CHAPTER II

REVIEW OF LITERATURE

The section will present the existing knowledge available on the issues related to Elderly care or Geriatric care. The literature on this topic from developed countries; developing countries and India was reviewed for writing this chapter. The chapter includes elaboration on the socio-economic conditions and health status of the elderly, and the health seeking behavior of elderly. It also reviews from literature the factors responsible for utilization of health care services. The review includes choice of providers and type and extent of barriers faced by elderly during utilization of those services. The last part covers factors associated with the barriers responsible for low utilization of health services.

2.1 Ageing: As a Concept

While dealing with the condition of the older persons, the emphasis is now on demographic changes at the macro level that refers to the ‘ageing of population’- a trend, which has characterized industrial or modern societies throughout the twentieth century but in recent decades, has become a worldwide phenomenon.

The phenomena of ageing can be described as a progressive functional decline, or a gradual deterioration of physiological function with health needs eventually become more complex (Lopez-Otin et al., 2013. With ageing, there is declining physiological and mental health, increase in dependency and limiting of the social roles and functioning, isolation and loneliness, economic hardship, mostly considered as the responsibility of the family and society (Sherlock, 2000). Ageing is a universal phenomenon and every object in the earth undergoes the process of ageing. In the human society, ageing was considered as a social phenomenon rather than physiological, as ageing is always understood in the background of the social milieu. A deeper understanding of ageing in the present day society needs the review of ageing as a process at the individual level and at the societal level as ageing posing a new socio-economic dimension. Like other social institutions, ageing is also a socially constructed concept and considered as social reality.
Ageing is one of the few concepts that have a time frame due to the differential development perspectives of the respective countries. Demographic transitions, social conditions and political environment are considered to be the important factors towards the changing views of the concept and perspective of ageing (Phillips, 2010).

2.2. Growing Ageing Population - An Impact of Demographic transition:

India’s population of 1.31 billion, the second largest globally, comprises 17% of the world’s total (United Nations 2015). The United Nations Population Division estimates that India’s population will in fact overtake China’s by 2028. As India’s population grows, its expanding share of older adults is particularly notable. Currently, the growth rate of the number of older individuals (age 60 and older) is three times higher than that of the population as a whole (Giridhar, Sathyanarayana et al. 2014). Three dominant demographic processes drive the growing share of older Indians: declining fertility rates due to improved access to contraceptives, increasing age at marriage, particularly among women, and declining infant mortality; increasing longevity because of advances in medicine, public health, nutrition, and sanitation; and large cohorts advancing to older ages (Bloom, et al., 2014).

**Fig 2.1 Steadily increasing life expectancies at older age**

![Graph showing steadily increasing life expectancies at older age](image)
India’s total fertility rate has decreased from 5.9 in 1950 to 2.3 in 2013 and is projected to drop further to 1.88 by 2050, which is below the replacement level. Life expectancy at birth has improved vastly over the last few decades, increasing from 36.2 years in 1950 to 67.5 years in 2015 and projected to rise to 75.9 years by 2050 (Figure 1) (United Nations 2015). Even more significant are its implications for population ageing. Life expectancy at age 60 has also increased dramatically, rising from about 12 years in 1950 to 18 years in 2015 and projected to rise further to more than 21 years by 2050 (see Figure 1). Average Indian life expectancy at age 80 has likewise increased significantly, from about 5 years in 1950 to more than 7 years at the present time. By the middle of this century, it is predicted to rise to 8.5 years (United Nations 2015). However, the progress that increasing life expectancy represents comes with the challenge of a burgeoning older population. In India, the population share of adults 60 and up grew from 5.4% in 1950 to 9% today (Figure 2)—in absolute number of individuals, this represents an almost six-fold increase, from 20.3 million in 1950 to more than 116 million today.

**Fig 2.2 Number of Indian olders growth as proportionate to country’s population**

![Graph showing percentage of total population at age 60 and 80 from 1950 to 2050](image)

Source: (United Nations 2015); dashed lines represent projections under a medium-fertility scenario

For comparison, this population increase of 95.7 million people is greater than the entire individual populations of all but 13 countries worldwide. Under a medium-fertility scenario, the
United Nations Population Division projects that adults 60 and over will comprise 19% of India’s total population by 2050—more than 324 million individuals, which is more than the current populations of all but five of the world’s nations. In terms of absolute numbers of adults 60 and older, India is currently second only to China, a standing that will likely remain constant over the next several decades (Table 2.1). Meanwhile, the proportion of the “oldest old” adults aged 80 and older has more than doubled over the past 65 years, from 0.4% of the total population in 1950 to 0.9% in 2015, and is projected to reach nearly 3% of the population—almost 48 million individuals—by 2050 (United Nations 2015). The dramatic and massive nature of these current and ongoing demographic shifts indicates that the population-ageing challenges India faces are sure to occur on an enormous scale.

Table 2.1 Countries with the greatest number of adults 60+, 2015 and 2050

<table>
<thead>
<tr>
<th>Country</th>
<th>2015 Adults 60+(thousands)</th>
<th>Country</th>
<th>2050 Adults 60+(thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. India</td>
<td>116,553</td>
<td>2. India</td>
<td>330,043</td>
</tr>
<tr>
<td>4. Japan</td>
<td>41,873</td>
<td>4. Brazil</td>
<td>69,882</td>
</tr>
<tr>
<td>5. Russia</td>
<td>28,730</td>
<td>5. Indonesia</td>
<td>61,896</td>
</tr>
</tbody>
</table>


2.3. Issues and Challenges faced by Growing elderly

2.3.1 Health, illness and wellbeing

The definition of health has been characterized in many ways since the World Health Organization (WHO, 1958) defined it as a state of physical, mental, and social well-being. The focus of the WHO on increasing life expectancy has led to a marked growth in the older population globally, both in relative and absolute terms. This is true not only of high income countries but also of the rest of the world. (WHO, 2012).

The overall health status of the elderly including well-being significantly impact on their economic security, level of independence and social interaction among this segment (Bloom et.al., 2010). One national level longitudinal study put an effort to understand the physical, social, psychological and economic aspects on the elderly and ageing process (Arokiasamy et.al.,
The ageing process could be effectively evaluated with the measure called subjective wellbeing that is defined as an individual cognitive and affective evaluation of his or her own life. (Diener, Lucas and Oshi, 2002). This evaluation comprises the individual’s own perception about their wellbeing and life as a whole. The sociological definition of the subjective wellbeing often includes the component of mental distress such as depression, anxiety, self-esteem and self-efficacy (Mellor et al., 2009).

The progression of ageing leads to loss of adaptive response towards stress and there is a growing risk of age related diseases resulting in increase in age specific mortality (Dev, 2001). A nested case-control study of general practitioners in South Netherlands Community residents found that the risk factors for multi-morbidity in elderly population included increasing age, higher number of previous diseases, and low socioeconomic status (Sinnige et al., 2013). Existing data shows that at least 50% of the elderly in India have chronic diseases (Bhatt et al., 2011).

As per the morbidity pattern, it reveals that the elderly is experiencing greater burden of illnesses compare to any other age group (NSSO, 2004). This epidemiological transition is one of the factor contributing to more morbidity among elderly in India (Arokiasamy et al., 2015). Over the period, there has been so much change in terms of urbanization, migration and also environmental and climatic conditions, all of which had an impact on the pattern of elderly problems. (Rajan and Prasad, 2008). A study conducted in Australia found that 85% of 70+ year elderly has multi-morbidity and the prevalence is higher among elderly with obesity, female elderly, elderly with low socio-economic status, elderly living alone and less educated (Walker, 2007).

Like many developing countries, India is also undergoing a rapid demographic and epidemiological transition. The major cause of morbidity and mortality in a country like India is NCDs). Health problems can lead to different types of disabilities among the elderly population (Andrade, 2009). There are evidences of deterioration in the physical and mental health of the elderly population in India especially those who belong to the vulnerable group or section of the society (Aliyar and Rajan 2008; Alam and Karan 2010; Pandey, 2011). With changing environment and modernization, the elderly are facing problems, which they never faced earlier (Gupta and Sankar, 2002; Rajan and Prasad, 2008). Female elderly is facing higher burden of
diseases in comparison with their male counterparts. However, in terms of health seeking behavior, males are utilizing more healthcare services in terms of hospitalization as compared to females (Rajan and Sreerupa, 2008). Elderly people, who belong to the disadvantages section of the society have a higher probability of living under adverse health conditions in terms of poor health status and inefficient access of of care (Nayar, 2007). Insufficient savings, lack of social security schemes and changes in the family structure has also resulted into adverse health outcomes among the elderly (Park et al., 2014). Literature shows that living arrangements such as living alone can led towards a poor self-rated health, high levels of disability and poor cognitive health among the elderly population (Ranjan and Kumar, 2003).

In comparison to the urban areas, the unavailability of transportation, larger geographical distances to the facility centres, higher rate of risk behaviour, limited workforce and financial barriers are the main cause behind the poor health outcomes among the rural elderly (Duggal, 2009).

As per the WHO estimates, approximately 3.2% Indians would fall below the poverty line due to high medical expenditure. About 70% of Indians are spending a large proportion of their income on healthcare and purchase of medicines (WHO, 2012). The high health care expenditure is attributed to the falling health among elderly, higher disability in later life, higher prevalence of chronic disease and co-morbidity among elderly (Gupta and Sankar, 2003; Medhi and Mahanta, 2007; Schoenberg et al., 2007). Reforming health systems in order to place prevention at the forefront of healthcare for the elderly has been acknowledged to be a major factor in reducing morbidity and expense (WHO, 2002b).

Both perceived health and chronic illness are major elements of health status in elderly and there is growing evidence that older people are at risk for manifold co-morbidities (Gijsen et al., 2004). While infectious, nutritional, maternal, and perinatal conditions have traditionally represented the greatest health threats in India, the country now faces a “triple burden of disease” comprising of infectious diseases; chronic conditions and violence and injury—particularly violence against women and girls (Bloom, Cafiero- Fonseca et al., 2014). The chronic disease corner of this triangle has been increasing substantially; in the past three decades, NCDs have surpassed infectious, nutritional, maternal, and perinatal conditions as a cause of death, both in absolute numbers and percentages. Non- communicable diseases, mainly cardiovascular
illnesses, cancers, and chronic respiratory diseases, have likewise surpassed these other conditions in the number of annual DALYs (Institute for Health Metrics and Evaluation, 2014).

India’s recent NCD morbidity and mortality increases are even more pronounced among older adults than in the general population. In 2013, an estimated 2.4 million deaths of Indian adults aged 50 to 69 were due to NCDs—nearly three quarters of all deaths in this age group and nearly half of these due to cardiovascular disease. Among adults 70 and above, NCDs caused some 2.7 million deaths, 93% of the total (Institute for Health Metrics and Evaluation, 2014).

**Table 2.2 India’s growing Morbidities, 1990-2013**

<table>
<thead>
<tr>
<th>Disease category</th>
<th>1990</th>
<th>Percentage of all deaths</th>
<th>2013</th>
<th>Percentage of all deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-communicable disease</td>
<td>3702920</td>
<td>40</td>
<td>5312560</td>
<td>53</td>
</tr>
<tr>
<td>Cardiovascular diseases</td>
<td>1215810</td>
<td>13</td>
<td>2095930</td>
<td>21</td>
</tr>
<tr>
<td>Cancers</td>
<td>433134</td>
<td>5</td>
<td>663032</td>
<td>7</td>
</tr>
<tr>
<td>Chronic respiratory diseases</td>
<td>1115340</td>
<td>12</td>
<td>1176740</td>
<td>12</td>
</tr>
<tr>
<td>Infectious, nutritional and others</td>
<td>4807890</td>
<td>52</td>
<td>3483130</td>
<td>35</td>
</tr>
</tbody>
</table>

Source: Institute of Health Metrics and Evaluation 2014

Exacerbating the problem is the issue of multi-morbidity, which complicates the management of NCDs considerably, especially because in India, as in many other countries, most health programs have a vertical, disease-specific approach that targets a single set of outcomes rather than dealing with the health of the individual holistically (Agrawal et al., 2014).

Although the reported burden of chronic illness is high, many NCDs affecting older adults remain undiagnosed due to lack of access to health education, services, and financial resources revealed in a cross-sectional study conducted in 10 Indian states (Joshi, Saboo et al. 2012). Apart from the various chronic morbidities, they also suffer from sensory related ailments such as vision and hearing (Ingle, 2008) that are further compounded with the events like frequent falling among them. The burden of chronic diseases and the incidence of disability increases with the increasing age leading to a major share of older person’s dependence on care givers. These result in a higher demand for intensive care in the old age with disability. The chances of disease burden increase and that of recovery to active status decrease as age increases (Kaneda et
al., 2004; Zimmer, 2005a and Jitapunkul et al., 1999). Given the increasing incidence of
disability with age, the ageing of the older population contributes towards increasing the
proportion of the older population suffering from disability as well. The elderly population
continue to suffer from chronic medical conditions and the prevalence of multiple chronic
condition will be expected to further increase (Wolf et al., 2002).

2.3.2 Ageing and Gender issues
Accompanying the ageing of the Indian population is increasing feminization in older age
groups, which brings its own unique issues and challenges. Although average life expectancy has
increased dramatically in India, it has not risen equally for males and females. Although
women’s life expectancy at birth has long exceeded men’s, as in most countries globally, the life
expectancy gender gap has been widening in India. In 1950–1955, Indian women’s life
expectancy at age 60 exceeded men’s by 0.07 years; by 2010–2015, this gap had doubled, and
by 2050–2055 it is projected to reach 2 years (Table 2.3). Meanwhile, although the male-female
gap in life expectancy at age 80 fell between 1950 and the present, it is expected to rise again
over the next 40 years (United Nations, 2015).

Table 2.3 Life expectancy of Male and Female at age of 60 and 80 years old, India 1950-2050

<table>
<thead>
<tr>
<th>Year</th>
<th>Male LE at 60</th>
<th>Female LE at 60</th>
<th>LE sex gap at 60</th>
<th>Male LE at 80</th>
<th>Female LE at 80</th>
<th>LE sex gap at 80</th>
</tr>
</thead>
<tbody>
<tr>
<td>1950-55</td>
<td>11.7</td>
<td>12.4</td>
<td>-0.07</td>
<td>4.2</td>
<td>5.2</td>
<td>-1</td>
</tr>
<tr>
<td>1980-85</td>
<td>14.1</td>
<td>15.5</td>
<td>-1.4</td>
<td>5.3</td>
<td>6.2</td>
<td>-0.9</td>
</tr>
<tr>
<td>2010-15</td>
<td>17</td>
<td>18.4</td>
<td>-1.4</td>
<td>6.8</td>
<td>7.2</td>
<td>-0.4</td>
</tr>
<tr>
<td>2030-35</td>
<td>18.5</td>
<td>20.1</td>
<td>-1.6</td>
<td>7.5</td>
<td>7.9</td>
<td>-0.4</td>
</tr>
<tr>
<td>2050-55</td>
<td>20.4</td>
<td>22.4</td>
<td>-2</td>
<td>8</td>
<td>8.9</td>
<td>-0.9</td>
</tr>
</tbody>
</table>

Source: United Nations 2015; 2030-2055 Figures are projections based on medium-fertility scenario

This growing longevity gap between the sexes implies that India’s older adult population is
growing increasingly female. In 1950, India’s population of female adults 60 and up was 50.8%.
In 2015, despite a high overall male/female sex ratio throughout the latter half of the twentieth
century (about 106–107 males per 100 females), this proportion has grown to approximately
52.5% and is projected to reach about 53% by 2050 under a medium-fertility scenario. In the
oldest old segment of adults 80 and above, the proportion of females is projected to increase
from the current 55% to 56% by 2050. Although the change in percentage points is somewhat
small, in absolute terms it represents hundreds of thousands of individuals. In comparison, about 51% of 60+ adults in China, the only country more populous than India, are currently female; by 2050, this proportion will actually decline by about 0.02%. The proportion of female 60+ adults in Brazil and the United States are also projected to decline, rather than increase, in the next 35 years (Brazil: from 56% to 55%; United States: from 54% to 53%) (United Nations, 2015).

This national trend obscures a great deal of heterogeneity across Indian states. Different male and female life expectancies and life expectancy gaps in different states and regions of the country imply that states will have dramatically dissimilar sex divisions among their older adult populations.

One of the most important implications of an increasingly female older adult population in India—including variations in the extent of this trend across states—will be the prevalence of widowhood among women. Among adults 80 and older, a majority of females, more than 60%, had been widowed, compared with just 27% of males (Desai, Dubey et al. 2015). This is highly significant because in many Indian communities, and particularly under traditional Hindu law, widowed women have historically suffered from social stigmatization and discrimination, although evidence exists for improvement in the treatment of widows in the country as a whole (Kadoya and Yin, 2012). Most notably, widowed females may suffer from income insecurity due to inheritance traditions that favor sons over daughters and insecurity in their living arrangements (Dey, Nambariar et al., 2012, Sathyanarayana, Kumar et al., 2014). Despite this, however, older female widows are also significantly less likely to engage in health care seeking behavior (Agrawal and Keshri, 2014).

Economic security for older Indian women—particularly widowed and deserted women, but also for women in general—is also a major concern. Labor force participation among women is very low, and a majority of women depend on their families for economic support (Government of India 2011). Policy changes and programs must pay attention to the special needs and situations of older women, particularly widows, to ensure the wellbeing of all of the country’s older population.

Because of ongoing age and gender demographic shifts; considerable heterogeneity in sex-based life expectancy gaps; and prevalence of widowhood across Indian states, ageing- and gender-
related issues will likely converge as India’s population continues to age over the next several decades. Policy changes and programs must pay attention to the special needs and situations of older women, particularly widows, to ensure the wellbeing of all of the country’s older population.

Within the elderly population, females report higher morbidity burden than their male counterparts; however, in terms of utilizing healthcare, males are found at the higher edge than females (Ranjan and Sreerupa, 2008). There is a growing body of evidence that in older people vulnerability for multiple, comorbid conditions increases and health-care seeking probably reflect this. There are limited studies on morbidity trends, pattern and utilization of services among the elderly population.

2.3.3 Ageing and Financial Insecurity
A major challenge of population ageing in India is income and housing security for older adults. This is due in part to a changing social and economic landscape in which the traditional family support system is breaking down in the households of many older adults. Among the elderly, a number of barriers have been observed: from pathological progression (Lynch, Brown, and Taylor, 2009) to family nuclearization and dependency (Gupta and Sankar, 2002; Rajan and Prasad, 2008) from reductions in earning potential (Selvaraj, Karan, and Madheswaran, 2010) to the salience of pre-existing inequities on the axes of gender, caste, and religion (Chatterjee and Sheoran, 2007). Across the board, the elderly population does not receive care commensurate to the conditions it suffers (access) and, second, that even where the care is physically accessible, costs of accessing this care hinder uptake (affordability) (Alam and Karan, 2010).

2.3.4 Ageing and Family-Social Network
In India, as in many East and South Asian countries, family has traditionally served as the prime source of support for ageing adults, with sons/family responsible for caring for their parents. However, evidence indicates that this support system has been declining due to factors such as increased urbanization and mobility. A 2011 United Nations Population Fund (UNFPA) survey carried out in selected states revealed that about a fifth of 60+ respondents lived alone or solely with a spouse. The main reasons cited for living without children were having no children, or children living in a different locality due to education, work, or marriage, rather than due to
personal preference. Furthermore, only 14% of these single-generation, older-adult households received financial support from friends or relatives (Alam, James et al. 2012). The traditional ancient culture with joint families and common land holding were a measure of safeguard against such lack of support. But in the last few decades due to modernization the elderly today does not enjoy the same status as they enjoyed in past. The fast pace of social change is affecting traditional caregiving mechanisms for the elderly. Hence, there is the need for a dynamic action plan to utilize the resources of the elderly and enhance their social status in the community. Migration of younger generation, lack of proper care in the family, insufficient housing, economic hardship and the break-up of the joint family have made the need for the comprehensive elderly care seem more relevant even in the Indian context (Bajwa and Buttar, 2002).

2.3.5 Ageing and Food insecurity

The magnitude of the malnutrition and undernutrition among the elderly population is underreported. In India, even though the percentage of elderly population is increasing steadily, less attention has been paid so far to the nutritional aspects in the elderly (Natarajan, 1993). The caloric intake of elderly people has uniformly been found to be inadequate Elderly people are at risk of poor nutrition for a number of reasons including economic pressures, poor dentition, reduced mobility, depression, loneliness, ageing tissues and inadequate food consumption (Mathew et al., 2016)

Nutritional status has a major impact on disease and disability and offers great promise for minimizing this oncoming burden. However, the current trend in developing countries is toward higher fat, more refined diets that contribute to increased risk of chronic disease, and the prevalence of chronic disease is already increasing rapidly. At the same time, social and demographic changes are placing elderly at even greater risk of food insecurity and malnutrition (Tucker and Buranapin, 2001).
2.4. Policies and Programme related to Geriatric Care

A thorough examination of the geriatric morbidity and Related risk factors are required to improve the delivery of health care to the elderly (Joshi et al., 2003). Recognizing the challenges posed by the rising ageing population, the various ministries of the Government of India, including the Ministry of Health and Family Welfare, the Ministry of Social Justice and Empowerment, and the Ministry of Rural Development, have initiated a number of policies and programmes for older populations.

Although the Indian government has proposed several schemes and resolutions to support an aging population, most of these have thus far met with limited success. At the 1991 United Nations General Assembly, member countries adopted the United Nations’ Principles for Older Persons, which encourages governments to incorporate the principles of independence, dignity, care, participation, and self-fulfillment of the elderly in their national policies and programs (1991). Soon after the declaration, India’s Ministry of Social Justice and Empowerment implemented an Integrated Programme for Older Persons (IPOP) in 1992 (Government of India 2015). Under this program, citizens aged 60 years and older are eligible to receive basic amenities such as food, shelter, health care, and other welfare services. The scheme also provides financial assistance to nongovernmental organizations (NGOs), voluntary organizations, and Panchayat Raj (local government) institutions to maintain old-age homes, continuous-care homes, and clinics for older persons.

In 1999, the National Policy on Older Persons (NPOP) sought to assure older persons that “their concerns are a national concern and they will not live unprotected, ignored or marginalized. It aims to strengthen their legitimate place in society and help older persons to live their last phase of life with purpose, dignity and peace. The policy visualizes that the state will extend support for financial security, health care, shelter, welfare and other needs of older persons, provide protection against abuse and exploitation, make available opportunities for the development of their potential and provide services so that they can improve the quality of their lives. The NPOP recognizes that older persons are a resource and render useful services in the family and community.
Also in 1999, the Ministry of Social Justice and Empowerment, which has primary responsibility of caring for older persons, commissioned a national project called OASIS (Old Age Social and Income Security) to examine the policy questions associated with old age income security in India. The basic mandate of the project was to make concrete recommendations for actions which the government can take today so that every young person can build up a stock of wealth throughout his or her working life that will serve as a shield against poverty in older age. Traditional informal means of economic support in old age, such as the joint family system in India, are increasingly unable to cope with increased life spans and medical costs during older age (Alam, 2004). This necessitates the need for introduction of formal, contributory pension arrangements which can supplement informal systems. The project report recommended the formation of a National Senior Citizen’s Fund for encouraging, catalyzing and complementing private sector efforts for the betterment of life of senior citizens in the country (OASIS Project Report, 2000).

Another major policy was initiated in 2007, when the Parliament of India passed the Maintenance and Welfare of Parents and Senior Citizens Act 2007, which permits older people to make an application against not only their children, but also any relative currently in possession of or slated to inherit their property, for support sufficient to permit them to lead “a normal life”.

The most recent national policy report is the National Programme for the Health Care of the Elderly (NPHCE), launched by the government of India in 2011 with the vision to provide accessible, affordable and high quality long term dedicated services to the elderly by creating more enabling environment for a society for all ages to promote active and healthy ageing (Verma, 2013). Home based care backed up by a predefined referral chain especially in rural and tribal areas should also be incorporated in the NPHCE. Other than having a national vision, the program has a decentralized vision that can make its policies demand driven to furnish services according to regional needs, which as the morbidity problem suggests, are very diverse. Implementation of the key strategies of the Integrated Programme for Older Persons (IPOP), increasing credibility of the National Council of Senior Citizens (NCSRC) and spreading awareness about the National Policy on Older Persons (NPOP) requires sincere state efforts to sustain the strength of the country’s human resource which is ageing steadily.
However, most of these schemes have not yet been implemented nationwide; many state-level governments have failed due to lack of resources and competing priorities. Moreover, in the states where these programs have been implemented, such as Himachal Pradesh, Punjab, West Bengal, Odisha, and Tamil Nadu, the utilization rate remains very low due to lack of public awareness and utilization rates of these schemes are typically below 20% of eligible individuals (Alam, James et al., 2012) with a wide gap between levels of awareness and levels of use due to factors such as corruption and difficult-to-navigate bureaucracy. Meanwhile, data from the IHDS-II suggest that only about 18% of adults 60 and up receive any sort of old-age pension and that 15% of all female widows 60 and older receive a widows’ pension (Alam, James et al., 2012).

In late 2015, the World Health Organization announced the development of a Global Strategy and Action Plan on Ageing and designated 2020–2030 as the Decade of Healthy Ageing. Although still in development as a draft, the Global Strategy and Action Plan calls on all countries to “commit to fostering healthy ageing, with action plans in place to maximize functional ability that reach everyone.” Its main strategic objectives include fostering healthy ageing, aligning health systems with the needs of older populations, developing long-term care, creating “age-friendly environments,” and improving measurement and evaluation. It may provide a promising framework for India to improve and maintain the lives and wellbeing of its ageing population in the years to come (WHO, 2016).

**2.4.1 Provisioning of geriatric care: India**

India is yet to be sensitized toward the need for a policy for comprehensive geriatric care, which otherwise will get absorbed in the myriads of problems our country is facing (Paul, 2016). Elderly care (Geriatric care) in India is relatively new and fast emerging as a critical element of both the public and private concern. Negative attitudes and limited awareness, knowledge or acceptance of geriatrics as a legitimate discipline contribute to inaccessible and poor quality care for India's old (Evans et al., 2011). Geriatric care cannot be single handedly managed by the government and public sector organizations, primarily because of the gargantuan numbers involved, which will only be increasing as the years go by. An amalgamation of ideas and services from public, private, and NGOs are needed for addressing the issue successfully.
The implementation of the existing policy and services with a provision for evaluation of the process and outcome, thereby making timely amendments at periodic intervals, is equally important for the geriatric population to draw the maximum benefits out of it (Paul, 2016).

Choice of Health care facility is a complex issue in India. There are several intricate factors, governed by diverse socio-physical determinants. The public service providers are inexpensive but are overburdened (Kumar et al., 2011) leading to problems of high waiting time and underutilization (World Bank, 2002) due to poor quality.

A key physical barrier to access is that many of the elderly in later phase require home-based care. Older Indians prefer to live and age at home rather than in hospitals. Accessibility to healthcare in India has always been reviewed at the aggregated level such as numbers of hospitals or primary health centers in given district or state and the reviews on the quality of the health care system have always been subjective and ambiguous. When the choice of provider is reviewed, the majority of people chose private units, often bypassing the nearest public units, in spite of private sector being expensive in most cases. Inability to develop and integrate plural systems of medicine and assign practical roles to the private sector has triggered the people to switch between inadequate services in public systems, and expensive private provisions or limit care consumed or forego care entirely except for life threatening situations, in which cases they would slide into debt (Rao et al., 2011).

A recent study from ICMR (2012) at the All India Institute of Medical Sciences revealed that 70 per cent of patients who died after receiving emergency care died in their home indicating the importance of developing home based care services for older persons. Institutional long-term care is virtually non-existent due to cultural and economic factors. In Indian society, inter-generational relationships, caring, ill health are considered private issues and generally kept within the family.

India is in the early stages of establishing policies and programs to support and address the growing needs of ageing population. At the current burden of disease levels, rising numbers of older people will likely increase the demands on the health system (Yip and Mahal, 2008). Less than 5% of the population has health insurance (either public or private), and roughly 72% of healthcare spending is out-of-pocket. The ageing population is particularly at vulnerable risk,
Therefore the need of health care and services range keeping in mind for the poor elderly where affordability is the barrier and the ones who are marginalized geographically (tribal or remote areas) located and where accessibility is the main issue. An analysis by (Yip and Mahal, 2008) documented wide disparity in access to health care for ageing Indians who are poor or live in rural areas and address the need for reformation of healthcare not just in an increase of funds but also in equality of access and distribution of the services. Planning of geriatrics services effective in terms of coverage and needs calls for a comprehensive and holistic approach.

2.4.2 Geriatric Care Provisioning in Other Countries: Successful Exemplars

**Sweden**

According to a recent study conducted that looks at the welfare of people aged over 65 in 91 different countries, Sweden ranks first in the world for the wellbeing of the elderly, followed by Norway and Germany (AgeWatch, 2015).

Most elderly care in Sweden is funded by municipal taxes and government grants. In 2014, the total cost of elderly care in Sweden was SEK 109.2 billion (USD 12.7 billion, EUR 11.7 billion), but only 4 per cent of the cost was financed by patient charges. Other than curative care, there is significant emphasis on preventive care and recreational care which is very much needed to this segment of the population. One example is physical activity on prescription, both for preventive purposes and as a form of treatment. Older people are prescribed not just exercise in general but a certain type of physical activity, sometimes in combination with medication, with doctors monitoring the results. To ensure high standards, the government recently invested SEK 1 billion in additional training programmes for staff working in elderly care, and is investing another SEK 180 million in 2016.

**Thailand:**

Health care services are classified into five levels: The first is the self-care level, which includes the enhancement of people’s capacity to provide self-care and make decisions about health; The second is the primary health care level, organized by the community for providing services related to health promotion, disease prevention, curative care and rehabilitation; the third is primary level healthcare, which includes medical and health services provided by medical and
health personnel at various health units ranging from community health posts, health centres and health centres of municipalities to out-patient departments of public and private hospitals and private clinics; the fourth is the secondary care level, which is provided by medical and health personnel with various degrees of specialized facilities; and finally tertiary care, which is provided by medical and health personnel in tertiary care hospitals.

Furthermore, specific care for the elderly is provided by both government and NGOs, such as government monthly subsidies, free medical care, elderly identification cards, day care services, mobile services, emergency shelter services, and assistive devices.

Thai government launched a health policy on 26 February 2001 which insured all people who were not in any health scheme, charging them a flat rate of a 30 bahts ($0.75) for all government health services. Health cards have been given to appropriate people to enable them to access health services. The services covered are drugs, intravenous solutions, oxygen therapy, investigations, basic dental care, health promotion activities and rehabilitation, regular room and food services, annual check-ups, and the use of therapeutic equipment.

**Denmark**

Denmark healthcare services have evolved greatly with respect to elderly care. The Danish social service and health-care system is based on free comprehensive medical and social care benefits by the government through a relatively high personal tax of 50–70% and a tax on goods and services of 25%. Approximately, 5.6% of Denmark’s gross national product is spent on health-care costs. The government assumes welfare of the elderly. The government works through the local leaders who make policies and programs according to the special needs of the community. Series of activities are available through which care will be provided at their doorstep such as senior care centers, social voluntary where elderly help each other, geriatric hospitals, and departments specialized in orthopedic, general internal medicine, terminal care, and dementia.

**Cuba**

Cuba is a third world country with a rapidly ageing population. With policies such as free health-care system that emphasizes on preventive medicine, Cubans enjoy high life expectancy,
with an average life span of 77 years, thus making it one of the oldest in the Americas. Cuba has a sound “cradle to grave” health-care system that is consistently supported by the government, who made health care an overarching national priority. The constitution considers health care as a right and its delivery is the responsibility of the state, with participation of the population in the development and the maintenance for the system. The fundamental element of Cuban health-care facility is the family physician who provides comprehensive care through the community center. The program for elderly includes continuous follow-up of elderly. Once evaluated, they are referred for geriatric consultations to either treat a serious disease or to prevent a complication. Cuba anticipated the increase in geriatric population in the 80s and invested heavily in geriatric programs in which they trained the specialists to oversee the health and welfare of elderly, established national network of social and economic welfare system. They have old people’s home for permanent live-in, grandparents’ home for day guests, grandparents club for those to prefer to live at home, and eat-in-together for those who are living alone to meet their nutritional needs. Their retirement age is 60 and they are encouraged to remain in force as long as possible. Postretirement, they are encouraged to be involved in social action, education, and transmitting cultural tradition. Special briefing sessions and educational sessions are conducted among the families with an intention to increase respect and consideration for the elderly.

**England**

England is an ageing society. It has a well-established health and social welfare policy that responds to problems, recognizing the complex interaction of physical, mental, and social care factors, which can compromise independence and quality of life. Their National Framework for older persons is a comprehensive approach toward elderly care aimed at providing improved quality of care, proper and adequate health-care services, promotion of healthy life styles, independence for those in old age, and prevention of social isolation and social exclusion. The health-care aspects are taken care through the National Health Services. For other caring needs various programs and schemes are in place, such as the pension scheme, carers’ allowance for the caregiver, meals on wheels for people who are unable to cook for themselves, and elderly day care centers to provide their social needs so that geriatric population is well-insulated in all aspect of care and is not left to fend for themselves.
2.5 Multidimensional aspect of Elderly Care

Healthcare needs of the elderly are not only economical but also social, psychological and physical. Institutional changes are required to ensure their social and psychological well-being (Salam, 2010). Health problems also need multi-disciplinary specialist care from various disciplines e.g. orthopedics, dental, ophthalmology, cardiovascular, psychiatry and urology. Thus, a model of care providing comprehensive health services to elderly at all levels of health care delivery is imperative to meet the growing health care needs of the elderly. Healthy ageing should include comprehensive promotional, preventive and rehabilitative aspects of health (Mane et al., 2014).

The demographic transition in India shows unevenness and complexities within different states. It has been attributed to the different levels of socio-economic development, cultural norms, and political contexts. Hence it will be a herculean task for policy makers to address the geriatric care that will take into account all these determinants. Needs and problems of the elderly vary significantly according to their age, socio-economic status, health, living status and other such background characteristics (Mane; 2016).

Therefore, it calls for the implementation of the required eldercare policies and programme that will allow and support this segment to contribute socially. Also, it should give due consideration and emphasis on the various dimensions such as appropriate infrastructure for elderly care provision and needed care that will help to cope well with the results of ageing and related effects (ICPD, 2014).

The Asia-Pacific Intergovernmental Meeting on the Second Review and Appraisal of the Madrid International Plan of Action on Ageing (MIPAA), 2012 was organized in Bangkok where the Bangkok statement on Asia-Pacific review of the Implementation of MIPAA was considered and adopted. The main recommendations of MIPAA include strengthening of the existing and new social protection systems, enabling and supportive environment, and most importantly developing health care system based on elderly needs through continuum of care. Major priorities of action included ensuring the participation of the elderly in development, advancing health and wellbeing into old age, and ensuring enabling environment for them.
The apparent success of medical science in increasing life expectancy is invariably accompanied by several social, economic and psychological problems in older persons, in addition to the medical problems. It needs to be understood that many of these problems require lifelong drug therapy, physical therapy and long-term rehabilitation (Yeolekar, 2005).

Care in old age demands a holistic perspective by integrating approaches from different dimensions. Such an integration contributes to building facilities that better serve the elderly population. It is to understanding ageing process from different dimensions so as to develop the facilities from a holistic perspective (Dey et al., 1999). India, yet to be sensitized toward the need for comprehensive geriatric care which otherwise will get absorbed in the myriads of problems our country is facing (Paul, 2016).

Medical care in old age is debated both within and outside geriatrics. Cause of a majority of geriatric problems are non-medical requiring either constant attention to the body or psychosocial and community care giving mechanisms.