Institute of Economic Growth

POLICY BRIEF

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THE OTHER SIDE OF INDIAN DEMOGRAPHICS: ACCELERATING GROWTH IN AGEING AND ITS CHALLENGES

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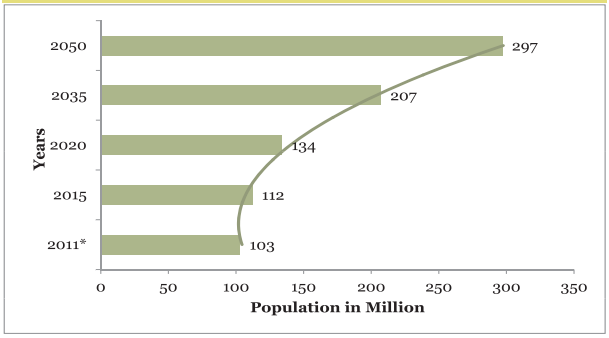
INTRODUCTION

With sustained decline in fertility–mortality parameters, improved public health and increasing life span in India, the size of the elderly population in the country is projected to grow almost thrice in a short span of next 40 years, i.e., from 103 million in 2011 to 297 million in 2050 (Figure 1). While this increase may not make ageing in India as pronounced as in Europe, North America and parts of the Asia-Pacific region, it will pose a range of socio-economic and health challenges, with considerable fiscal and financial implications for the economy. A great deal of these issues may also stem from gradual cessation in traditional values and erosion in multi-generational living arrangements. Growing influence of market institutions and changes in women's role to become an economic agent may cause further weakening in various traditions, needing a fresh look at the accelerating pace of ageing in the country and its attendant issues.

Figure 1 Increase in elderly population, 2011–2050



Source: Elderly population for 2011* is the Census figure, and the rest are drawn from World Population Prospects, UNDESA (2012 revision), http://esa.un.org/unpd/wpp/index.htm

OBJECTIVES AND METHODOLOGY

Drawing upon issues emanating from population dynamics and changes in age structure, the United Nations Population Fund (UNFPA, India) along with the Institute of Economic Growth (Delhi), Institute for Social and Economic Change (Bangalore) and Tata Institute of Social Sciences (Mumbai) has launched a major research project to study ageing issues in the country, including socio-economic and health conditions of the olds. Titled 'Building a Knowledge Base on Population Ageing in India (BKPAI)', a primary survey of older adults was conducted in seven rapidly ageing states including Odisha, West Bengal, Maharashtra, Himachal Pradesh, Punjab, Tamil Nadu, and Kerala (Alam et al. 2012). This policy brief highlights a few important findings of the survey.

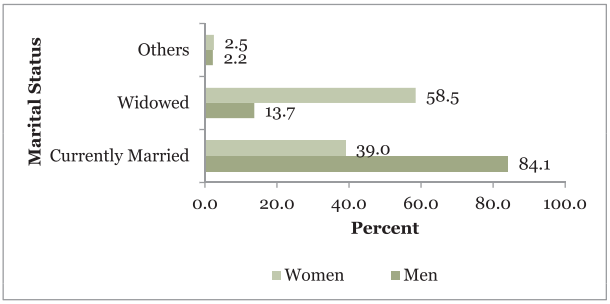
KEY FINDINGS

The elderly profile brings out by the BKPAI survey is slightly different from some other ageing societies in the world. To illustrate, the survey suggests clustering of older Indians in relatively younger age cohorts. Almost two-thirds of the aged in the study areas (62%) are in the 60-69 year age group. This indicates that the ageing scenario in India is still in its formative stages and, therefore, the government has a window of opportunity to blueprint its ageing policies and implementation mechanism. With regard to the sex ratio, marital status and literacy level of the sample population, there is a host of disturbing observations from the data. One is that there are more elderly

The authors are at the Institute of Economic Growth, New Delhi. This policy brief is drawn using data collected during the survey conducted by three collaborating institutions—ISEC, IEG, and UNFPA—as part of the research project 'Building a Knowledge Base on Population Ageing in India'. All opinions are of the authors only and do not necessarily reflect those of the institutions mentioned.

women than elderly men (the sex ratio is as high as 1113). This implies feminisation of ageing. Another is that a considerable majority of elderly women are widows (Figure 2).

Figure 2 Distribution of elderly by marital status, 2011



Most of them are illiterate and may therefore easily fall prey to serious economic and health vulnerabilities. There are many other serious issues. A few of the more critical include: (i) involuntary participation of a large proportion of elderly persons in physically strenuous and poorly paid informal economic activities; (ii) no or inadequate income; (iii) growing changes in living arrangements of the elderly; (iv) feminisation of the ageing population with growing share of widows, particularly after reaching 75 and 80; (v) low levels of physical, mental and functional health conditions; and (vi) limited access to and inadequate knowledge of several government-run welfare schemes.

A few of these issues are further elaborated in rest of this discussion.

WORK PARTICIPATION OF SAMPLE ELDERLY

The analysis of this data reveals a much higher elderly participation in economic activities than may usually be the case. Although work participation declines with age, it remains substantial even among those over 80. In addition, the work intensity of the working olds is also fairly high. The survey found that a large proportion of those economically active work almost full time—well beyond four hours a day. Such intense work participation in later ages clearly indicates serious insecurity and necessity to earn in older ages due to no or inadequate flow of family income towards the olds.

Figure 3 Currently working elderly by age and sex (%, 2011)

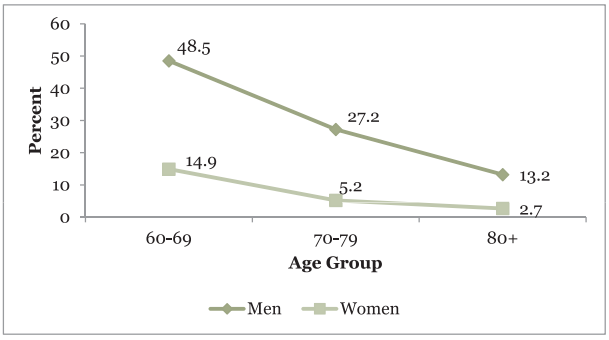


Figure 3 breaks down the elderly's participation in work by age and sex; the share of working men, particularly those over 80, appear strikingly high. Therefore, a question to ponder may be: can we justly celebrate our growing longevity or relate it to the country's socio-economic progress?

Disturbingly, poor and less educated older adults participated more in work than those more educated and wealthier. Similarly, higher work participation among the lower social groups (SC/ST) reconfirms our earlier contention and indicates that elderly work participation is largely an involuntary decision taken in response to economic compulsions. Among the states surveyed, Maharashtra, considered as the financial hub of the country, has the highest elderly work participation rate followed by Odisha, while Kerala has the lowest.

LEVELS OF PERSONAL INCOME

Most surveys conducted in India and elsewhere have deliberately avoided gathering information on personal income. However, since this survey was designed to investigate the socioeconomic and health statuses of the elderly population as well, it attempted to collect information on the personal income of the elderly. The survey reveals that 74% of elderly men and about 41% of elderly women report receiving some personal income, however meagre—almost half (43%) of all elderly receive no income and 22% receive less than Rs 12,000. Merely 14% receive Rs. 50,000 or more per annum. Significant gender differentials in personal income are noticed. There were no significant variations in personal income by place of

residence. A message to draw from this may be the low economic worth of the elderly with a big majority of them incapable of meeting their health and economic needs independently. Does it leave them to face poor self-esteem, indignation and economic subordination? While this question deserves serious consideration at policy levels, it may also be noticed that a fraction of them receive good income and may generate demand for various goods and services produced especially by the private sector. Many of them may also cater to knowledge-based skill requirements of the country in a situation when the country is facing shortage of the skilled workforce and ranked poorly in global talent competiveness indices (see http://global-indices.insead.edu/gtci/).

LIVING ARRANGEMENT

The traditional family based living arrangement remains the common practice across all the seven states under reference. However, a striking issue relates to high proportion of loner women in three major states including Tamil Nadu (26.4%), West Bengal (10.5%), and Maharashtra (10.1%). Bulk of them are unfortunately widows.

A big majority of the elderly, as happens in most traditional societies, is co-residing with their families, but a fifth of them are also living alone or with their spouse; and a significant 6% are living alone. A higher proportion of elderly women (10%) than elderly men (2%) live alone. The percentage of urban elderly women living alone is slightly higher than their rural counterparts.

ELDERLY HEALTH AND WELLBEING

Psycho-mental health: measures of General Health Questionnaire (GHQ) and Subjective Well-being Inventory (SUBI)

The analysis on self-rated health shows that around 55% of the elderly rate their health as poor or fair on a five-point scale. Thus, self-rated health appears to be lower among elderly Indians than among the elderly in developed countries. Self-rated health also has a close connection with the mental and physical health of the elderly. The GHQ and SUBI measures of mental health status also revealed that nearly half the elderly require some health assistance, which challenges the healthcare system. Both self-rated and mental health conditions have a strong socio-economic gradient, with the poor and low castes facing much bigger risks.

Declining functionality and need for support

Three measures were used in the survey to examine functionalities of people in their old age: (i) capabilities to perform activates of daily living (ADL) like eating, drinking, bathing, etc., (ii) capabilities to perform more intense instrumental activities of daily living (IADL) like going to market, operating a bank account, dialling phone numbers independently, etc., and (iii) loco-motor disability. The study shows that over 5% of the elderly in study areas have serious functionality issues with regard to the ADL functions, necessitating formal or informal care and support. With the decline in family size and greater participation of women in economic activities, often informal care is difficult to summon. Formal or institutional care, on the other hand, is largely beyond the reach of elderly populations in India.

Prevalence of acute and chronic morbidity

Acute (short duration) morbidity in the population is around 13%, with a higher prevalence in rural areas and among women. The burden of morbidity—irrespective of acute or chronic—increases significantly with age. The elderly also suffer from both communicable and non-communicable diseases. The ensuing health care needs must be addressed simultaneously. Over 90% of the elderly received treatment for acute morbidity.

The survey collected information from the elderly on various chronic (long duration) ailments as well. The prevalence of orthopaedic and musculoskeletal ailments are the most common diseases reported by the olds. Other ailments with relatively higher prevalence include cataract, diabetes, asthma, chronic obstructive pulmonary disease (COPD) ailments, hypertension, and heart diseases. Interestingly, arthritis, cataract, and asthma are very common in rural areas. On the other hand, hypertension, diabetes, and heart diseases are more prevalent among the urban elderly. Out-of-pocket

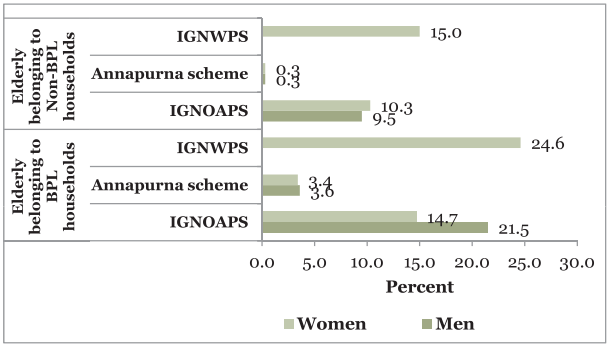
expenditure on treatment was found to be very high for both types of diseases with a very large proportion of expenditure goes to purchase of drugs and medicines. Most of this expenditure is borne by the families, causing many of them to face consumption catastrophe.

AWARENESS AND UTILISATION OF WELFARE SCHEMES BY SAMPLE ELDERLY

Social security schemes for elderly

The utilisation of these schemes by older persons is poor. Further, some non-BPL elderly also utilise these schemes suggesting poor administrative mechanism (Figure 4). Another important finding of the survey relates to a wide gap between awareness and utilisation of government funded facilities such as the Indira Gandhi National Old Age and Widow Pension Schemes (IGNOAPS/IGNWPS).

Figure 4 BPL and non-BPL elderly utilising national social security schemes by sex (%, 2011)



Rashtriya Swasthya Bima Yojana

The survey specifically posed questions on both awareness and coverage of the elderly under Rashtriya Swasthya Bima Yojana (RSBY). Only 14% of the BPL elderly knew about the RSBY. There is no significant variation by place of residence or gender in awareness. However, the non-BPL elderly knew more about the scheme, although the scheme is exclusively targeted to the BPL.

POLICY RECOMMENDATIONS

Based on the survey data, we recommend the following policy measures.

- The economic and social welfare of the elderly must be improved to meet high poverty, income insecurity, poor health status, and social deprivation in old age.
- Provisions of national flagship programmes, including MGNREGA and RSBY, should be targeted better.
- Elderly health must be improved by promoting a healthy life style, subsidising assistive technology and creating geriatric medical infrastructure in a big way.
- As is the case with many countries in the world, attempts may be made to evolve a public pillared old age pension scheme for the entire 65+ elderly population.
- Building stronger intergenerational relationship to ensure better economic support from young to old.
- The participation of professionals and the educated elderly in economic activities after retirement should be enhanced. In particular, the private sector may be geared to use this pool through selective mechanism. It may help them to minimise their labour cost and achieve greater competitiveness.
- Promoting policy and programmes to address the needs of older women.
- Effective implementation of age-related policies and programmes.
- Institutionalising human rights instruments to protect the basic rights of the elderly.
- Engaging private sector establishments operating in 60+ markets to support elderly welfare activities by utilising a part of their funds for corporate social responsibility.
- Promoting programmatic and policy oriented research and evidence based advocacy.

For any further information, please contact the Academic Programmes Officer | academic@iegindia.org

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