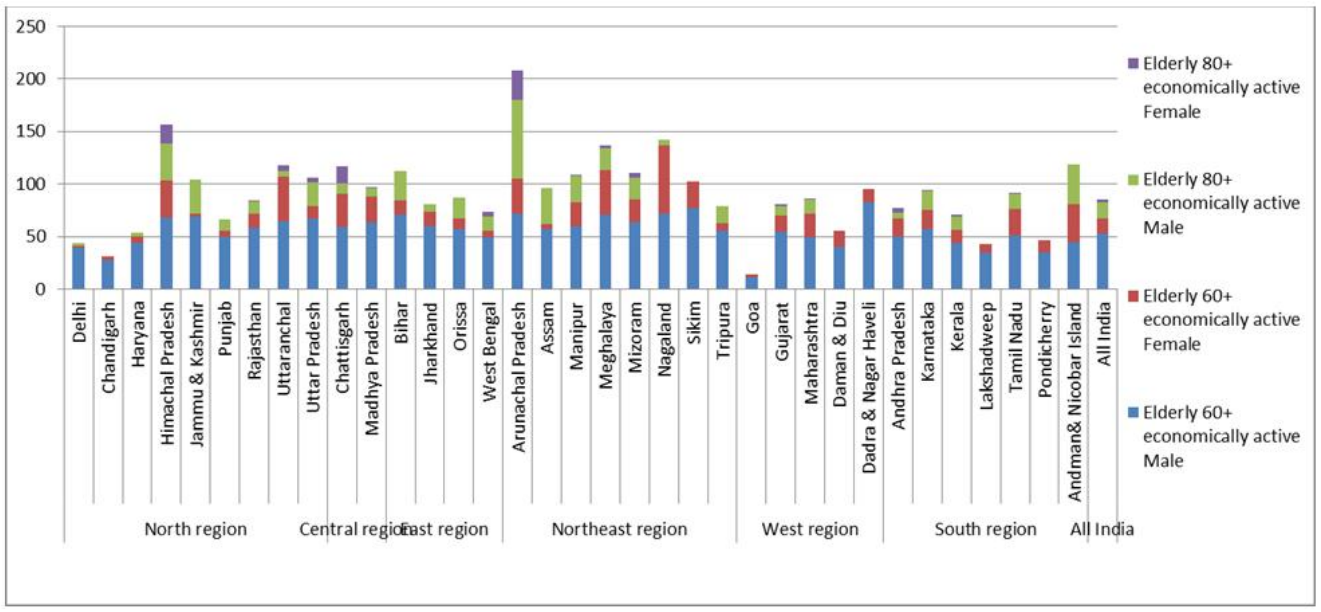

Figure 1. Region cum State wise percentage of Employment Status among the older in India as per NSSO 2004

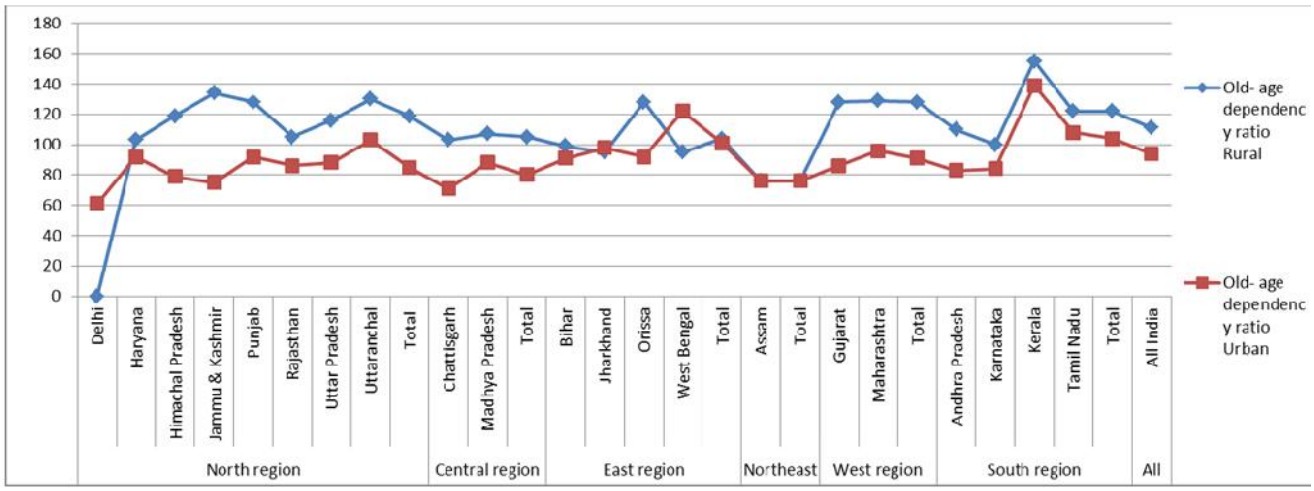

Figure 2. Old- age dependency ratio for rural and urban areas by region and major states India

Only 15 percent of the older in the urban areas had regular employment compare to 1.6 percent of the older in rural areas. Thus, in the country majority of the older people were engaged in agricultural work either as land owners or causal labour in rural areas which has erratic income compare to urban older's as agricultural production is very much depend on climatic factors and physical ability of the individual to carry out the agricultural activities. The employment status of the older people would be understood based on their involvement in the economic or income generation activities and were presented in the table 2. Interpretation of the table showed that 38.2 percent of the older person from the rural areas and 20.2 percent of older person from the urban areas were engaged in economic activities. In the entire country 33.8 percent of older were involved in economic activities. On the other hand majority of the older were economically non active and it is more among older female. Further, urban older female shows slightly more economically non active compared to rural older female. In the NSSO 52nd round (1995-96) among 1000 older person 407 person in rural and 219 person in urban areas reported to be not employed in the preceding days on the date of survey due to bad health. State wise there is much variation of the involvement in economic activity among the older person of 60 + years and 80+ years as well as both sex in India (Figure 1). According to NSSO survey estimates the dependence ratio has increased over time and reached 119 during NSSO 60th round except for NSSO 52nd round, where it shows a decline (87). The cause for dip in the proportion of aged in the 52nd round lack evidence for scientific explanation however it is attributed to age- reporting bias. It also shows that the burden of the aged on the working population has increased substantially during the last decade. The estimates for major states were given in the Figure 2. It shows state wise variation in dependence ratio with highest old age dependence ratio for both in rural and urban areas in Kerala followed by Jammu & Kashmir, in the rural areas of Uttaranchal and in urban areas of Maharashtra.

Health status of Older: Health status of older people would be understood based on physical mobility, self-perception

Table 3. Distribution of Health status of older person based on sex and sector in India

Health status of older	Period	Rural			Urban			Rural + Urban		
		Male	Female	Person	Male	Female	Person	Male	Female	Person
Physical Mobility										
Cannot Move and confined to bed or home (Per 1000) 2004										
Age groups (years)										
60-64		27	34	31	33	34	33	29	34	31
64-69		51	50	51	34	63	50	47	53	50
70-74		79	132	105	77	116	97	78	128	103
75-79		117	163	139	113	185	147	115	170	141
80 & above		220	326	269	239	323	283	225	325	273
All aged		67	88	77	68	100	84	68	91	79
Self-perception of aged persons about their health (Per 1000) 2004										
Self-perception of aged persons with sickness										
Excellent/ very good		19	14	17	31	19	24			
Good/fair		580	525	553	641	620	631			
Poor		401	460	429	327	360	345			
Self-perception of aged persons without sickness										
Excellent/ very good		81	43	62	114	72	92			
Good/fair		772	770	771	775	780	778			
Poor		147	187	167	111	148	130			
Perception of aged person about change in their state of health (Per 1000)										
Perception of aged person with illness about their state of health 2004										
Much Better		24	18	21	25	19	22	24	18	21
Somewhat better		88	71	79	82	81	81	86	74	80
Nearly the same		497	511	504	599	572	585	525	530	528
Somewhat worse		322	315	319	240	266	254	300	300	300
Worse		50	60	55	42	46	44	48	55	52
Perception of aged person with without illness about their state of health										
Much Better		37	25	31	37	33	35	37	27	32
Somewhat better		106	100	103	122	114	118	110	103	107
Nearly the same		686	669	678	699	702	700	689	677	686
Somewhat worse		108	141	124	100	104	102	106	133	119
Worse		10	13	11	7	12	10	9	13	11
% of Hospitalized cases receiving free medical treatment as inpatients during last 12 months from employer 2004										
Government		1.23	1.97	1.54	0.65	9.45	7.8	2.97	4.67	3.71
Private		0.81	0.7	0.75	1.03	1.59	1.28	0.90	1.00	0.93
Rate of hospitalization (number per 1,00,000) during last 12 months by sex among older 2004										
		6303	4894	5607	10194	8085	9118	7223	5688	6459
Reporting ailment during the last 15 days		285	282	284	352	383	368	301	307	304
Reporting ailment on the previous day of the date survey		224	229	226	312	342	327	245	257	251
Number per 1,00,000 of person (60 and above years) reporting Average duration of ailment in days (2004)										
		38.3	46.1	42.3	104.5	96	99.6	50.9	57.5	54.4
Average loss of household income due to ailment(Rs.) during the last 15 days before survey for 60 years and above (2004)										
		113	37	76	75	20	46	103	32	67
Number of older persons (per 1,00,000) who were not employed preceding the date of survey due to chronic diseases										
Type of Chronic diseases										
Cough/ whooping cough	1995-96	24995	19533	22241	17855	14187	15982			
	2004	800	800	700	400	200	300			
Piles	1995-96	3289	1605	2440	3218	1831	2510			
	2004									
Problems of Joints	1995-96	36306	40448	38395	28540	39254	34010			
	2004	3000	4000	3400	2600	4500	3500			
High/low B.P.	1995-96	10791	10474	10635	20022	25086	22557			
	2004	2300	5300	3600	5000	5900	5400			
Heart disease	1995-96	3385	2658	3025	6828	5309	6062			
	2004	9500	5900	8000	16500	16200	16400			
kidney/ Urinary problem	1995-96	3846	2273	3063	4917	2407	3649			
	2004	7800	2800	5700	8900	3300	6300			
Diabetics	1995-96	3617	2815	3223	8525	6582	7544			
	2004	3000	5200	4000	6800	3600	5300			
Cancer	1995-96	197	312	254	183	393	290			
	2004	1800	3600	2600	2500	5600	3900			
Neurological disorders	1995-96	na	na	na	na	na	na			
	2004	4000	3500	3800	5100	3300	4300			
Accidents	1995-96	na	na	na	na	na	na			
	2004	7400	6500	7000	5200	6700	5900			
Any	1995-96	52670	51409	52034	52822	56029	54459			
	2004	11600	14000	12600	12500	11300	12000			

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Number of Aged persons per 1,00,000 by type of disabilities							
Visual	1995-96	24886	29133	27028	22547	26016	24318
	2004	1200	1400	1300	500	700	600
Hearing	1995-96	13944	15607	14783	11083	13182	12155
	2004	0	0	0	200	0	100
Speech	1995-96	3203	3763	3485	2930	3439	3190
	2004	0	0	0	0	0	0
Locomotor	1995-96	10671	11535	11107	7957	9374	8681
	2004	1700	2000	1800	2200	1600	1900
Amnesia/Senility	1995-96	9551	11344	10455	6076	7977	7047
	2004	-	-	-	-	-	-
Any disability	1995-96	38002	42455	40247	33285	36696	35027
	2004	-	-	-	-	-	-

Table 4. Per 1000 distribution of hospitalized cases within one year by nature of ailment for older people based NSSO 60th round (2004)

Nature of ailment	Rural			Urban			Rural+Urban		
	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
Gastro- Intestinal									
Diarrhoea/ dysentery	33	62	45	22	33	27	29	52	39
Gastritis/ gastric or peptic ulcer	37	54	44	30	24	27	34	43	38
Worm infestation	4	0	2	1	2	1	3	1	2
Amoebiosis	4	5	4	1	1	1	3	4	3
Hepatitis/ jaundice	5	4	5	14	4	9	8	4	6
Cardio- Vascular diseases									
Heart Disease	95	59	80	165	162	164	118	96	109
Hypertension	23	53	36	50	59	54	32	55	42
Respiratory including ear/ nose/ throat ailments	25	25	25	21	34	27	24	28	26
Tuberculosis	42	18	32	11	5	8	32	14	24
Bronchial asthma	111	47	84	80	54	68	101	49	78
Disorders of Joints and bones	30	40	34	26	45	35	29	42	34
Diseases of Kidney/ Urinary system	78	28	57	89	33	63	82	30	59
Prostatic disorders	12	0	7	14	0	7	12	0	7
Gynaecological disorders	0	14	6	1	18	9	0	16	7
Neurological disorders	40	35	38	51	33	43	44	34	40
Psychiatric disorders	9	5	8	1	3	2	7	4	6
Eye ailment									
Glaucoma	14	9	11	6	50	26	11	24	16
Cataract	77	132	100	64	94	78	73	118	92
Diseases of skin	10	8	9	1	1	1	7	5	6
Diabetes mellitus	30	52	40	68	36	53	43	46	44
Febrile illness									
Malaria	12	10	11	4	6	5	9	9	9
Whooping cough	8	6	7	4	2	3	7	4	6
Fever of unknown origin	43	44	43	25	31	28	37	39	38
Disability									
Locomotor	17	20	18	22	16	19	19	18	18
Visual including blindness (Excluding cataract)	12	14	13	5	7	6	9	11	10
Diseases of mouth/ teeth/ gum	2	1	1	0	0	0	1	0	1
Accidents/ injuries/ burns/ fractures/ poisoning	74	65	70	52	67	59	67	66	66
Cancer and other tumours	18	36	26	25	56	39	20	43	30
Other diagnosed ailments		127	110	115	103	110	103	119	110
Other undiagnosed ailments		13	16	11	10	10	16	12	14

about their own health status and changes in their state of health, rate of hospitalization, average duration of ailment in days, average loss of household income due to ailment in Rs., unemployment due to illness, type of disabilities etc. which is presented in the table 3. For the aged persons the ability to move is an important indicator for assessing their own physical condition of health. It also indicates the degree of their dependence on others for movement and performing their daily routine. The proportion (number per 1000) of the aged person who cannot move around and are confined to their home or who cannot move at all and are confined to bed for each sex and sector is given in table 3. It was found from the table that about 8 percent of the aged persons were either confined to their home or bed. The proportion of aged persons reporting confinement to their home or bed was found to increase with the age for all categories, being as high as 273 per 1000 for aged persons aged 80 and above years.

The incidence of confinement to home or bed is seen to be higher among women than among the men in both rural and urban areas. It might be due to increase longevity in women compared to men which seems to increase further as the years of longevity increases. The self-perception about one's health is an important attribute for getting an idea about a person's actual feeling about his own health condition. A person may be considered himself as being in good health if he feels so. This is the criterion generally used in NSSO surveys to classify an individual as sick or otherwise. Moreover, it reflects the mental health of that person. Based on this idea the information about the perception of aged persons about their own current health was collected in the survey and was presented in the table 3 separately for those with sickness and those without any sickness. It was seen that as high as 55 to 63 percent of the aged with sickness felt that they were in good

and fair condition of health. The proportion among the aged without sickness was ranged between 77 to 78 percent and it might be possible that they considered their sickness as a problem of ageing. Further among the aged, men seemed to have the self-feeling that they had a better health condition even with sickness compared to the aged women. On contrary to this, about 13 to 17 percent of the aged who were not even sick considered themselves as having a poor state of health. When the perception of an aged person about changes in their own state of health was inquired; 52 percent of the aged person with illness reported that their state of health is nearly the same. Similar finding was reported for both sex and sector with marginal differences. Further, 68 percent of the aged person without illness reported that their state of health is nearly the same. Hence, there is no change in state of health among the older person with illness or without illness and they seemed to be get adjusted with their health problems. NSSO data of 2004 provides information about the older people who received medical treatment and duration of ailment among the older people and presented in the table no.3.

From the table, it was found that those who received free medical treatment from employer as inpatients during the last 12 months; 3.71 percent received from government facilities and only 0.96 percent received from private facilities. 304 older persons per 1000 reported to have ailment during the last 15 days and ¼th of older persons per 1000 reported to have ailment on the previous day of the date of survey. The average duration of ailments in days per 1,00,000 person of 60 and above years in the year 2004 was reported to be 54.4 days for the entire country and for urban older male it was reported to be highest i.e. 104.5 days. The loss of household income due to ailment during the last 15 days before the survey for those 60 years and above was Rs. 67 for India. However, among the rural male it was the highest (Rs. 113) (Table 3). But for women it was Rs. 32 ranging from Rs. 20 (urban) to Rs. 37 (rural) when average duration of ailment in days for women in the entire country was 57.5 days which was higher compare to older male. This shows that women have more tolerance towards their illness or maintain silence attitude towards suffering from diseases. Table no.3 shows that during 1995-96 most of the older persons preceding the date of survey were suffering from the chronic diseases like cough/ whooping cough, problems of joints, high / low B.P and were unemployed due to this illness.

However from 2004 there is a change in the diseases profile among the older people. Data from NSSO survey (2004) showed that most of older people had heart diseases, diseases of kidney/ urinary problems/ diabetics, cancer, neurological disorders, accidents/ injuries/ fractures and these were the reason for them for not being into employment preceding the date of survey (Table 3). Thus there seems to be a change in the disease profile among the older people with subsequent increase in the life style related diseases within one decade. Further, the number of aged person per 1,00,000 by the type of disabilities were also presented in the table no. 3. Analysis of the table showed that during 1995-96 most of the disabilities among the older were of visual, hearing, locomotor and amnesia. However, in the NSSO 2004 (table no. 4) most of the diseases among older per 1000 that lead to hospitalization during the last 12 months was heart disease, bronchial asthama, diseases of kidney/ urinary system, neurological disorders, cataract, diabetes mellitus, hypertension and accidents/injuries burns/ fracture and poisoning etc. Thus, the examination of data showed an increase in diseases pattern which involve inpatient treatment requiring more medical expenses for treatment as longevity increases. Therefore, the older people had to be educated to bring change in their usual life style to lead a qualitative healthy life as they ages.

DISCUSSION

According to the 2011 census, India has 103 million older people above 60 years of age. The proportion of the elderly has risen from 5.63 per cent in 1961 to 8.3 in 2011. The growth rate among elders was much higher than the general population growth rate of 2 percent per annum during last two decades (1991-2011). It is projected that by 2050 the share of 60+ populations will climb to 19%, or approximately 323 million people. The centenarians in the country jumped from 2 lakhs (2001) to 6 lakhs (2011) and growing at the rate of 1 person attaining 100 years of age in every 12 minutes. The older dependency ratio will rise dramatically from 0.12 to 0.31 due to demographic transition and increasing life expectancy. However, with increasing age the increase in the burden of non-communicable and communicable disease among the elderly will also be of great concern as the changing social setup will not be able to provide care for them as (a) higher share of women will be in the workforce and thus less able to provide care for the older people in their family (b) children would be less likely to live with their parents.

Moreover, different stages of demographic regimes within the country had created interstate disparity which resulted in differential degree of population ageing across states and a lack of policies to deal with these issues has been a major concern for the country. The present study also found a decreasing trend in the support being provided by the children towards their parents both in rural and urban areas which is further increases as the distance of residential location changes showing lack of receiving adequate social support and care from their children and other relatives during most needed staged of their life. About 2.9 per cent of older in India live alone out of which majority were older women (4.1 per cent) and this may be due to higher incidence of widowhood among the older females than males . The significance of the living arrangement among the older people with their level of economic dependence was reported by Rajan, 2006. The present study also found that the majority of the older were economically non active and it is more among urban older people.

The dependence ratio also has increased over time and it shows state wise variation with highest ratio for both rural and urban in Kerala areas followed by Jammu & Kashmir and in the rural area of Uttaranchal and in urban areas of Maharashtra. The vulnerability among the older people is not only due to an increased incidence of illness and disability, but due to their economic dependency upon their spouses, children and other younger family members. It further limits their access to food, clothing and health care particularly medicine which features as the highest unmet need, The social negligence of the aged further arises due to cultural, social and economic relations within the society and its coexistence with demographic process and development which

erode the previous notion that children will take care of the parents in the old age is wearing away in India (Dandekar, 1993) particularly in urban area and seems to be spreading to the rural areas (Desai 1985). The vulnerability of the aged is mainly implied in the family size and family set up. Changing family ties and formation of the small and nuclear family had led to a negligence of the aged and the position of the aged become more vulnerable and are often treated as a burden to the family particularly those belong to poor standards of living (PKB Nayar 1992). Current study findings demonstrate that health situation among older is awful in India with about one-fourth of the older person reporting poor health status although it might be higher than reported due to biasness in reporting and also with increased age the reporting of poor health status increases (Joshi, Kumar, & Avasthi 2003). Reporting of poor health status is higher among females than male despite they enjoy higher life expectancies compared to male. In this study the female elder population is less likely to be hospitalized than their male counterpart and it is supported by previous study conducted by Agarwal *et al*., 2009. Further, ageing diminishes the capacity to work and earn; reduced capacity for income generation and a growing risk of serious illness are likely to increase the vulnerability of elders to fall into poverty, regardless of their economic status (Lloyd-Sherlock 2000).

Angus Deaton and Christina Paxson (2000) report that when elderly people move in with their children their consumption levels are determined by their own lifetime resources and not by those of their host family contradicting the prevailing assumption in the society that the children are the major supporter and resource providers to the older people. The current study found an increase in the life style related diseases among the older person within one decade showing transition in the disease profile towards non- communicable diseases among the older people demanding more expenditure and investment in health care of older people at individual, family, society and national level. The inability in the initial endowment of an individual which further deteriorates as they go up in the life cycle makes them more vulnerable and offering limited scope for risk management and maintenance of cope up strategy in maintaining level of living (Zwi 1999). There is a perceived notion that the older person's presence in a household will reduce economies of scale as it increases the consumption of more private goods such as medicines that can reduce overall welfare of the households. Therefore, the older people had to be educated to bring change in their usual life style to lead a quality healthy life as they ages.

Modernization and development have brought changes in the way of life towards the adoption of unhealthy nutrition, physical inactivity, and consequent obesity contributing to the prevalence of diabetes. Chatterji et.al. (2008) reported that almost one-half of older Indians have at least one chronic disease such as asthma, angina, arthritis, depression, or diabetes. They have high rate of smoking (26 percent) and inadequate physical activity (18 percent) which will be likely translate into future ill health. It suggest that the "health care services will need to shift resources and services to respond to an aging population. Considering the present trend of disease pattern it is projected that by 2030 nearly one-half of India's disease burden with high level of chronic conditions is to be borne by older adults who will represent a much greater share of the total population. Further the aging of India's population will lead to increases in the prevalence of chronic conditions such as diabetes and hypertension. Rao *et al*. (2003) reports that elderly suffering from serious illness and lack of medical facilities in the villages and poor economic condition might be responsible for the lower health status among them. The disease transition will demand for treatment of non-communicable diseases will increase which is more complex and expensive. Further the need for palliative care will also rise up in future while currently the country has woefully poor palliative care facilities. Nayar (2000) reports that the attitude of both health care professional and common people appears to consider the illness of elderly was an essential part of old age and most of the illness of the old have no cure except palliatives. The lack of access to the basic pain relief drugs like morphine shows that thousands of Indians needlessly suffering long and agonizing deaths with cancer and other conditions. It is estimated that in India, a two-year increase in life expectancy would increase annual GDP approximately 1 percent by 2025. But, it will only be beneficial unless and until it's older population are healthy and contributes to production. The poor health status with long term non- communicable diseases will be disaster for the future economic and social security of the country.

Within the total consumption of elderly, health consumption is the largest while other consumption is about 6 percent of the total consumption. The India's social security system will face huge challenges due to its ageing population and the rapidly rising life expectancy requires a longer period of retirement support for each elderly. Moreover, there is an increase in the consumption of health care resources disproportionately with age; therefore retirement financing will have to consider the healthcare needs (Asher 2006). In the country the share of expenditure on social security and welfare has been at about 2 percent in total public expenditure. However, share of expenditure by Central and State Governments on National Social Assistance Programme (or National Old Age Pension Scheme) was about 0.03 (or 0.028) percent of total public expenditure in 2003-04. Thus, the magnitude of public expenditure on pensions for older people is negligible showing low public support to the aged in India. Further, aging population creates economic challenges, besides bringing imbalance in the ratio of both working people to the elderly population and of active health care professionals to potential patients. As the older population expands, it also reduces the number of people funding healthcare, putting further burden on government budgets.

Bhattachariya and Sapra (2008) reports that according to national surveys less than 10 percent of Indians have health insurance from private or public sources, and about 72 percent of health care spending is paid out-of-pocket. Further, India's health insurance scheme for the poor only covers those ages 65 and younger, leaving India's oldest population predominantly vulnerable. Within the older Indian population, women face additional risks because of their long nurtured poorer health and fewer accesses to health care than men of similar backgrounds (Kakoli Roy and Anoshua Chaudhuri 2008). The Indian government and several states have begun a variety of programs designed to increase access to health care or health insurance for the majority of the population that

lacks sufficient access (David E. Bloom *et al*. 2010). Rising numbers of older people will put new and increasing demands on the health care system. The correlation between public health spending and increase in the survival of the elderly and other vulnerable groups done by Mansour Farahani, Subramanian, and David Canning (2010) found that a 10 percent increase in public health spending decreases deaths by about 3 percent among the elderly, women, and children. Presently, the country has introduced new public funds for reviving its health care system. An analysis by Yip and Mahal (2008) acknowledged wide inequality in access to health care by older people who are poor or live in rural and remote areas. It suggested health care reforms combining funding with inequality of access and setting regulatory mechanism to limit cost inflation. Thus, resources in cash and kind channeled through insurance and infrastructure strengthening is inadequate to address the current problems of inaccessible and unaffordable health care system and services coupled with future challenges posed by ever increasing aging populations having lower standard of living and affected by non-communicable diseases.

Conclusion and Recommendation

Thus it can be concluded that India's older people has low living standards and there is increasing trend of receiving less support from children and other family members. There is also disease transition from communicable to non-communicable diseases which require huge medical expenses for treatment. Increase in longevity calls for special attention towards older people specially focusing on 70+ aged, female, living alone, poor. Further the older people of various states are at different state of ageing population each state need different plan of action and program initiatives to address their older people issues. As the country is growing to face the new emerging challenges due to ageing and longevity; the health care for older people needs a holistic approach with more research and evaluation of physical, mental, functional and socio-economic health in order to develop an older friendly health care system which would be effective, affordable, accessible, comprehensive, and able to maintain continuity in content and time. The health care services for older people should focus more on health promotion and disease prevention services, early detection and curative services. This requires pro- active contribution from health professionals at all level to the system.

Under progressive economic and development, socio-cultural revolution and demographic alterations the ever growing elderly population in the country needs special attention in several aspects. Foremost of all it needs a health care system which indemnifies good health status and assures longevity with disability free life among elderly in the country. Further, it should insure the financial security of older people, as the majority of them are economically dependent on working population. Additional, the most important aspect is to give special attention to ensure social support & well-being of these ever increasing older people because of the new emerging problems due to undergoing social changes like increasing trend of nuclear family norms, immense migration, increasing social and familial insecurity, and absence of caretaker to look after the elderly in the family. Moreover, there is a need to sensitize the community about the emerging elderly issues and associated problems in order to make them efficient to address the challenges. Finally, amalgamations of all these prerequisites possess major challenge for policy makers and program planners in the country.

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