



# CARE OF ELDERLY IN INDIA: ISSUES AND CHALLENGES

*Habibullah Ansari Ph D. (Sole Author)*

Associate Professor, Division of Social Psychology, A. N. Sinha Institute of Social Studies, Patna- 800001, India.

## Abstract

The condition of the elderly could be dealt with two perspectives in India. One, which confirms that due to social and demographic changes Indian elderly are facing trouble; second stands that yet the forces of social change has been penetrated the Indian society and elderly are in better position than the past. This paper is review of research analysing how the elderly are taken care by the family? How far the forces of social change have influenced the Indian society? Their health conditions, treatment seeking behaviours, welfare services of the government, certain challenges that have arisen for their condition and some solutions have also been explained on the basis of secondary sources of data.

**Key words:** Social change, family, care of elderly, health and treatment, challenges for the elderly.

## INTRODUCTION

Elderly are the senior citizens of the society and are generally addressed with respected words in Indian society. They have contributed substantially to the wellbeing of their children and other family members, society, and the nation and still continue to do something in some forms or the other. They are generally considered as storehouse of the knowledge and wisdom. In their old age when they become physically weak and developed some disabilities, this is the duty of family, society and government to take care of them. Not much was done earlier in India but now they are becoming a focus point of the public concern, public policy and research in recent years.

In India there are two types of views about the care of the elderly. The first view stand by that earlier the condition of the elderly was all right, they were respected in the family and society and were comfortable. Only in recent decades the conditions of the elderly has started deteriorating due to the processes of social and economic changes such as industrialisation, urbanisation, migration, advancement of technologies, higher education, employment of women, etc., and so the elderly have lost their previous status in the present society. It is also assumed that the condition of the traditional family system has deteriorated. The joint family system is breaking into nuclear families of husband-wife and children and the elderly are now considered to be a burden. They are projected as only consumers not producers (Sati, 1996; Guha, 1992; Chaudhari, 1992; Kohli, 1996).

According to the second view elderly are still respected and are taken care by their family members and kiths and kinsin the Indian society and forces of social change have not yet penetrated in the Indian society as it has happened in the western industrialised countries and in India still traditional values and culture are intact. Though there are some changes in the advancement of technology, fashion, medical sciences etc but the Indian traditional spirit is still intact. Due to increased income of the average households in India elderly are leaving more comfortably than 100 years ago (Shah, 1999; Desai, 1981; Ansari, 2000; Nayar, 1992; Wadley, 1996).

Actually in India, most of the studies on the conditions of the elderly are influenced by the worldview of the western industrialised countries. There the care of elderly population is an alarming problem as they constitute a significant population, for example 23.55% in Sweden, 20.72% in U.K., 16.86% in USA, and in India it was only 8.6% (Census 2011; Occasional paper No.2, 1992). Further, the first view largely reflects the orientation of the urban middle class elderly while the condition of the elderly in rural India is quite different as majority of the older people live in rural areas. Actually all older people are not dependants and not only consumers but many of them are engaged in economic productive works, household chores and contribute meaning fully to the family. Actually they are mainstay for the children and women in the family (Ansari, 2011).

There is not a single, linear perspective to understand the Indian elderly. Their conditions may be understood through several perspectives in several contexts i.e. Socio-cultural perspective, economic and industrial context, psychological and physiological aspects, demographical transition and life course perspectives, historical and time perspectives, rural-urban perspectives, class and caste perspectives, and inter-continental perspective.

For the formulation of policy and programmes which perspective will be suited to locate the most marginal and most vulnerable segment of the elderly in Indian society? Which section of the elderly is in a position to avail the existing welfare programmes introduced by government? What are the actual needs of the elderly and what sorts of welfare suggested for them and what are the gaps between actual needs and policies and programmes? These are some questions which have to be understood properly. Policies and programmes have to be made according to the needs and priorities of the elderly, through the measures suited to the local social and cultural context, if they are to benefit these senior citizens in any significant way. The elderly belonging to rural areas have different needs than their urban counterparts. Conditions of the elderly belonging to different socio- economic strata will also differ.

Many welfare services introduced by the government are not beneficial to the 90% of Indian elderly who live in remote villages and they have no excess of adequate transport facilities, health services, and communications services. Majority of them are involved in manual casual labour. Even in their sixties and seventies, they have to work for livelihood (Ansari, 2002). When they become weak and infirm, they need all sorts of helps and supports. For them there is meaning of such relaxations as tax benefits, provident funds, gratuity etc. The old age homes could provide shelter and support to the destitute elderly but the destitute are not in a position to afford it. Even those who can afford to do not want to stay there because this would imply separation from their kith and kin and forsaking any meaningful engagement.

In the era of globalisation and privatisation when the pressures on the families of all classes is increasing and the state is withdrawing its financial support from social welfare, the role of community initiatives, NGOs and individual volunteers become very important. The elderly of poor households are going to be further impoverished and move towards destitution. That is where the elderly may experience the worst of the negative impact of globalisation. For the better-off, increasing loneliness and neglect may become more important issues. It should be debated whether the various organisations should work as pressure groups, advocacy centres, a form of alms-house, or work towards enhancing the capacities of the communities to look after their elderly, giving them a life of dignity and fulfilment. Their approach to care for the elderly should be holistic and engrained with the community and society (Ansari, 2013).

The condition of elderly in third world is quite different from the other industrialized countries. The demographic phenomena, socio-cultural changes, changes among structures of family, health facilities, institutionalisations, retirement, dependency ratio, government programmes and policies may be quite different from the industrialized western world. In the same way the condition of rural-urban elderly of those countries might be different from the third world.

## **ROLE OF FAMILY AND OTHER TRADITIONAL SOCIAL INSTITUTIONS IN CARE OF ELDERLY IN INDIA**

In India there is a greater role of family and other traditional institutions for the care of the elderly, disables, children, widows, issueless women etc though these institutions are on declining and changing.

Either because of the inherent social bonding of the human being in the Indian society or because of India has not yet so developed as the elderly could be provided high-tech assisted care in nursing homes and old age homes so there is only the family or kinship which has to take care of elderly. John Willigen (2000) of USA, working on ageing in India and USA says, "In India we have the joint family systems, in the west you have old age homes, India is better." He further explains that on an average, older Indians live in large households compared to the Americans. He concludes that joint families in India are robust and important.

Various types of other traditional social institutions apart from family such as neighbourhood, community, caste and clans are somehow also contributing in care of elderly in India. As, they work as pressure groups for the family members to take care of their elderly. The family is a place where everybody is taken care whether it is elderly, widows, disabled, ill, unemployed, youth and children. Traditionally something is inherent in the Indian family system which is forcing them to take care of their elderly. However, this institution is disintegrating and required to protect and preserve.

Supporting the above views and indicating rural perspective, A. M. Shah (1999), an Indian sociologist, writes, "The vast majority of elderly people living in rural areas (90%) about social and psychological issues, the elderly of rural are better," (Shah, 1999). Some other sociologists in India found that the joint family still exists in major parts of India and majority of the elderly live in joint families (Desai, 1981; Mukherji, 1965; Kapadia, 1966; Gore, 1965; Ishawaran, 1986; Nayar, 1992, Ansari, 2013). H. Ansari (2011) finds in some north Indian villages that offering food and water to the elderly is considered to be a means to show respect to them. Service of the elderly in general and in condition of disability particular considered as punya (a good deed which adds up in the individual's 'account' towards his/her salvation or rebirth) in many cultures. The Hindu believes it to be equivalent to a holy deep in the River Ganga, while Muslims believe that the same is equivalent to pilgrimage 'Haj'.

## DEMOGRAPHIC CHANGES IN INDIA IS STILL VERY SLOW

To see the elderly through the changes in the ratio of the population of children, adult and old is the demographic perspective. The ratio of the population is changing fast in some countries and slow in some other countries. But the demographic changes in India and in the Western countries may not be the same. The growth of population and birth control may be seen differently. Likewise the dependency ratio of the elderly should also be counted differently. If we locate the proportion of the elderly population and the population of the children we can see the differences. In industrialised countries the percentage of the elderly (60+) is increasing and the population of the children (0-14) is decreasing.

All over the world the elderly population (60+ Age) is increasing rapidly. Japan is having highest elderly population in the world followed by Italy and Greece (Table: 1).

**Table: 1**

### Percentages in Top Ten Countries of Elderly People

SL NO.	Countries	Percentage of elderly
1	Japan	26.30
2	Italy	22.40
3	Greece	21.40
4	Germany	21.20
5	Portugal	20.80
6	Finland	20.50
7	Bulgaria	20.00
8	Sweden	19.90
9	Latvia	19.40
10	Malta	19.20

Source: <http://www.worldatlas.com/articles/countries-with-the-largest-aging-population-in-the-world.html> (retrieved on August 25, 2016)

However, the proportion of elderly (60+) population in India is relatively small, which is increased from 6.8% in 1991 to 8.6% in 2011, i.e., less than 2% increase over two decades (Registrar General and Census Commissioner, 2013). In India the age of senior citizen is 60 years and above, so the elderly population is also counted on that ground though in other countries it is being counted at the age of 65 and above. As per the report of the Census of India 2011 total elderly population was 103.8 million (Table 2.2 & 2.3). Also, with the shifting demographic pattern, the proportion of elderly can be expected to increase rapidly in the coming decades. Still the population of children and young age groups are much higher than the elderly population. In last three successive Censuses of India it could be seen that largest proportion of age groups has been between 15 year and 59 years (Table 2 & 3).

**Table: 2****Percentage of Population in selected age groups India: 1991 to 2011**

Age group (years)	Census 1991 <sup>*</sup>	Census 2001 <sup>@</sup>	Census 2011 <sup>@</sup>
0-4	12.2	10.7	9.3
5-9	13.3	12.5	10.5
10-14	11.8	12.1	11.0
15-59	55.4	56.9	60.3
60+	6.8	7.4	8.6
Age not stated	0.6	0.3	0.4
* Excluding Jammu & Kashmir			
@ Excluding Mao Maram, Pao Mata and Purul Sub Divisions of Senapati district of Manipur			

Source: [http://www.censusindia.gov.in/2011census/Age\\_level\\_data/Age\\_level\\_data.html](http://www.censusindia.gov.in/2011census/Age_level_data/Age_level_data.html)

**Table: 3****Population of selected age groups India: 1991 to 2011 in millions**

Age group (years)	Census 1991 <sup>*</sup>	Census 2001 <sup>@</sup>	Census 2011 <sup>@</sup>
All ages	838.6	1028.6	1210.6
0-4	102.4	110.4	112.8
5-9	111.3	128.3	126.9
10-14	98.7	124.8	132.7
15-59	464.8	585.6	729.9
60-99	56.5	76.5	103.2
100+	0.2	0.1	0.6
Age not stated	4.7	2.7	4.5
* Excluding Jammu & Kashmir			
@ Excluding Mao Maram, Pao Mata and Purul Sub Divisions of Senapati district of Manipur			

Source: [http://www.censusindia.gov.in/2011census/Age\\_level\\_data/Age\\_level\\_data.html](http://www.censusindia.gov.in/2011census/Age_level_data/Age_level_data.html)

The aged population is a by-product of a demographic revolution which is usually called the demographic transition. Due to the demographic changes the researchers raised the issue that the elderly are becoming more dependent on the active population today than in the past years but in calculation of dependency ratio of the elderly in Indian context is somehow not correct because many elderly even after their 60 years of age continue to work such as in unorganised or agricultural sectors where there is no retirement age. One has to continue to work as long as their physical energy permits. In addition, in India child labour is also prevalent. Generally the calculation of dependency ratio is based on the calculation of population of children (0-14) plus the population of elderly (60+) who are considered to be dependants upon the population of 15-59 years. So the notion of dependency is not a sound parameter of judging society's burden of the elderly.

Life expectancy is increasing but this is also very slow in India and many Asian regions. The average life expectancy is considered to be 65.6 years at birth in India but this average has increased more due to decline in infant mortality rate rather than increased survival of older age groups. Also in rural areas the

percentage of survival of the elderly is lower among the poorest and the poor social groups than the middle and well off (Ansari, 1997).

In India the trend is seen that more developed states have higher percentage of elderly population and lower developed have less proportion of the older persons. The top five states the highest older population is seen in Kerala followed by Tamil Nadu, Punjab, Maharashtra and Andhra Pradesh (Table 4). As, these states are considered to be the developed states of India. Among the five states of India the lowest proportion of elderly was in Assam followed by NCT of Delhi, Jharkhand, Bihar and Jammu & Kashmir (Table 4). These states are seems to be poorest in India.

**Table: 4**

**Percentage of elderly (60 +) population in Top 5 and Bottom 5 States in India**

Top 5 States	Percent elderly	Bottom 5 States	Percent elderly
Kerala	12.6	Assam	6.7
Tamil Nadu	10.4	NCT of Delhi	6.8
Punjab	10.3	Jharkhand	7.1
Maharashtra	9.9	Bihar	7.4
Andhra Pradesh	9.8	Jammu & Kashmir	7.4

Source: [http://www.censusindia.gov.in/2011census/Age\\_level\\_data/Age\\_level\\_data.html](http://www.censusindia.gov.in/2011census/Age_level_data/Age_level_data.html)

It is also important that population ageing in the developing world is accompanied by persistent poverty. Just saying that due to demographic transition the problem of Indian elderly is increasing is not seems to be valid. In India, where there in low productivity, poverty, unemployment, poor health facility, poor welfare infrastructures, and over all low quality of life in comparison to western countries. So to blame only demographic transition is not seems be pertinent for the Indian elderly.

However, it is projected that between 2015 and 2050 the proportion of the world's elderly population over 60 years will be nearly double from 12% to 22%. By year 2020, the number of people aged 60 years and older will outnumber children younger than 5 years. The pace of population ageing is much faster than in the past. In 2050, 80% of older people will be living in low- and middle-income countries. All countries face major challenges to ensure that their health and social systems are ready to make arrangements for the most of this demographic shift. France had almost 150 years to adapt to a change from 10% to 20% in the proportion of the population that was older than 60 years .However, places such as Brazil, China and India will have slightly more than 20 years to make the same adaptation (WHO, 2017).

While this shift in distribution of a country's population towards older ages – known as population ageing - started in high-income countries (for example in Japan 30% of the population are already over 60 years old), it is now low- and middle-income countries that are experiencing the greatest change. By the middle of the century many countries for e.g. Chile, China, the Islamic Republic of Iran and the Russian Federation will have a similar proportion of older people to Japan (WHO, 2017).

## **HEALTH PROBLEMS OF THE ELDERLY:TREATMENT IS NOT SUFFICIENT**

Health of the elderly often denotes their disability and frailty when they become weak and lose the mobility and not able to do their own care such as going to bathrooms and defecation. Disability and Functionality of elderly are also measured through Activities of Daily Living (ADL), Instrumental Activities of daily Living (IADL) as well as locomotor disability. The prevalence of locomotors limitations was much higher with nearly half of the elderly having problems of vision. At the same time, the use of aids and assistive devices to overcome the locomotors limitations is very limited. While the socio-economic gradient was evident for ADL and IADL, it was not so in the case of locomotor disability, which was mainly a function of age (UNFPA, 2012).

The most severe form of disability among the elderly is called 'Alath' in local lingua in rural Bihar (Ansari, 2015). Alath is a state of complete disability and immobility when elderly can't take food, can't go to bathrooms without assistance and they are lying in the bed permanently. That called terminated illness or illness before death. Alath is generally followed by death. Such kind of disabled elderly are around 5 %

which near the national level proportion (Mishra U S, 1993, Ansari H, 2015). The state of Alath is very important for the policy point of view because all security measures are needed for this period.

According to the NSSO (58<sup>th</sup> Round, 2002) data on locomotors disability it was found among 11% and 9% of the older persons in rural and urban areas respectively, 27% were suffering from visual impairment in the rural areas; and the corresponding figure for urban areas was 24%. Further 15% and 12% older persons were suffering from hearing disability in rural and urban areas respectively. In another study it was found that there were 33% elderly among the age 80 and above and 6% among the young older persons (60-70) had significantly restricted or no mobility (Agewell Foundation, 2011).

Health of the older persons is related to their perception of disease and illness. The self-perceived health problems and taking treatment (Health seeking behaviour) of the elderly depends on their economic class. In one study in north Bihar it was found that the perception of 'lots of health problems' was reported by the 100% of elderly in the poorest group, whereas, among the well-off it was 66.66%. Being health problems among 100% in the poorest, only 36.36% of them were taking treatment but among the well-off being 66.66% health problems 50% were taking treatment. This happened because of perception of the severity of the disease. The poorest elderly hardly consider themselves as ill unless they become bedridden but the well-off reports as ill even at a little health problems (Ansari 2015).

Treatment seeking behaviours is also graded according to their socio-economic class. Among the poorest 72.72% used to consult the quacks (untrained medical practitioners) followed by the poor (67.56%), the better-off (55.55%) and the well-off (33.33%) (Ansari, 1997). Just contrary to that majority of the elderly from the well-off (33.33%) and better-off (11.11%) and few from poor (5.40%) and middle (9.0%) and no elderly from the poorest class used to consult the trained medical practitioners such as MBBS or MD for their treatment (Ansari, 2015). The causes of not taking treatment have been cited as non-availability of doctors nearby, non-availability of transport but major cause was the monetary. Monetary cause was cited by the poorest and the poor groups more than the better-off and well-off.

## **POLICY AND PROGRAMMES FOR THE ELDERLY IN INDIA ARE NOT SUFFICIENT**

For prioritization of the policy formulation it is necessary to find who are the most vulnerable sections in the society requires any assistance first. Economically it was found, in one study in north Indian villages, that there were around 49% of the elderly were found under the poorest and the poor categories. As per the caste category- around 50% were among the scheduled castes and most backward castes, and around 40% were among the special categories- widow, widower, divorcee, unmarried, issueless etc adding 13% physically disabled (Ansari, 2002). So roughly around 40% elderly are the most vulnerable and they require all sorts of assistances and helps. In India, though, majority of elderly are taken care by their close relatives and distant relatives but majority of the care providers are themselves so poor and have inadequate resources that they cannot provide adequate care and services to their elderly such as medicine, food, living spaces etc. Some needs of the older people are general for all elderly of all sections of the society while some other needs are specific for a particular group. The Alathanxiety has significant influence on the lives of the adults and elderly. All attempts are made during active life to ensure that there should be someone who takes care in their old age when they become weak and infirm. Policy and programmes are required for that period of life first.

### **National Policy on Older Persons (NPOP)**

The Indian government has announced the National Policy on Older Persons in 1999 on the eve of the 'United Nations International Year of Older Persons' and declared the year 2000 as the National Year of Older Persons. That policy highlighted the plight of the vulnerable older persons- such as widow, women in general, the poor, rural residents, the disabled and chronically ill (including mentally ill). The other facilities as the programmes show that the strengthening the primary health services, providing geriatric care facilities at secondary and tertiary level, starting new specialized courses in geriatric medicine, starting mobile health services for the ailing old persons, meeting the education, training and information needs of the older persons and so on. In 2010, the Ministry of Social Justice and Empowerment set up a committee

to draft a new National Policy on Senior Citizens which draft was submitted in 2011. It takes a broader view of the issues involved.

However, unfortunately, major proportion of the elderly living remote villages have different problem of basic needs such foods, shelter, clothes etc and they hardly avail these facilities. When they fell ill permanently and a permanent caregiver is needed in that case yet any mechanism has not been developed by the government.

### **Integrated Programme for Older Persons (IPOP)**

In 1992 this programme was initiated to provide support to Non-Governmental Organizations for running and maintenance of old age homes, day care centres and mobile Medicare units for older persons living in slums, rural and inaccessible areas where proper health facilities are not available, in the form of financial assistance up to 90% of the project cost. The funds are, however, very limited, increasing to over five thousand Indian Rupees (i.e., approx. USD 85) per beneficiary annually in 2008-2011. But even more significant is the small number of beneficiaries relative to the number of elderly (.037%)(Ansari H and Priya R, 2014).

### **Old age pension: social security schemes**

For the pension of the elderly working under unorganised and agricultural sectors, the government of India has started a projects called Old Age Social and Income Security (OASIS) through which everybody has to deposit rupees 5 per day and if it will be sustained for whole working years (35years) then there would be large pool of money which could be given as pensions. But they failed to understand the daily cash income and household expenditure about the rural poor (Sujaya, 2000:19). A meagre amount of pension is given presently to the older persons come under BPL family at the rate of Rs. 200 to 500 which has been promised to increase up to Rs 1000 per month in some states and Rs 2000 in some other states. This is only a token payment and cannot afford income or livelihood security and under that only a fraction of the elderly population is covered by old age pension and other schemes(Ansari H and Priya R, 2014).

### **National Social Assistance Programme (NSAP)**

In 1995 the National Social Assistance Programme (NSAP) was initiated by the central government to ensure minimum national standards for social assistance in addition to the benefits that states might provide. Two of its schemes address the elderly: the Indira Gandhi National Old Age Pension Scheme (IGNOAPS), a non-contributory old age pension (launched 2007), and the Annapurna Scheme for free food grain to the poor elderly (Ansari H and Priya R, 2014).

Under IGNOAPS Rs. 200 (approx. USD 3.3) monthly per poor elderly was provided as central government assistance to all persons below poverty line aged over 65. In 2011, Government lowered the age limit to 60 years, increasing the number of beneficiaries from 17.1 million to 24.3 million. Simultaneously, the rate of pension was increased from Rs. 200 to Rs. 500 to persons of 80 years and above. Even with this large programme, it is only token support, and only about one-fifth of the elderly population is covered. For the poor elderly, it barely mitigates their destitution. Annapurna Scheme was launched by Ministry of Rural Development in 2000-2001 for indigent senior citizens of 65 years of age or above who were not getting the pension. 10 kg of food grains per person per month is to be supplied free of cost under the scheme(Press Information Bureau, 2000; Ansari H and Priya R, 2014)).

### **National Programme for Health Care for the Elderly (NPHCE)**

This programme was launched in 2010-11 provides dedicated preventive, curative and rehabilitative services to the elderly persons. Health care of the elderly is viewed in a medicalised, institutional framework, linked to non-communicable diseases alone. Also, there is no explicit mention of the traditional systems. While there is widespread use of the traditional systems and practices especially for non-communicable diseases, even by modern doctors, there is no formal mechanism for integrating the strengths of various systems (NPHCE, 2014).

## **The National Institute of Social Defence**

This Institute was set up to provide technical inputs to the Government of India and is now the nodal training and research institute for interventions in the area of 'social defence'. It conducts several diploma and certificate courses on geriatric care and also programmes for caregivers organised in collaboration with NGOs, provided training to 4,500-6,000 persons per year over the period 2007-11 (Planning Commission, 2012).

## **Law for the elderly**

The Maintenance and Welfare of Parents and Senior Citizens Act, 2007 provides for: maintenance of parents/senior citizens by children/relatives made obligatory and justifiable through tribunals, revocation of transfer of property by senior citizens in case of negligence by relatives, penal provision for abandonment of senior citizens, establishment of Old Age Homes for Indigent Senior Citizens, and adequate medical facilities and security for Senior Citizens. The main aim of that law was to prevent abuse and abandonment of the elderly by their children and other relatives.

Some privileges are also provided by other ministries to the elderly such as the Ministry of Health and Family Welfare has created separate queues for older persons and geriatric clinics in government hospitals. The ministries concerned with transport have made provisions such as a separate ticket counter for senior citizens, fare concessions and provision of lower berths to elderly passengers, wheelchairs at stations for old age passengers and introducing bus models that are convenient to the disabled and elderly. However, such provisions in India are used largely by the urban, educated upper and middle class elderly and for the vast majority meeting basic needs is still an issue, and doing so with dignity is even more challenging.

For the elderly of rural and poor sections, the only provision for long was non-contributory pension schemes. Then came support for Old Age Homes in rural areas. In fact, the increasing decline of social and cultural resources, primarily responsible for detriment of the conditions of the elderly of all sections, needs to be checked or replenished by new forms. The social capital and social cohesion across caste, class, gender and religious identities can be strengthened through appropriately designed measures that meet 'felt needs', such as for breaking the loneliness and providing meaningful activity for the elderly (Ansari H and Priya R, 2014). The policy draft of 2011 values an "age integrated society". It states that the endeavour will be to facilitate interaction between the old and the young as well as strengthen bonds between different age groups. It believes in the development of a formal and informal social support system, so that the focus is on strengthening the capacity of the family to take care of senior citizens. The policy seeks to reach out in particular to the bulk of senior citizens living in rural areas who are dependent on family bonds and intergenerational understanding and support (Min. of S.& J., 2011).

## **CHALLENGES AND SOLUTIONS FOR THE CARE OF THE ELDERLY**

The major challenge for the elderly is the increasing population of older persons all over the world. This demographic transition is more rapid in the western industrialised countries than the third world developing countries. In industrialised countries they age with the advancement of medical care and other facilities which the third countries lack. In such a condition of poor health care facilities, poverty and unemployment the condition of the increasing elderly population is alarming and challenging.

Another challenge is the disintegrating traditional family system and kinship support. Though it is slow in Indian continent and yet the forces of social change have not penetrated as it happened in the industrialised countries. But this social institution is slowly braking down and it requires protection and preservation.

The most affected segment of the society by social change is the youth population. It is observed that slowly the value system among them is diminishing. Socialisation of the younger generation with proper samskara is essential for the care elderly. In India it is the youth who support the elderly so the youth could be trained and socialised in a way with the value system so that they could respect and take care of their senior citizens.



Poor medical care is a big challenge for everybody for but it is more challenging for the elderly. Specialised geriatrics care is hardly available to the elderly and disabled. Majority of the older persons are depending on the untrained medical practitioners.

Social security in India for everybody is difficult except those few who are in salaried jobs in organised sectors. The majority of the masses (more than 94%) are working in unorganised sectors either as casual labourers or daily-wage earners where there are no retirements and no retriial benefits. They have not any social security in their old age. So providing at least some social security at old age is essential.

Another challenge for the elderly is to create age-friendly environment in the surrounding areas and at other public places where the older persons could travel/walk easily. This is not in the agenda of the policy makers and planners to develop public places as age-friendly such as construction of railway foot over bridges, parks without any barriers, easy excess to the bus stands and buses, except the few places in the metro cities where some convenience have been started recently but yet not fully functional.

Not proper development of technology to ease the life of elderly by the science and technology. Yet the third world, particularly India, is so poor in developing the age-friendly, age-care technology through which their life could be made easy such walking sticks, moving electric chairs, age-friendly toilets, age-friendly busses and trains and any other modes of public transportation.

## CONCLUSIONS

The care elderly in India could be seen in Indian perspective, as per the Indian society and culture. Still the older persons are considered to be the respected persons in society and family. The forces of social change have not occurred in Indian society as it happened in the western industrialised countries. Though there are changes in the life styles, fashion and technology in India but still the basic values in the society are more or less intact. Though the traditional joint family system is breaking but majority of the elderly are living in joint families and majority of them, except the few, are they taken care by their close relatives which is almost nonexistent in the western countries. Demographic transition has taken place in India but it is slower than the developed industrialised countries. The proportion of the population of children is much higher than the elderly population in India. Migration of younger generation from the rural to urban centres has not impacted negatively the care of the elderly in all cases. Though the majority of the family members are caring for their aged but majority of them are themselves very poor. Their problems are graded as per their socio-economic status. The poor have different problems- mainly the fulfilling the basic needs whether the well-off have different problems. Though the elderly have many health problems and many are bedridden but their family members are taking care of them without any geriatric training and use of technology whereas in the western countries they have advanced medical care with sophisticated technological support system. In India the health care services for elderly is very poor and there are no exclusive services for them. They have depend on general medical care whatever available to all. Their level of perception of diseases and treatment seeking behaviours are graded as per the socio-economic status. The poor used to consult the ordinary local medical practiceners whereas the rich go to the trained medical practiceners in towns. Providing adequate health services is a challenge for the elderly. Though government has several welfare policies and programmes for the elderly which is not sufficient and majority are depending on the family. So the family should be protected and given incentives to those who take care of their elder persons.

**REFERENCES**

- Agewell Foundation(2011): Study on Human Rights of Older Persons in India. Agewell Foundation, New Delhi.
- Ansari, H. and Priya, R.(2014):*Policies and politics of ageing in India: Social and technological options*.Gerontechnology, Vol 12, No. 4, 2014, ISSN 1569-1101 (paper); 1569-111X (electronic), doi 10.4017/gt.0000.00.00.000.00; pp: 219-228. June 2014. <http://gerontechnology.info/index>(15.11.2019)
- Ansari, H.(2015):*Who Cares for the Extreme Disabled Elderly? An Examination of their Condition in Rural Bihar*.TheIndian Journal of Gerontology, Vol 29, No. 3, 2015. (ISSN 0971-4189), <http://www.gerontologyindia.com/journal.htm>(15.11.2019)
- Ansari, H. (2000): Are the elderly a Burden? An examination of their conditions in Rural Bihar, Man in India, Ranchi, 80: 195-213.
- Ansari, H. (2002):*Significance of Traditional Social Institutions for the Elderly in the Changing Context of Rural Gopalganj, Bihar*. Doctoral dissertation submitted to the Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi.
- Ansari, H. (1997): *A study of life and Health of Aged in Gopalganj District of Bihar*, New Delhi, Unpublished M. Phil. Dissertation (Submitted to SMCH/SSS/JNU).
- Ansari, H. (2005): Social Situation of Elderly in India in Ageing and Society: The Indian Journal of Gerontology, vol. XV, No. I & II, Jan- March, April- June 2005, Kolkata, India.
- Ansari, H. (2007):*Indian Elderly among Marginal Sections: Programmes and Policies in the Era of Globalisation* published by *eSocial Sciences*, Mumbai, India (8/2/2007) <http://www.esocialsciences.com>
- Ansari, H. (2011): Perception of Social Change among Elderly: Changing Role-Relations of Younger Generations, Intergenerational Bonds and Family Dynamics in Rural Bihar. *Ageing & Society: The Indian Journal of Gerontology*, Vol. XXI, No. I&II, Jan-June 2011. PP: 25-50).
- Census of India (2001): Census of India, Series 11, Bihar provisional publication Totals, Paper No. 1 & 2. Rural urban distribution of population, Sudhir Kumar Rakesh, Director of Census, Bihar.
- Census of India (2011): Registrar General and Census Commissioner, August 2013. Social and Cultural Tables – Age Data Highlights, Census of India 2011, Ministry of Home Affairs, Government of India.
- Central Statistics Office(2011):*Situation Analysis of the Elderly in India*.Ministry of Statistics and Programme Implementation, Government of India.
- Chaudhary, D. Paul(1992): *Ageing and the Aged*, New Delhi, Inter India Pub. 5-70.
- Desai, I. P. (1981): The craft of Sociology and Other essays. Delhi, Ajanta, pp: 92-111.
- Gore, M. S. (1965): *Urbanisation and Family Change*. Bombay: Popular Prakashan.
- Ishwaran, K. (1986). Interdependence of the Elementary and Expanded Family. In Augustine, J. S. (Eds) *The Indian Family in Transition*, New Delhi: Vikas Pub House.
- Kapadia, K. M. (1966): *Marriage and Family in India*.Bombay Popular Prakashan.
- Kohli, A. S. (1996): *Social situation of the Aged in India*, New Delhi, Anmol Pub.P-5.
- Ministry of Social Justice and Empowerment(2008): *Integrated Programme for Older Persons –A Central Sector Scheme*. Government of India, New Delhi.
- Ministry of Social Justice and Empowerment(2011): (Draft) *National Policy for Senior Citizens*, 2011.Ministry of Social Justice and Empowerment, Government of India, New Delhi. <http://socialjustice.nic.in/pdf/dnpsc.pdf> (15.11.2019)
- Ministry of Social Justice and Empowerment(2011): (Draft) *National Policy for Senior Citizens*, 2011.Ministry of Social Justice and Empowerment, Government of India, New Delhi. <http://socialjustice.nic.in/pdf/dnpsc.pdf> (15.11.2019)

- Mishra, U.S. (1999): Health Implications of Ageing, 266, 267; *Medico Friend Circles Bulletin*, Nov-Dec, 1999 pp: 5-6.
- Mukherji, R. K. (1965): *Sociologists and Social change in India Today*, New Delhi: Prentice Hall.
- Nayar, P. K. B. (1992): *Needs and Problems of the Aged: A study in Kerala*. New Delhi: ICSSR (Memeo).
- NPHCE(2014): *National Programme for Health Care of the Elderly*, Department of Health & Family Welfare, Ministry of Health & Family Welfare, Government of India. [http://mohfw.nic.in/index3.php?lang=1&deptid=36\(08.05.2014\)](http://mohfw.nic.in/index3.php?lang=1&deptid=36(08.05.2014)).
- NSSO(2002: India - Survey of disabled persons, July 2002 - Dec 2002, NSS 58th Round.National Sample Survey Office-M/O Statistics and Programme Impmletation (MOSPI), Government of India.
- Office of the Registrar General and Census Commissioner, India (1992): *Ageing in India: Occasional paper No.2 of 1992*, p.15.
- Planning Commission(2012): *Working Group on Social Welfare for Formulation of the Twelfth FYP – 2012-17.Social Justice and Social Welfare Division, Planning Commission, Government of India.*[http://planningcommission.gov.in/aboutus/committee/strgrp12/st\\_pwd.pdf](http://planningcommission.gov.in/aboutus/committee/strgrp12/st_pwd.pdf) (19.11.2019)
- Press Information Bureau(2000): “Annapurna” Scheme, Government of India, New Delhi.<http://pib.nic.in/infonug/infyr2000/infoaug2000/i010820001.html> (19.11.2019).
- Registrar General and Census Commissioner of India(2013): *Social and Cultural Tables – Age Data Highlights, Census of India 2011, Ministry of Home Affairs, Government of India, August 2013.*
- Shah, A. M. (1999): *Changes in the Family and Elderly; Bombay.Economic and Political Weekly*, Volume-XXXIV, No. 20, May, 15, 1999, P-1179.
- Shah, A. M.(1998): *The Family in India: Critical Essays*. New Delhi, Orient Longman, pp: 65-67.
- Sujaya, C.P. (2000): “National policy on older person”, *Seminar*, Issue 488, April 2000, New Delhi. [http://www.india-seminar.com/2000/488/488\\_sujaya.htm](http://www.india-seminar.com/2000/488/488_sujaya.htm) (13.04.2014).
- UNFPA(2012): *Report on the Status of Elderly in Select States of India, 2011.*<http://www.seniorindian.com/index.htm> (19.11.2019).
- Wadley, Susan S. (1994): *Struggling with Destiny in Karipur 1925-1984*, New Delhi, Vistaar
- WHO, (2017): *Ageing and health Fact sheet No. 404 September 2015.*Retrieved from <http://www.who.int/mediacentre/factsheets/fs404/en/>(11.12.2017).
- Willigen, J. V. (2000): *Social Ageing in India and America; Seminar*, 488, April, 26-29.