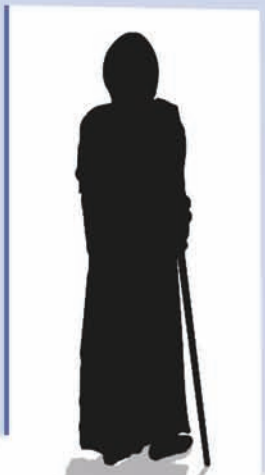
Building knowledge base on
Population Ageing in India
Working paper: 2



Studies on Ageing in India

A Review

S. Siva Raju

UNFPA

Editor's Note

Dear readers,

In most countries of the world, including India, population ageing is likely to become a serious policy and programmatic issue in the coming decades. UNFPA in collaboration with the Institute of Social and Economic Change, Bangalore and the Institute of Economic Growth, Delhi has launched a major research project to build a knowledge base on population ageing in India (BKPAI). The study focuses on social, economic, health and psychological aspects of elderly. This peer reviewed publication is one in the series of working papers. We are sure that the findings of this publication will help in generating a healthy debate and policy response amongst a wider cross-section of scholars, professionals, policy makers and civil society.

Editorial Team

Citation Advice:

S. Siva Raju. 2011. “Studies on Ageing in India: A Review”, BKPAI Working Paper No. 2, United Nations Population Fund (UNFPA), New Delhi.

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The study has been supported by the United Nations Population Fund - UNFPA and reviewed by a wider group of demographers and researchers prior to its finalization. The contents, analysis, opinions and recommendations are solely of the author/s, and do not necessarily reflect the views of UNFPA.

Studies on Ageing in India: A Review

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December 2011

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Abstract

The paper outlines the status of research on ageing in India and provides a situational analysis of elderly in terms of economic, social, psychological and health aspects, and elder abuse. The paper also develops issues upon which models of care for the elderly can be framed and argues that factors such as place of residence, social class and gender among others tend to influence such models of care. The paper draws from population censuses, various rounds of the NSSO and several published and unpublished articles, papers and project reports. The review shows that not all aspects of ageing have been uniformly researched and many of them are micro-level localised studies based on small samples.

The paper suggests that the institution of the family needs to be protected and strengthened through professional welfare services, including financial support to low income families, and counselling services both to the elderly and to family members. The review of psychological issues shows that there were many studies conducted abroad and a dearth of studies in India particularly on determinants of happiness in old age. There is a gap in our understanding of the modes of frustration, degree of social adjustment and the need patterns of different elderly age and social groups, old age ailments, physical infirmities and mental health. The paper suggest models of care and well being of five groups of elderly to better target services to their differing needs. These are: (a) rural elderly, (b) urban poor elderly, (c) urban middle income well-to-do elderly, (d) female elderly and (e) elderly living alone. More studies are needed which use a multidisciplinary approach and do not view the elderly as passive receivers of care but as significant contributors to the family, society and country.

1. Background

Population ageing is the most significant emerging demographic phenomenon in the world today. In 1950, the world population aged 60 years and above was 205 million (8.2 per cent of the population) which increased to 606 million (10 per cent of the population) in 2000. By 2050, the proportion of older persons 60 years and above is projected to rise to 21.1 per cent, which will be two billion in number. Asia has the largest number of world's elderly (53 per cent), followed by Europe (25 per cent). This pressure of increasing numbers of elderly will intensify in the next 50 years. In 2050, 82 per cent of the world's elderly will be in developing regions of Asia, Africa, Latin America and the Caribbean while only 16 per cent of them will reside in the developed regions of Europe and North America. Population ageing is therefore rapidly emerging as the problem of developing countries. Ageing was not only an Asian trend up until 2000, but it is going to continue to dominate Asia in the next century as well (UNFPA, 1999).

Old age presents its special and unique problems but these have been aggravated due to the unprecedented speed of socioeconomic transformation leading to a number of changes in different aspects of living conditions. The needs and problems of the elderly vary significantly according to their age, socioeconomic status, health, living status and other such background characteristics (Siva Raju, 2002). For elders living with their families - still the dominant living arrangement - their economic security and well-being largely depends on the economic capacity of the family unit (Alam, 2006). In traditional Indian society, the informal support systems of family, kinship and community are considered strong enough to provide social security to its members, including older people. Urbanisation, industrialisation and the ongoing phenomenon of globalisation have cast their shadow on traditional values and norms within society. Gradual nuclearisation of the joint family, erosion of morality in economy, changes in the value system, migration of youth to urban areas for jobs or work and increasing participation of women in the workforce are important factors responsible for the marginalisation of older people in rural India. As a result, the elderly depend on 'money-order economy' and their intimacy with their children is only from a distance (Vijaykumar, 1999). The many physiological, economic, emotional and interpersonal facets of ageing influence the social functioning and well-being of individuals in different ways. Changing traditional values, mobility of the younger generation, changes in family structure and role of women have contributed to a 'crisis in caring' for the elderly (Prakash, 2004). Many facets of the generation gap contribute to marginalisation of older persons and their wisdom by the younger generation, leading to conflicts, lack of respect and decline of authority, neglect and sometimes even exploitation or abuse.

Given the rate of population ageing that developing countries like India are experiencing, there is a need to focus on ageing issues and to take effective measures for improvement in the quality of life of elderly in general and elderly women in particular. A country as large and complex as India needs to work out an extensive plan for the care and well-being of the elderly as necessary according to differences in levels of urbanisation as well as in cultural and familial systems. The rural poor, who mostly work in the informal or unorganised sector face insecure employment, insufficient income, and lack access to any form of social security and good quality and affordable health care. Generally, they have to pay a large percentage of their income for even basic healthcare services. As the interrelation of health and

economic status continues throughout one's life, it is of special importance among the elderly whose livelihood depends on their physical ability and who do not have any provision for economic security. Social security pensions, though meager in amount, create a sense of financial security for the elderly, who benefit through schemes such as old age pension, widow's pension, agricultural pension and pension for informal sector workers. However, the proportion of elderly who benefit from these schemes has to be improved significantly.

Due to industrialisation and urbanisation and the changing trends in society, it is the urban elderly who are more likely to face the consequences of this transition as the infrastructure often cannot meet their needs. Lack of suitable housing forces the poor to live in slums which are characterised by poor physical conditions, low income levels, high proportion of rural migrants, high rates of unemployment and underemployment, rising personal and social problems such as crime, alcoholism, mental illness, etc. along with total or partial lack of public and community facilities such as drinking water, sanitation, planned streets, drainage systems and access to affordable healthcare services. With the increasing prevalence of slum dwellers who come to urban areas in search of better opportunities, a significant proportion of them would be elderly. While rural India continues to provide family support in old age, the forces of globalisation have touched many a life leading to migration of children to cities or abroad.

The major objective of the present paper is to review studies conducted on various issues of the elderly in India with a view to identify gaps and suggest measures to address them. Given the heterogeneity among the elderly in India, the paper also identifies issues upon which to build different models of care of the elderly. This paper draws from various published and unpublished articles, papers and project reports. The paper outlines (a) the status of research on ageing in India; (b) a situational analysis of the elderly in India under the categories of economic, social, psychological, health and elder abuse; and (c) models of care for the elderly based on the above. The status of literature on ageing in India is not very rich nor is this review exhaustive.

2. Status of Research on Ageing in India

The Research Agenda on Ageing for the 21st Century, which was jointly developed by the United Nations Office on Ageing and the International Association of Gerontology, was adopted by the Second World Assembly on Ageing at Madrid, Spain in 2002. India is a signatory to the Madrid International Plan of Action on Ageing (MIPAA) that sets an agenda for formulating and implementing public policies on ageing and influencing the direction and priorities for scientific gerontology in the coming decades. According to UN (2002), "there is a need to assess the 'state of the art' of existing knowledge, as it varies across countries and regions and to identify priority gaps in information necessary for policy development." Accordingly, attempts have been made to review the body of knowledge in the field of ageing and to identify the priority areas of research in the field of ageing in India (Prakash, I.J., 2004, Ramamurti, 2005, Siva Raju, 2006).

Though many ancient writers and poets have discussed at length the problems of old age, the scientific interest in ageing in India is a 20th century, post-independence (1947) phenomenon. If we look at the

status now, the science of gerontology is still in its infancy in India. The interest of social scientists and social work professionals on various issues of ageing is of recent origin. Only recently older people were identified as a priority group in implementation of social welfare policies and government interventions (Gokhale, 2005). The gerontological research carried out by a few Indian institutions[1] aims mainly to ascertain the living conditions of the elderly residing in different geographical regions; examine issues related to their social, psychological and health problems and conduct evaluative studies to assess the impact of various schemes meant for the welfare of older persons. Data on various ageing related issues like age and sex structure, rural-urban residence, literacy, marital status, work status, dependency status, disability and health status are regularly collected and compiled by various organisations like Census, National Sample Survey Organisation, Central Statistical Organisation. The research output in the areas of the behavioural and social sciences in India has so far outweighed that of the biological and medical sciences (Ramamurti, 2005). In an annotated bibliography (TISS, 1999) on research on the elderly, literature (both published and unpublished) was documented in two volumes. In the first volume, 884 articles, 44 books and five theses were documented; Volume 2 cites 888 articles (many unpublished being presented at conferences, workshops etc.) and 115 theses/ reports/ books published by NGOs and research institutions. This review though not exhaustive, compiled information on the research on ageing in India. The report also mentions, "There are various studies - most of them small micro studies conducted in different corners of the country and there are a few scholars who have published literature in the field". The annotated bibliographies document studies from as early as 1972 till 2000. The research survey studies as cited in these volumes and subsequently reviewed by Bose and Shankardass (2006), were mostly conducted in different states - Bihar, Gujarat Karnataka, Kerala Maharashtra, Orissa, Punjab, Rajasthan and Uttar Pradesh. They also suggested that, there is limited theoretical and methodological focus, quite oblivious of the developments of and debates in the field of gerontology. The investigators came mainly from the disciplines of psychology, sociology, social work and anthropology. The review of these articles shows that all aspects of ageing have not been uniformly researched. The areas covered under the study were: Problems of adjustment and coping; post-retirement life satisfaction; the elderly in the family; caregiving; social supports; attitudes; inter-generational interaction; leisure utilisation roles; techno-social changes and the family; elder care across subcultures; impact of demographic changes; quality of life; and widowhood problems (Ramamurti, 2005).

There is a need to adopt a multi -disciplinary and multi-activity approach to the issues of ageing. Most of the earlier studies have been attempted at micro-level on a small sample of the elderly living in a specific geographical area. While the paper documents the above-stated aspects, the focus is to highlight the different dimensions, rather than to analyse the methodological rigour of these studies.

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3. Situational Analysis of the Elderly in India

3.1 Demographic Profile

The demographic profile of the elderly population in India, as per 2001 Census, showed that in the case of the general population, the majority of the elderly (75 per cent) are living in rural areas and the rest (25 per cent) are in urban areas (*see* Appendix). While 53 per cent among elderly males are literate, the figure drops to only 20 per cent among elderly females. The data on work status of the elderly (NSSO, 2006) revealed that 36 per cent are still in the labour force and two-thirds (64 per cent) of them are out of the labour force. Over a quarter of elderly (26.9 per cent) are self-employed and the casual labourers among the older population are to the extent of 7.4 per cent. Only 1.5 per cent of them are in regular salaried employment. Elderly males are more economically active as compared to elderly females. The data on old age dependency ratio (NSSO, 2004) revealed that it was higher in rural areas (125) than in urban areas (103). Further, it was observed that a higher number of males in rural areas, 313 per 1000, were fully dependent as compared to 297 per 1000 males in urban areas. For the elderly females, an opposite trend was observed (706 per 1000 for females in rural areas as compared with 757 for females in urban areas). Overall, 75 per cent of the economically dependent elderly are supported by their children and grandchildren. As 90 per cent of the total workforce in India is employed in the unorganised sector, retirement from gainful employment precludes financial security like pension and other post-retirement benefits. It is estimated that one-third of the elderly population live below the poverty line and another one-third of them are living just above the poverty level. The profile of the National Old Age Pension Scheme (NOAPs) beneficiaries revealed that most of the pensioners were women - widows - not blessed with sons and having a very low economic status.

3.2 Economic Aspects

It is generally believed that the elderly are a burden on the family and the nation as they do not contribute to the national income. This is not always true. In India, 40 per cent of the elderly who are 60 and above are working. The figure rises to 61 per cent in the case of males. On the other hand, there are adults (in the age group 15-59) who are not working and are dependants (Bhagat and Unisa, 2006). In India, an overwhelming proportion of elderly (90 per cent) whose children are alive, live with their children (Bloom *et al*., 2010). For elders living with their families - still the dominant living arrangement - the economic security and well-being are largely contingent on the economic capacity of the family unit. Particularly in rural areas, families suffer from economic crises, as their occupations do not produce income throughout the year. Inadequate income is a major problem of the elderly in India (Siva Raju, 2002). Nearly 90 per cent of the total workforce is employed in the unorganised sector. They retire from their gainful employment without any financial security like pension and other post-retirement benefits. The Ministry of Social Justice and Empowerment, Government of India (1999), in its document on the National Policy for Older Persons, has relied on the figure of 33 per cent of the general population below poverty line and has concluded that one-third of the population in the 60 plus age group is also below that level. Though this figure may be understated from the older people's point of view, even at this estimate, the number of poor older persons comes to about 23 million. As per the Policy, the coverage under the Old Age Pension Scheme for poor persons, which is 2.76 million

(as on January 1997) will be significantly expanded, with the ultimate objective of covering all older persons below the poverty line. Women are more likely to depend on others, given lower literacy and higher incidence of widowhood among them (Gopal, 2006). Hence, the greater vulnerability of women due to higher life expectancy than men and the higher incidence of widowhood indicates the need to have a special focus on gender-based policy implications and social security needs of women. Vulnerable groups like the disabled, fragile older persons and those who work outside the organised sector like landless agricultural workers, small and marginal farmers, artisans in the informal sector, unskilled labourers on daily, casual or contract basis, migrant labourers, informal self-employed or wage workers in the urban sector and domestic workers deserve mention here.

Under the standardised economic security policy the government is providing retirement benefits for those in the organised sector and economic security benefits for those in the unorganised sector. The National Old Age Pension Scheme (NOAPs) is in operation all over India and the reports indicate that the most vulnerable sections of Indian society, namely, women and lower caste individuals have benefited from this scheme. Governments of all states and Union Territories have their own schemes for old age pension and the criteria for eligibility and the quantum of pension vary. The combined national budget allocation for the NOAPs comes to 0.6 per cent only as compared to 6 per cent of Central Government revenue expended on pension for its employees (Irudaya Rajan, 2001).

There is a need to protect and strengthen the institution of the family to enable it to cope with its responsibility of taking care of the elderly. Along with effective professional welfare services there is a need to develop counseling services for both, the elderly, and their family members. It is also important to provide financial support to low income families having one or more elderly members.

3.3 Social Aspects

These days, due to a change in family structure, the elderly are not given adequate care and attention by their family members. This trend is fast emerging partly due to growth of "individualism" in modern industrial life and also due to the materialistic thinking among the younger generation. These changes lead to greater alienation and isolation of the elderly from their family members and from society at large. Due to the changes in the family structure and the value system, respect, honour, status and authority, which the elderly used to enjoy in traditional society, has gradually started declining, and in the process the elderly are relegated to an insignificant place in our society (Niharika, 2001). Though the younger generation takes care of their elders, in spite of several economic and social problems, it is their living conditions and the quality of care, which differ widely from society to society.

The loss of the decision-making power is experienced more by those who have surrendered their property in favour of younger members and thus have no control over the sources of income. The loss of status and decision-making power is felt more by ageing women than men (Nandal *et al.*, 1987, Siva Raju, 2004). Khan and Raikwar (2010), in an empirical study of 320 people over 60 years of age in Delhi, selected through multi-stage stratified random sampling, suggest that 89 per cent of the respondents expected that their family members should take care of them but only 37 per cent are actually taken care of by their family members. Ninety- two per cent of the elderly felt that they should be included in

important household matters but only 26 per cent of them were actually involved in family affairs. Though a majority of the younger generation view the elderly as a socioeconomic burden, the advantages of having an elderly person at home such as care in times of sickness, advice in family matters, education and all-round development of the family are also recognised by a few from the younger generation. An increase in the duration of un-utilised time during the post-retirement period as compared to the pre-retirement period is also noticed among the elderly. Religiosity seems to have increase with age. A quantitative study to understand the role of spirituality and ageing process (Pandya, 2010) in 906 elderly respondents in Mumbai reveals that the spirituality was perceived to provide support, aid relationship building and maintenance, facilitate coping with stress and ideas, and issues in relation to death and dying.

3.4 Psychological Aspects

The review of literature on the elderly in relation to emotional maturity, lifestyles, death anxiety, locus of control and religiosity shows that most of the studies have been conducted abroad (Bowling, 2008) and that there is a dearth of information about the elderly in this context in India. One particular study in India has investigated the effect of socio-economic status and sex on emotional maturity, lifestyles, death anxiety, locus of control and religiosity of the elderly (60+). The study concludes that socioeconomic status is a significant factor influencing lifestyles and religiosity among the elderly in India; sex significantly affects overall emotional maturity, emotional instability, emotional regression, personality disintegration and lack of independence; the normal coping, exploitative, domineering-authoritarian and one-upmanship styles of life; religiosity and locus of control; and the interaction effect is significant only for emotional regression, personality disintegration, lack of independence and the individualistic, pampered, spoiled and domineering-authoritarian lifestyles (J.P. Yadav, 2004). As older people become aware of their inability and incompetency, they begin to revise their ideas about themselves. They also have to start coping with reduced income, change of status, loss of friends and spouse and lastly, their waning physical health. Psychological changes accompany the passing of years, slowness of thinking, impairment of memory, decrease in enthusiasm, increase in caution in all respects and alteration of sleep patterns. Social pressure and inadequate resources create many dysfunctional features of old age. Further, it is well known that the incidence of mental illness is much higher among the elderly than among the young. The psychological problems encountered by retired persons are much greater and the impact on the individual is entirely different as compared to those in the unorganised sectors. Decline in health status, income security and a break in professional routine together contribute to various socio-psychological problems for the retired people. The attitude of family members towards the retired person changes and his attitude towards his family members also changes. Attitudes towards old age, degradation of status in the community, problems of isolation, loneliness and the generation gap are the prominent thrust areas resulting in socio-psychological frustration among the elderly (Mohanty, 1989).

Happiness in old age depends to a great extent upon a busy life, good health, access to funds and having a spouse and social contacts. Anxiety is reported to be at higher levels among the elderly in general. A majority turn to religion for overcoming their feelings of anxiety by reading or reciting religious books and hymns. Studies have found that non-institutionalised older people are better

adjusted than institutionalised and geriatric patients. The younger generation as well as the elderly themselves view institutionalisation of the elderly unfavourably, which is partly due to a deep rooted tradition in our society that it is the duty of the children and family to look after the elderly. Some of the factors that are found to influence the adjustment of the elderly are rigidity; flexibility; role availability and role involvement; nature and quality of husband-wife communication; marital satisfaction; nature and quality of attitude to retirement; attitude to future and death; and satisfactory physical and mental health (Ramamurti and Jamuna, 1993). The problems of retirees mainly include: shortage of money, passing time, widowhood, feeling of being physically weak, fear of death, mental tension, feeling of social neglect and feeling of neglect by family as well as by friends (Raghani and Singhi, 1970). Mishra (1987) found that with increase in income and adequacy of income of the older persons, their level of adjustment also increased, indicating significant association between sound financial position and successful adjustment.

There is a scarcity of research both in India and abroad on the modes of frustration, social adjustment and needs of people in different stages of the life cycle. The level of frustration, degree of social adjustment and the need patterns of three agegroups comprising both males and females - 30-40 years, 45-55 years, and 60 years and above - belonging to the middle-class were ascertained in a study referenced below. The findings of the study do not prove the hypothesis that the need for nurturance increases with age, but do indicate a slight trend in this direction. The results, however, prove the hypothesis that women have a greater need for nurturance than men in old age(J.P. Yadav, 2004).

Most of the elderly are reported to have a negative self-image and poor self-concept (Ramamurti and Jamuna, 1984). Changes in looks and likeability and a feeling that others alienate the elderly greatly contribute to the negative self-image. It has been noticed that after the age of 50, people gradually manifest more problems and display poor adjustment and life satisfaction till the age of retirement. However, after retirement they slowly and gradually find adjustment and as such, their life satisfaction and adjustment increase show higher index until the age of 70 when the negative effects of ageing once again become more pronounced (Ramamurti, 1978). The significant determinants of successful ageing, according to some studies (Ramamurti and Jamuna, 1992, Niharika, 2004, Siva Raju, 2006), include self-acceptance of ageing changes, self-perception of health, perceived functional ability, perception of social support, inter-generational amity, belief in *karma* and afterlife, flexibility, range of interests, activity level, marital satisfaction, religiosity, certain value orientations and economic well-being.

3.5 Health Conditions of the Elderly

It is obvious that people become more and more susceptible to chronic diseases, physical disabilities and mental incapacities in their old age. As age advances, due to deteriorating physiological conditions, the body becomes more prone to illness. The illnesses of the elderly are multiple and chronic in nature. Arthritis, rheumatism, heart problems and high blood pressure are the most prevalent chronic diseases affecting them. Some of the health problems of the elderly can be attributed to social values also. The idea that old age is an age of ailments and physical infirmities is deeply rooted in the Indian mind and many of the sufferings and physical troubles which are curable are accepted as natural and inevitable

by the elderly. Regarding the health problems of the elderly of different socioeconomic status, it was found (Siva Raju, 2002) that while the elderly poor largely describe their health problems, on the basis of easily identifiable symptoms, like chest pain, shortness of breath, prolonged cough, breathlessness/ asthma, eye problems, difficulty in movements, tiredness and teeth problems, the upper class elderly, in view of their greater knowledge of illnesses, mentioned blood pressure, heart attacks, and diabetes which are largely diagnosed through clinical examination. In a study by Mutharayappa and Bhat (2008) NFHS-2 data was analysed to examine the type of lifestyle adopted by the elderly and its effects on their health conditions. "It was found that lifestyle adversely affects health and increases morbidity conditions among the elderly. Lifestyle habits such as alcohol consumption, regular smoking and tobacco chewing have adverse effects on one's ability to control diseases."

As early as 1990, Gore while analysing the social factors affecting the health of the elderly, concluded that, "while there are no data showing direct relationship between income level and health of elderly individuals, one would assume that the nutritional and clinical care needs of the elderly are better met with adequate income than without it. If so, the poor countries and the poorer segments of the elderly population within each country would experience problems of health and well-being". In a study (Wason and Jain, 2011) of 962 elderly persons aged 60 and above in Jodhpur city, it was found that nearly 50 per cent of the subjects were at risk of malnutrition in low income group which was higher than the high income (29.5 per cent) and middle income groups (33.3 per cent). It was also observed that respondent's age and income significantly affect the Mini-Nutritional Assessment scores of the aged population.

The main area of concern among the elderly is their health, which can in turn have a significant impact on their economic security, level of independence and social interaction. The analysis of NSS data by Rajan, Risseeuw and Perera revealed a huge majority (70 per cent) of the elderly reporting their health status to be ranging from "excellent" to "good/fair" while around a quarter of the elderly reported their current health to be poor. Previous analysis has uncovered that such a high percentage of positive assessment of health status was despite a large number of the elderly reporting to be suffering from at least one disability or chronic ailment. Their analysis throws light on the difference in self-reported health status across sex. Despite the female disadvantage in reported health status and preponderance of older women among immobile elderly, a much greater proportion of men are hospitalised as compared to their female counterparts (87 vs. 67 per 1000). The diseases among the elderly for which there are more hospitalised cases than the rest are heart diseases, cataract and bronchial asthma. Based on the observations made on the health status of India's elderly, it can be concluded that some definite health intervention is necessary to cater to specific complications in old age (S. Irudaya Rajan, Carla Risseeuw and Myrtle Pereira, 2008).

In addition, an investigation carried out by Vasantha Devi and Premakumar (2000) have brought to light that elderly members are confronted with various nutritional, physiological and other general problems. The rural elderly are mostly illiterate with low income. They suffer from more nutritional, physiological and other problems. The men are more literate, economically independent and face less physiological and nutritional problems as compared to their female counterparts. When the literacy level, income level and employment status improve, they seem to be more comfortable with their health conditions and living status.

Some clinical studies have found that multiplicities of diseases are normal among the elderly and that a majority of the old are often ill with chronic bronchitis, anaemia, hypertension, digestive troubles, rheumatism, scabies and fever (Mutharayappa and Bhat, 2008). Some of the cases of disability among the elderly, as reported by a few medical studies, are difficulty in walking and standing, partial or complete blindness, partial deafness and difficulty in moving some joints, indigestion and mild breathlessness. The differential ageing phenomena, both physical and mental, appear to depend on environmental and social factors such as diet, type of education, adjustment to family and professional life, and consumption of tobacco and alcohol. Generally, when we compare the pre-and post-retirement situation of health of the retired, it is seen that if a retired person keeps himself/herself fit before and immediately after his/her retirement, he/she can be free from illness during the post-retirement period; but once an illness starts, before or just after the retirement, he/she continues to face it during the post-retirement period. Based on a study of hospital data, Pathak (1982) has found that 62.6 per cent of the elderly patients had cardiovascular ailments, 42.4 per cent had gastrointestinal problems, 32.5 per cent had uro-genital problems, 19.8 per cent had nervous breakdowns, 19.2 per cent had respiratory problems, 11.6 per cent had lymphatic problems, 7 per cent had high or low blood pressure, 11.2 per cent had ear and eye problems, 4.8 per cent had orthopaedic problems, 5.7 per cent had surgical problems while 37.3 per cent of the elderly had problems with all their systems. Darshan and others (1987) have carried out a study of the elderly in various slums scattered in and around the city of Hissar. Among the 85 subjects interviewed by them, 67.1 per cent were sick at the time of the survey. Out of these, 73.7 per cent were suffering from chronic illness. Gupta and Vohra (1987) observed that only a few elderly with psychiatric disorders were being cared for in the inpatient wards in hospitals or as residents of homes. A recently conducted medico-social study of the urban elderly in Mumbai (Siva Raju, 2002) has revealed that the influence of the factors such as educational status, economic status, age, marital status, perception on living status, addictions, degree of feeling idle, anxieties and worries, type of health centre visited and whether or not taking medicines, on both the perceived and actual health status of the elderly is found to be significant and varies considerably across different classes and sexes of the elderly.

At an advanced age, due to restricted physical activity, a majority of the elderly change their living habits, especially their dietary intake and duration of sleep. There is a general perception in the community that since the old lead a sedentary life, they should eat less food, have more rest and develop more interest in religion to occupy them. Several factors like lack of physical movement, absence of a work routine, ill-health, etc. are observed to be responsible for irregularity in the sleeping schedule of the elderly (Siva Raju, 2002). The allocation of less time to sleep among the lower strata of the elderly probably indicates the compulsions for them to work. Besides, inadequate facilities in the household go against resting or sleeping during the day. The wide differences observed among the male and female elderly in this stratum is probably due to greater prevalence of health problems, compulsions to continue in labour force, and the resultant stress and worries about unfinished tasks, which the male elderly mostly face.

Mental health of the elderly is another important factor in understanding their overall health situation. It is generally expected that the elderly should be free from mental worries since they have already completed their share of tasks and should lead a peaceful life. But often the unfinished familial tasks

like education of children, marriage of daughter(s), etc. become a source of worry over a period of time. It is noticed (Siva Raju, 2002) that the worries among the poor are usually about inadequate economic support, poor health, inadequate living space, loss of respect, unfinished familial tasks, lack of recreational facilities and the problem of spending time. In an epidemiological study on dementia in Maharashtra (Saldanha *et al*., 2010), with 2145 randomly selected respondents, the prevalence of dementia in the community was seen to be 4.1 per cent and the risk of dementia increases more than five-fold in the oldest old.

Some of the earlier research works (Purohit and Sharma, 1972; Pathak, 1975; Mishra, 1987; Sati, 1988) have reported that there is a considerable difference in the perception of old people of their health status and the reality. It is presumed that such differences narrow down as socioeconomic status of the elderly increases because with higher education and income they would have greater access to health/ medical information and services. There is a general perception among the elderly that they are prone to illnesses mainly due to their advanced age and that it is natural to suffer from such health problems. However, in reality, most of their diseases are minor in nature and curable at the initial stage itself. Most of them neglect the illnesses and postpone seeking medical aid. In some cases, due to neglect of timely medication, the health problems become aggravated and sometimes lead to death. Although the retired persons enjoy the benefit of pensions, a large number of the elderly in India, who did not belong to the 'employed' category, do not enjoy any social security benefits. During the service period, certain medical facilities such as free treatment and supply of medicines from the government hospitals/ dispensaries are provided to the employees. But these facilities are not available after retirement, when the old people are really in need of such subsidies. Thus retired government servants face a hard time after retirement if they are suffering from any serious illness.

There appears to be a significant difference in the health situation of the elderly living in rural areas in comparison to those living in urban areas. The elderly people living in rural areas appear to be much healthier as compared to those residing in urban areas. Interestingly, the prevalence of chronic disease among females is higher than that among males in the case of urban areas while reverse is the case in rural areas (CSO, 2000). The prevalence of various types of physical disabilities was found to be quite high among the elderly. All types of disabilities were also found to be more prevalent in rural areas as compared to urban areas. A study by Moneer Alam (2006), indicates that a very large majority of the elderly suffer from curtailed functional abilities in physical (eating, bathing, dressing, walking, climbing stairs, getting-up from a sitting position, etc.) as well as in sensory (hearing and vision) health domains. This forces them to rely on formal or informal help in their day-to-day activities. These problems of incapacitation are found to be particularly acute among the lower income groups. Women are the worst sufferers, with less of filial support. A study by Balagopal (2009), to examine morbidity among 206 sampled elderly in an urban slum in Chennai showed that 40.5 per cent of ailments of the elderly were not medically treated and the two most important reasons for not seeking care were financial problems and the perception that the ailment was not serious. The author concluded that social policy of developing countries like India underplays the healthcare requirements of the elderly, especially elderly women. Another study wherein two sub-sample surveys were conducted by Ramamurthy and Jamuna shows the utilisation pattern of various available health services and assesses the impact of the geriatric services made available. It indicates that while lessons are to be learnt from the experiences of the west, the

policies to be adopted by India need to be geared to existing factors like changes in beliefs and practices, relative responsibility of the kin and the community, values attached to the health and the elderly. Mere availability of services does not ensure its utilisation. The knowledge and understanding of services available, accessibility of services and willingness to utilise the services are some of the important factors playing a role. In assessing healthcare services delivery, it is important to note the load of disease, the availability of existing services and their capability to handle this existing load, to identify the areas that need strengthening and the lacunae that need to be fulfilled (Ramamurthy P.V. and Jamuna D., 2004).

It is clear from the above review of earlier studies on health of the elderly that the health and well-being of the elderly are affected by many interwoven aspects of their social and physical environment. Family support is found to be an important factor for socio-psychological well- being of the elderly (Devi and Murugesan, 2006). These range from their lifestyle and family structure to social and economic support systems, to the organisation and provision of health care. The pattern of various inputs for developing the appropriate social policy for the welfare of the elderly may have to be suitably modified in view of the diversity of the factors and their differential influence on the living conditions of the elderly.

3.6 Elder Abuse

A review of the few studies that focused on elder abuse indicates that the most likely victim of elder abuse is a female of very advanced age, role-less, functionally impaired, lonely and living at home with someone primarily their adult child, spouse or other relatives. Studies in India indicate (Rao 1995, Siva Raju, 2002) that more women than men complain of maltreatment in terms of both physical and verbal abuse. The prevalent patterns of elder abuse include mainly psychological abuse in terms of verbal assaults, threats and fear of isolation, physical violence and financial exploitation. The health profile of the elderly victims indicates that a person suffering from physical or mental impairment and dependent on the caretakers for most of his or her daily needs is likely to be the victim of elder abuse. Though a large section of victims of elder abuse are less educated and have no income of their own, old people with high educational background and sufficient income are also found to be subjected to abuse.

Regarding the profile of abuser, son and daughter-in-law together, daughter-in-law and spouse, were mentioned by the elderly respondents (Vijay Kumar, 1991; Rao, 1995). Spouses were also found to be the most likely abusers. Besides dependent position of the older person being a risk factor, other factors, such as perceived powerlessness, social isolation, drug or alcoholic addiction and anti-social behaviour of the abusers have also been found to be related to elder abuse. Certain major and frequently cited explanations about elder abuse are: cycle of abuse or inter-generational transmission of violence, dependence because of impairments, intra-individual dynamics, stress, negative attitudes towards the elderly and social isolation. It is likely that abuse may occur due to the interplay of several of these factors.

Incidences of crime against the elderly have been increasing over the years. These crimes range from hurt, robbery, murder and even sexual assault. A recent study (Patel, 2010) based on content analysis of reports published in two leading newspapers between 2004-2008 shows that most of the crimes against the elderly remain unreported. Female victims outnumber male victims and more crimes against the elderly were reported from urban areas as compared to rural areas (78 per cent and 22 per cent respectively). Surprisingly, 60 per cent of the crimes were committed indoors and most of them during the day. It was also found that 25 per cent perpetrators were their own family members.

4. Framing Models of Care for the Elderly: Some Emerging Issues

A society as large and complex as India needs to explore the contemporary society to work out an extensive plan for the care and well-being of the elderly. The plan would vary from those in the more developed countries due to the different stages of urbanisation and differences in the cultural and familial systems in India. The diversity that has emerged in the ageing process necessitates that research efforts focus on different ageing issues in society. This in turn is expected to promote the development of effective age-related policies and programmes. The heterogeneity among the elderly population cannot and should not be ignored, while framing various models of care for the elderly in our society. For social and familial relations of the elderly, there appears to be a steady change in care-giving from the traditionally secure joint family care of the elderly to extended family care in which care by adult children forms a major part. Scholars cite that if the present trend continues, there will likely be a decrease in elder care by adult children in the future, which will create more demand for old-age homes. India is at a crossroads and has to decide whether to go the family care way or the institutional/ community care way. Liebig and Rajan state that for a country like India, the State cannot enter as a major player in elder care in view of the high (prohibitive) cost to the exchequer and the low national priority to elder care. The need to develop models of home or family care may be supplemented by suitably adapting them to a variety of respite services while at the same time suitably adapting them to Indian conditions (Phoebe S. Liebig and Irudaya Rajan, 2005).

Variations in models for the care of the elderly would be influenced by factors such as whether the place of residence is urban or rural, social class differences and gender dynamics to name a few. The issues upon which different models for the care of the elderly may be developed and the same required to be tested for their efficiency and potential replication are outlined in the following section.

4.1 Rural Elderly

In traditional Indian society, the informal support systems of family, kinship and community are considered strong enough to provide social security to its members, including older people. Urbanisation, industrialisation and the ongoing phenomenon of globalisation have cast their shadow on the traditional values and norms within the society. Gradual nuclearisation of the joint family, erosion of morality in economy, changes in the value system, migration of youth to urban areas for jobs or work and increasing participation of women in the workforce are important factors responsible for the marginalisation of older people in rural India. As a result, the elderly depend on 'money-order economy' and their intimacy with their children is only from a distance (Vijaykumar, 1999). The rural

poor, who mostly work in the informal or unorganised sector face insecure employment, insufficient income, lack access to any form of social security and good quality or reasonably priced health care and generally have to pay a large percentage of their income for even the most basic healthcare services. As the interrelation of health and economic status continues throughout one's life, it is of special importance to the elderly whose livelihood depends on their physical ability and who do not have any provisions for economic security. Social security pensions, though meager in amount, create a sense of financial security for the elderly, who benefit through schemes such as old age pension, widow's pension, agricultural pension and pension for informal sector workers. However, the proportions of the elderly who benefit from these schemes have to be improved significantly.

4.2 Urban Poor Elderly

Due to industrialisation and urbanisation and the changing trends in the society, it is the urban elderly who are more likely to face the consequences of this transition as the infrastructure often cannot meet their needs. Lack of suitable housing forces people to live in slums which are characterised by poor physical condition, low income levels, high proportion of rural immigrants, high rates of unemployment and underemployment, rising personal and social problems such as crime, alcoholism, mental illness, etc. along with total or partial lack of public and community facilities such as drinking water, sanitation, planned streets, drainage systems and access to affordable healthcare services. With the increasing prevalence of slum dwellers that come to urban areas in search of better opportunities, a significant proportion of them would constitute the elderly.

4.3 Urban Middle Income and Well-to-do Elderly

While awareness regarding the process of ageing and its changes is of prime importance in utilisation of services among the poor, the middle income and well-to-do largely require scope and opportunities to improve their later life in all aspects— health conditions, financial prospects, physical environment, family relationships and community participation. The awareness of improving the quality of later life has led to the emergence of a section of the elderly who are healthy and active and therefore, refuse to sit placidly contemplating the sunset when they can lead a productive and purposeful later life well into their 80s and 90s. The healthy elderly have to be acknowledged as a resource and the notion that they are social and economic burdens has to be discarded. While rural India continues to provide the support of the family in old age, the impact of urbanisation has touched many a life leading to migration of children to cities or abroad. Many elderly are well-off due to their prosperous children but are left alone to take care of themselves.

4.4 Female Elderly

Gender-related differences show that women worldwide typically live longer than men, leading to a process called the 'feminisation of later life'. The female elderly are more likely to be widowed, have low economic security, lower educational attainment, less labour force experience and more caregiving responsibilities than their male counterparts. Traditional gender roles stressing the woman's place within the home with little decision-making power, lack of opportunities for education and earning a

living may affect their social and economic status. The absence of gender-specific health services, poor health due to child bearing, less nutrition and their priority role as the providers of care for the young and the elderly combined with economic deprivation throughout their lives, often make the female elderly face a greater risk of ill-health in later life. Considering the demographic, cultural and income differences between genders, ageing means more challenges for women than for men. As most women outlive their male counterparts, they are more likely to be taking care of their husbands in their later years. The burden of care giving often leads to deteriorating health and mental stress among older women. Nowadays, with the increase in longevity, the older woman also takes care of her very old parents or in-laws. Moreover, if those women are employed, they face a dilemma between the responsibilities of their jobs and their caregiving obligations, especially seen among the rural and urban poor who cannot source external help/staff. There are several situations that women face in their young age which have implications in their old age. Malnourishment in girls, low educational standards, limited job opportunities - all these make them dependent both in their active life and in old age. For instance, in a study conducted by Wason and Jain in Jodhpur (2011), it was observed that the risk of malnutrition was more among females (42.2 per cent) than among males (32.9 per cent). Today, even if the urban setting provides better scope to earn a living, their status within the family continues to be dependent on their husband and they sometimes have little or no say in the aspect of financial saving for old age. The loss of status at the death of their husband only increases the situation of dependency in old age. This dependency can become more complex as the woman grows older, given the situation that she has no source of income or right to property as seen in traditional families, where her relationship with her son and daughter-in-law decides her fate in old age.

4.5 Elderly Living Alone

Those elderly who are living alone have to be identified and made aware of the services that are available to them. These services range from home care (cooking, cleaning etc.) and utility services (paying of bills, taxes etc.), medical care (treatments, medication, emergency services etc.), security (verification of domestic staff, repairmen; installation of double doors, alarm systems, building security) to the establishment of an elder-friendly living environment (grab bars in bathrooms, adequate lighting in passages and stairways etc). The elderly should be supported and enabled to register for and avail of these services (Siva Raju, 2002, 2008).

5. Conclusion

The status of ageing in India reflects that the issues pertaining to socioeconomic and demographic profiles, living arrangements, problems of and services to the elderly, interpersonal relationships especially of the urban elderly are highlighted to a great extent. No doubt, concerted efforts made by researchers have so far led to a better understanding of ageing issues. However, the diversity that has emerged in the ageing process necessitates our research efforts to focus on different ageing issues in society. This, in turn, is expected to promote development of effective age-related policies and programmes.

The review of the earlier studies reveals that many scholars view the elderly as passive receivers of care. Further, the problems of the vulnerable elderly like widowed females, disabled, fragile older persons and those from the unorganised sector are inadequately covered. Most studies conducted to assess various issues of the elderly are exploratory and descriptive. Ageing needs multi- and inter-disciplinary perspectives. The development of social gerontology reveals that disciplines like sociology, demography, psychology, anthropology, geography, law, social policy and administration, management, economics, nutrition, as well as varied professional training like social work, nursing, counseling and clinical psychology focus on various ageing issues. However, no single disciplinary focus gives a holistic understanding. A combination of qualitative and quantitative approaches is required for a more comprehensive understanding of ageing issues. The wide variation in levels of development and socioeconomic status of people living in different geographical regions make national level studies on elderly essential. Analysis of both secondary and primary data needs to be attempted, wherever necessary, which in turn will help to focus on ageing issues, both at micro and macro levels. The focus of social gerontology is not only concerned with people in later life but also the social institutions which particularly affect that period such as retirement, pensions and welfare policy. Given the changes in the socioeconomic profile of the elderly, there is a need to recognise them as a resource group and to develop suitable policies and programmes for their integration into the development process.

A majority of the studies conducted so far in India are localised and based on sample surveys on specific segments of elderly with a specific disciplinary focus. However, the fact that India's elderly are a heterogeneous group necessitates proper stratification of the group. Variations in living situations need to be viewed in the context of factors like age, gender, marital status, region, educational and occupational status of the elderly. A holistic approach to population ageing taking social, economic and cultural changes into consideration is needed to effectively solve the emerging problems of the elderly.

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Appendix

Table A. Demographic Profile of India's Elderly, 2001

Demographic Aspects	Total	Male	Female
60+ Population (in millions)	76.6	37.8	38.8
Percentage of 60+ population	7.4	7.1	7.8
Decadal growth rate of 60+	35.2	28.6	42.2
Old age dependency ratio (Number of 60+ per 100 persons in the 15-59 age group)	13.1	12.4	13.8
Literacy rate of 60+	36.3	52.8	20.3
Non-worker percentage among 60+	59.7	39.7	79.1
Marital status of 60+ (per cent)			
Never Married	2.0	2.5	1.5
Married	64.5	82.1	47.3
Widowed	33.1	15.0	50.7
Divorced / Separated	0.4	0.3	0.5
Percentage of rural elderly		75.0	
Sex ratio (number of females per 1000 males)		1029	
Percentage of 60+ below poverty line		33	

About the Project

The United Nations Population Fund - UNFPA supported project BUILDING KNOWLEDGE BASE ON POPULATION AGEING IN INDIA (IND7P41G) aims at contributing and further expanding the existing knowledge base on the emerging population dynamics in India which are resulting in significant shifts in the age structure towards higher proportions of older persons aged 60 years and above. The project supports the preparation of a series of thematic studies using existing secondary data sources as well as the collection and analysis of new primary data. Dissemination of the findings to various stakeholders is a key objective of the project to help enhance the overall understanding of the situation of elderly in the country for further research and policy analysis on the growing numbers of India's senior citizens. The project is a partnership between the Institute for Social and Economic Change (ISEC), Bangalore, the Institute of Economic Growth (IEG), New Delhi and UNFPA, Delhi.

More information on the project can be obtained from http://www.isec.ac.in/prc.html or www.iegindia.org or www.indiaunfpa.org

The first phase of the project includes several commissioned papers prepared by experts using existing secondary data sources such as the National Sample Survey Organisation and the National Family Health Surveys. The second phase of the project involves an updated situation analysis through the collection of primary data from seven states in India which have relatively higher proportions of elderly. These are Himachal Pradesh, Kerala, Maharashtra, Orissa, Punjab, Tamil Nadu and West Bengal. The survey data includes socio-economic characteristics, family dynamics, living arrangements, health and awareness of social security programmes of the elderly.

The papers prepared by experts in India under the project are listed on the back cover of the series of working papers. The project invites the readers to provide feedback and help finalise the papers for publication.

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