



Caring for Our Elders Institutional Responses

INDIA AGEING REPORT 2023



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डॉ. वीरेन्द्र कुमार
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सामाजिक न्याय और अधिकारिता मंत्री
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Message

Ageing is a natural stage of human life. Population Ageing is a global phenomenon. The number of elderly is increasing across the world, and India is no exception. Population of senior citizens presently shares 10% of the total population of India. By 2036, 14.9% of the population of our country will comprise of senior citizens. Population Ageing has many societal and policy implications. The United Nations Population Fund (UNFPA) has prepared this Report 'Caring for Our Elders: Institutional Responses-India Ageing Report 2023', bringing forth the response of the Government and Non-Governmental Organisations towards issues concerning senior citizens.

In our society, parents or senior citizens have always been revered, next to Almighty. It is rightly said in Sanskrit that a person who respects and serves senior citizens every day, his age, educational qualifications, fame and strength enhance day-by-day.

“अभिवादनशीलस्य नित्यं वृद्धोपसेविनः।
चत्वारि तस्य वर्धनन्ते आयुर्विद्या यशो बलम् ॥

Keeping such thoughts in mind and spirit, Indian children, across all communities and strata, have always served their parents till death. However, fast rate of urbanisation has to a large extent disintegrated the traditional family system as children move out to cities, and also abroad, in search of livelihood, leaving their parents back home. Many a times, it is also seen that despite children wanting their parents to stay with them in cities, parents fail to adjust with the fast urban way of living in their old age and prefer to go back to their native place. It is here that Government comes into the picture in order to fill up the gap. The National Policy on Older Persons, 1999 considers Institutional care as the last resort when personal circumstances are such that stay in Old Age Homes becomes absolutely necessary.

Since 1992, Government of India has been maintaining and running Old Age Homes for indigent senior citizens. Grant-in-aid is provided to Non-Governmental Organisations (NGOs) for running and maintenance of such Homes, wherein shelter, food, health, clothing and recreation are provided to the residents of such Homes. Presently, a total of 566 Senior Citizen Homes in the country, maintained by 414 different NGOs, are being assisted under the Scheme of Integrated Programme for Senior Citizens. Since 1995, Government of India is also implementing a non-contributory Old Age Pension Scheme, benefitting senior citizens belonging to Below-Poverty Line families. Gradually, many other essential Schemes including Financial Security Schemes, Health Insurance Schemes, Health Care services etc. have been developed and being implemented by the Government of India for the care and welfare of senior citizens.

I am happy that UNFPA-India has taken up the initiative in preparing the India Ageing Report-2023 highlighting upon the Institutional responses available for senior citizens in the country. The Report is highly appreciable. I hope that the Report will give a new direction to all stakeholders in this field for serving the senior citizens.

(Dr. Virendra Kumar)



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संदेश

संयुक्त राष्ट्र जनसंख्या कोष, भारत (यूएनएफपीए, इण्डिया) ने भारतीय वरिष्ठ नागरिकों की स्थिति, आवश्यकताओं और उनकी सेवा कर रही संस्थाओं का समग्रता से अध्ययन करते हुए एक शोध रिपोर्ट हमारे वृद्धजनों की देखभाल संस्थागत प्रतिक्रियायें (केयरिंग फार अवर एल्डर्स, इन्स्टिट्यूटशनल रिस्पॉन्स) नामक शीर्षक से तैयार की है। इस रिपोर्ट में वैश्विक स्तर पर लगातार बढ़ रही वृद्धजनों की आबादी एवं उनके लिए किये जा रहे अन्तर्राष्ट्रीय संस्थागत प्रयासों का समुचित वर्णन किया गया है। भारत सरकार, वैश्विक संस्थागत प्रयासों से साहचर्य बैठाने हुए भारत के 149 मिलियन वरिष्ठ नागरिकों की समुचित देखभाल के लिए कृत संकल्प है।

यूएनएफपीए, इण्डिया ने सामाजिक न्याय अधिकारिता मंत्रालय, भारत सरकार द्वारा वृद्धजनों के कल्याण के लिए किये जा रहे कार्यों का विवरण दिया है। साथ ही भारत सरकार की राष्ट्रीय वयोश्री योजना जैसी सकारात्मक योजना के व्यापकता का भी उल्लेख किया है। भारत सरकार की नीतियों विशेष रूप से माता-पिता, भरण-पोषण और कल्याण अधिनियम 2007 में किये गये संशोधन से बच्चों के उत्तरदायित्व का जो निर्धारण किया गया है वह उल्लेखनीय है। इस रिपोर्ट में भारत सरकार के साथ स्वयंसेवी संस्थाओं और नागरिक समाज के अनुकरणीय कार्यों का लेखा-जोखा है, जो इस क्षेत्र में कार्य करने के लिए इच्छुक लोगों के लिए प्रेरणादायी होगा। इस रिपोर्ट में कारपोरेट जगत द्वारा किये जा रहे प्रयासों का भी उल्लेख है। ज्ञातव्य है कि भारत सरकार भी वृद्धजनों के लिए नवाचार वाली संस्थाओं को प्रोत्साहित करने का कार्य कर रही है, जिसमें बड़े पैमाने पर सीएसआर निधि का उपयोग किया जा सकता है।

मैं आशा करती हूँ कि यूएनएफपीए, इण्डिया की यह रिपोर्ट वृद्धजनों के लिए कार्य करने वाले सभी हितधारकों के लिए उपयोगी सिद्ध होगी। मुझे विश्वास है कि यूएनएफपीए, इण्डिया द्वारा इसे तरह की शोधपरक भविष्य में भी प्राप्त होती रहेगी।

धन्यवाद....

Pratima Bhoumik
(प्रतिमा भौमिक)

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Government of India
Ministry of Social Justice & Empowerment
Department of Social Justice & Empowerment

Department of Social Justice and Empowerment, being the nodal Ministry for the care and welfare of senior citizens, congratulates United Nations Population Fund (UNFPA)-India for bringing out the detailed Report on "Caring for Our Elders: Institutional Responses - India Ageing Report 2023" covering all the major aspects pertaining to institutional care and welfare of senior citizens in the country.

2. As per the Report of the Technical Group on Population Projections-July 2020, the projected population of senior citizens by the year 2036 will be 22.7cr., amounting to 14.9% of the total population of the country, with female senior citizens outnumbering their counterparts. Government of India has been implementing various schemes and programmes for the welfare of senior citizens, especially the indigent ones, for meeting their basic needs of shelter, food, health, clothing and recreation. With advancements in technology, we will be able to serve the senior citizens in a more inclusive way. The Department has been part of preparing Vision-2047 for timely interventions, wherein many existing schemes and programmes will be strengthened and many more initiatives will be undertaken.

3. Government has been always proactive in serving the senior citizens, especially during the COVID-Pandemic period, we have witnessed how every stakeholder, including the Central and State Government, Family, Communities and Civil Society Organisations played their best role during this emergency time. Such an integrated coordination amongst the stakeholders will continue to be needed on a sustained basis for the wellbeing of senior citizens. We also wish good health to senior citizens of the country so as to enable them to remain productive for their families and society at large. We hope that every family builds up a strong inter-generational bonding so as to enable every elderly to respectfully spend the last phase of life with their family.

4. I once again congratulate UNFPA-India for bringing available information regarding Institutional care of senior citizens at one place.


(Saurabh Garg)



PREFACE

The world's population is not only expanding but also growing older, marked by increased life expectancies, and decreasing fertility rates across nearly all countries. With the right policies, an ageing population can provide a silver dividend from their assets and wealth - offering vast experience and skills, and invaluable time for communities.

The UN has declared 2020-2030 as the Decade of Healthy Ageing that underscores caring for elders requires a whole-of-society approach as the ageing of the population not only impacts health systems but also many other aspects of society, including labour and financial markets and the demand for goods and services, such as education, housing, long-term care, social protection, and information.

UNFPA has been at the forefront of increasing the knowledge base of population ageing in India and taking necessary steps to harness opportunities and address challenges. Expanding upon its previous edition from 2017, the India Ageing Report of 2023 '**Caring for our Elders - Institutional Responses**' undertakes a comprehensive re-evaluation of the living conditions and welfare of older individuals within the nation. It leverages the latest data available to provide an up-to-date perspective on the challenges and opportunities faced by the ageing population that are wide ranging viz., physical and mental health, digital skills and technology, mobility, housing, finance and social care.

While India as a nation has the largest cohort of young people, the population above 60 years will double from 10.5% in 2022 to 20.8% by 2050. Ageing is rapidly progressing in many states. The incidence of widowhood and higher life expectancy among older women are key demographic characteristics in India. As fewer women work and earn less in comparison to men, there are acute poverty impacts associated with the feminization of the aged which will require attention from the policy makers.

I am grateful to the Ministry of Social Justice and Empowerment for its continued support, partnership, close cooperation and dedication to the aged in India. I congratulate the authors for their commendable effort. I am hopeful that the report will give a new direction to policymakers, researchers and others interested in quality care and support for the elderly.

For the elders deserve nothing less.

Andrea M. Wojnar
UNFPA India Representative
& Country Director Bhutan

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Acknowledgements

India Ageing Report 2023 focuses on the institutional arrangements that undergird the implementation of the National Policy for Older Persons in India. The report pools together existing knowledge on population ageing in India and maps senior-centric activities carried out by governmental and non-governmental organizations working with the elderly. Drawing upon the learnings from the first-ever nation-wide sample survey on the elderly conducted by the International Institute for Population Sciences, Mumbai the report also canvasses the utilization of elder care services in India and makes suggestions for strengthening schemes and programmes.

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Abbreviations

ADL	activities of daily life
AISCCON	All India Senior Citizen's Confederation
ARDSI	Alzheimer's & Related Disorders Society of India
AVYAY	Atal Vayo Abhyuday Yojana
BKPAI	Building a Knowledge Base on Population Ageing in India
BPL	below poverty line
BPS	Bharat Pensioners Samaj
CBO	community-based organization
COVID-19	coronavirus disease 2019
CSR	corporate social responsibility
ESHG	elderly self-help group
FESCOM	Federation of Senior Citizens of Maharashtra
IGNOAPS	Indira Gandhi National Old Age Pension Scheme
IGNWPS	Indira Gandhi National Widow Pension Scheme
ILC-I	International Longevity Centre-India
Kerala SCSC	Kerala Senior Citizen Service Council
KSSM	Kerala Social Security Mission
LASI	Longitudinal Ageing Survey in India
MHU	mobile health unit
MIPAA	Madrid International Plan of Action on Ageing
MSJE	Ministry of Social Justice and Empowerment
MWPSC Act	Maintenance and Welfare of Parents and Senior Citizens Act

NGO	non-governmental organization
NISD	National Institute of Social Defence
NPHCE	National Programme for Health Care of the Elderly
NPOP	National Policy on Older Persons
NSE	National Stock Exchange
PHC	primary health centre
PRI	Panchayati Raj Institutions
RRTC	Regional Resource and Training Centre
SAARC	South Asian Association for Regional Cooperation
SCCD	Senior Citizens Council of Delhi
SCW	senior citizens' welfare
SDG	Sustainable Development Goal
TANSECA	Tamil Nadu Senior Citizens' Association
UNFPA	United Nations Population Fund
UT	Union Territory

Setting the Context

1.1 Introduction

The global population is growing as well as ageing. The age structure of the population is changing owing to demographic transition with increasing levels of life expectancy and decreasing levels of fertility in almost all countries, leading to an increase in both the share and number of older persons across the world. Population ageing is associated with a rise in the proportion of population termed as 'old', usually at 60 or 65 years and above. Population ageing has been more pronounced in developed nations as they have passed through their demographic transition from high levels of fertility and mortality to lower levels, ahead of many of the developing countries. However, it is more rapid in developing countries now as they have been able to reduce fertility and mortality levels in a shorter span of time.

Globally, there are 1.1 billion persons aged 60 years or above in 2022, comprising 13.9 percent of the total population of 7.9 billion.¹ Over the next three decades, the number of older persons worldwide is expected to double to 2.1 billion by 2050, with the share rising to 22 percent of the total population. This increase in the number and share of older persons will be visible across all regions of the world. In more developed regions, the share of older persons will increase from 26 percent in 2022 to 34 percent in 2050, while in less developed regions, it will increase from 11.5 percent to 20 percent during the corresponding period. The absolute number of older persons in less developed regions is likely to more than double from 772 million in 2022 to 1.7 billion in 2050.

With a population of 649 million aged 60 years and above, Asia is home to about 58 percent of the global population of older persons. In the next three decades,

¹ Department of Economic and Social Affairs, Population Division, *World Population Prospects 2022*, Online Edition (United Nations, 2022), available at <https://population.un.org/wpp/>.

This unprecedented rise in the ageing population will have significant implications for health, economy, and society in India. Preparing for the anticipated increase in the number of older persons and having the right policies and programmes for the well-being of the current and future older generations is one of the immediate priorities of the government and other relevant stakeholders.

the share of older persons in the total population (13.7 percent), and their absolute number will be doubled in Asia: there will be 1.3 billion older persons, constituting 25 percent of the total population by 2050.

India is not an exception to this phenomenon. There are 149 million persons aged 60 years and above in 2022 (as on 1 July), comprising around 10.5 percent of the country's population. By 2050, the share of older persons will double to 20.8 percent, with the absolute number at 347 million.²

This unprecedented rise in the ageing population will have significant implications for health, economy and society in India. Preparing for the anticipated increase in the number of older persons and having the right policies and programmes for the well-being of the current and future older generations is one of the immediate priorities of the government and other relevant stakeholders.

1.2 International Policy Frameworks on Ageing

1.2.1 First World Assembly on Ageing, Vienna, 1982

To generate worldwide attention on the global issue of population ageing, the UN General Assembly, through a resolution in 1978,³ decided to organize the first ever World Assembly on Ageing in Vienna, Austria, in 1982. It was meant to be a forum to launch an international action programme aimed at guaranteeing economic and social security to older persons and opportunities to contribute to national development. The Vienna International Plan of Action on Ageing was the first international instrument on ageing, providing a basis for the formulation of policies and programmes on ageing; it was endorsed by the UN General Assembly in 1982.⁴

² Author analysis based on academic research. For data sources, please see Department of Economic and Social Affairs, Population Division, *World Population Prospects 2022*, Online Edition (United Nations, 2022), available at <https://population.un.org/wpp/>.

³ <https://www.un.org/en/conferences/ageing/vienna1982#:~:text=The%20UN%20General%20Assembly%2C%20in,and%20organizations%20concerned%2C%20a%20World.>

⁴ <https://www.un.org/en/conferences/ageing/vienna1982.>

The aim of the Plan of Action was to strengthen the capacities of governments and civil society to deal effectively with the ageing of populations and to address the developmental potential and dependency needs of older persons. It promoted regional and international cooperation and included 62 recommendations for action addressing research, data collection and analysis, training, and education as well as the following sectoral areas:

- health and nutrition;
- protection of elderly consumers;
- housing and environment;
- family;
- social welfare;
- income security and employment; and
- education.

1.2.2 International Day of Older Persons

International days are occasions to educate the public on issues of concern, to mobilize political will and resources to address global problems, and to celebrate and reinforce achievements of humanity. On 14 December 1990, the United Nations General Assembly designated 1 October as the International Day of Older Persons.⁵ The UN marks the day by encouraging countries to draw attention to and challenge negative stereotypes and misconceptions about older persons and ageing, and to enable older persons to realize their potential.

1.2.3 United Nations Principles for Older Persons, 1991

In 1991, the General Assembly adopted the United Nations Principles for Older Persons⁶ based on the International Plan of Action on Ageing, 1982. The principles provided that older persons in society ought to have independence, the ability to participate

⁵ <https://documents-dds-ny.un.org/doc/RESOLUTION/GEN/NR0/564/95/IMG/NR056495.pdf>.

⁶ <https://documents-dds-ny.un.org/doc/RESOLUTION/GEN/NR0/581/79/IMG/NR058179.pdf>.

in society, access to care, the full dignity of life, and entitlement to self-fulfilment, among other rights. It encourages governments to incorporate the following principles into their national programmes whenever possible.⁷

Independence

1. Older persons should have access to adequate food, water, shelter, clothing and healthcare through the provision of income, family and community support, and self-help.
2. Older persons should have the opportunity to work or have access to other income-generating opportunities.
3. Older persons should be able to participate in determining when and at what pace withdrawal from the labour force takes place.
4. Older persons should have access to appropriate educational and training programmes.
5. Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
6. Older persons should be able to reside at home for as long as possible.

Participation

7. Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
8. Older persons should be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.
9. Older persons should be able to form movements or associations of older persons.

⁷ <https://www.ohchr.org/en/instruments-mechanisms/instruments/united-nations-principles-older-persons>.

Care

10. Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.
11. Older persons should have access to healthcare to help them maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.
12. Older persons should have access to social and legal services to enhance their autonomy, protection and care.
13. Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
14. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy, and for the right to make decisions about their care and the quality of their lives.

Self-fulfilment

15. Older persons should be able to pursue opportunities for the full development of their potential.
16. Older persons should have access to the educational, cultural, spiritual and recreational resources of society.

Dignity

17. Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.
18. Older persons should be treated fairly, regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

1.2.4 Second World Assembly on Ageing, Madrid, 2002

To mark the twentieth anniversary of the First World Assembly on Ageing, the Second Assembly was held in Madrid, Spain, in 2002. It was devoted to an overall review of the outcome of that event in a

As the demographic changes are expected to be the greatest and most rapid in developing countries, where the older population is expected to quadruple by 2050, the Assembly recognized the importance of placing ageing in the context of strategies for the eradication of poverty and to achieve full participation of all developing countries.

global effort to address the 'demographic revolution' that was taking place all over the world. The main aim was to advance the global ageing agenda beyond the 1982 Plan of Action and address the global force of population ageing and its impact on development.

Responding to growing concern over the speed and scale of global ageing, the Assembly adopted its main outcome documents—a Political Declaration and Madrid International Plan of Action on Ageing (MIPAA), 2002, which committed governments to act to meet the challenge of population ageing and provided the world policy makers with a set of 117 concrete recommendations, covering three main priority directions:

- (a) older persons and development;
- (b) advancing health and well-being into old age; and
- (c) ensuring enabling and supportive environments.

As the demographic changes are expected to be the greatest and most rapid in developing countries, where the older population is expected to quadruple by 2050, the Assembly recognized the importance of placing ageing in the context of strategies for the eradication of poverty, as well as efforts to achieve full participation of all developing countries in the world economy. It promoted a new recognition that ageing was not simply an issue of social security and welfare but of overall development and economic policy and stressed the need to promote a positive approach to ageing and overcome the negative stereotypes associated with it.

Stressing the need to ensure that ageing has a basic place in all development agendas—both domestic and international—governments committed themselves to the full protection and promotion of human rights and fundamental freedoms, recognizing that persons, as they age, should enjoy a life of fulfilment, health, security and active participation in economic, social, cultural and political life. It recognized the greater role of civil society organizations and the private sector.⁸

⁸ <https://press.un.org/en/2002/soc4619.doc.htm>.

The Assembly gave the United Nations Regional Commissions responsibility for translating the International Plan of Action on Ageing into regional action plans reflecting, among other things, the demographic, economic and cultural specificities of each region and serving as a basis for implementing the recommendations.

1.2.5 Review and appraisal of the Madrid International Plan of Action on Ageing

The review and appraisal of the MIPAA takes place every five years. The process involves a participatory 'bottom-up' approach engaging both civil society and older persons and is designed to assist Member States in receiving feedback on the policies and programmes they have implemented.

Following the review and appraisal at the national level, UN Regional Commissions coordinate consolidation of information at the regional level. Reviews and appraisal processes culminate with a global review at the Commission for Social Development.⁹

The first review and appraisal exercise, covering the period 2003–2007, was conducted in 2008 at the 46th session of the Commission for Social Development; the second, covering the period 2008–2012, was conducted in 2013 at the Commission's 51st session; and the third, covering the period 2013–2017, was conducted in 2018 at its 56th session.

In these reviews and appraisal cycles, while welcoming the progress made, UN Regional Commissions continued to report significant challenges in monitoring the implementation of MIPAA. Those challenges include:

- (a) the lack of data availability, particularly age-disaggregated data, in many countries;

⁹ United Nations Economic and Social Council, 'Modalities for the fourth review and appraisal of the implementation of the Madrid International Plan of Action on Ageing, 2002', Report of the Secretary-General, Commission for Social Development, available at <https://www.un.org/development/desa/ageing/resources/commission-for-social-development-reports.html>.

- (b) the inability to carry out comparative analyses between countries in several regions owing to the absence of agreed indicators at the regional level;
- (c) difficulties in gathering inputs from all relevant ministries where coordination units on ageing do not exist at the national level; and
- (d) the lack of capacity and limited national institutional frameworks in some countries and regions to engage on or respond to the review and appraisal process at the national level.

The fourth review and appraisal of the MIPPA is scheduled to be completed in 2023. In the run-up to this, various UN Regional Commissions organized regional conferences on ageing; meeting of the Standing Working Group on Ageing; Regional Intergovernmental Conference on Ageing; and prepared regional progress reports on the implementation of the plan.

The UN Regional Commissions identified additional emerging issues at the regional level, including the need for action to:

- (a) generate significant, renewed momentum for advancing ageing issues with youthful populations and multiple competing development needs;
- (b) establish appropriate links between the MIPAA, ageing-related policies, the 2030 Agenda and other relevant commitments;
- (c) rethink social protection systems in the context of rapid population ageing and growing inequalities, and ensure an inclusive approach to addressing the needs and situations of older persons;
- (d) promote lifelong learning opportunities in order to guarantee equal access to decent work by older persons and to ensure that people can remain productive and competitive in the labour market throughout the course of their lives;
- (e) increase access to information and communications technology and promote digital literacy of older persons;

- (f) ensure that older persons can benefit from the fast-growing frontier technologies, such as robotics and artificial intelligence, which have the potential to improve healthcare, accessibility and transportation systems and increase social connections;
- (g) strengthen health policies and programmes for the prevention, detection, diagnosis, treatment and care of non-communicable diseases, bearing in mind that population ageing is among the major factors contributing to the rising incidence and prevalence of such diseases; and
- (h) ensure access by older persons to sexual healthcare and raise awareness of the realities faced by older persons because of their sexual orientation.

1.3 United Nations Decade of Healthy Ageing: 2020–2030

The United Nations Decade of Healthy Ageing (2021–2030) is a global collaboration—aligned with the last 10 years of the Sustainable Development Goals (SDGs)—that brings together governments, civil society, international agencies, professionals, academia, the media and the private sector to improve the lives of older people, their families and the communities in which they live.¹⁰

The UN Resolution (75/131),¹¹ which follows endorsement of the Decade by the World Health Assembly, expresses concern that, despite the predictability of population ageing and its accelerating pace, the world is not sufficiently prepared to respond to the rights and needs of older people. It acknowledged that the ageing of the population not only impacts our health systems but also many other aspects of society, including labour and financial markets and the demand for goods and services, such as education, housing, long-term care, social protection, and information. It thus requires a whole-of-society approach.

¹⁰ <https://www.who.int/initiatives/decade-of-healthy-ageing>.

¹¹ <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N20/363/87/PDF/N2036387.pdf>.

The Decade of Healthy Ageing provides a new opportunity to address the gender power relations and norms that influence health and well-being for older women and older men and the intersectional links between gender and age.

The Resolution also calls upon the World Health Organization to lead the implementation of the Decade in collaboration with the other UN organizations. Governments, international and regional organizations, civil society, the private sector, academia, and the media are encouraged to actively support the Decade's goals.¹²

The Decade will be based on the human rights approach, which addresses the universality, inalienability and indivisibility of the human rights to which everyone is entitled, without distinction of any kind, including the rights to enjoyment of the highest attainable standards of physical and mental health; an adequate standard of living; education; freedom from exploitation, violence and abuse; living in the community; and participation in public, political and cultural life. The organizations engaged in the collaboration will adhere to their own guiding principles and values.

The Decade of Healthy Ageing provides a new opportunity to address the gender power relations and norms that influence health and well-being for older women and older men and the intersectional links between gender and age.¹³

The Decade will address four areas of action.

- (a) *Creating age-friendly environments*: Physical, social and economic environments are important determinants of healthy ageing. Age-friendly environments are better places in which to grow, live, work, play and age. Environments play an important role in determining the physical and mental capacities of individuals as they move into old age, also impacting how well they adjust to loss of bodily functions and other forms of adversity that they may experience at different stages of life, particularly in later

¹² <https://www.who.int/news/item/14-12-2020-decade-of-healthy-ageing-a-new-un-wide-initiative>.

¹³ World Health Organization, Decade of Healthy Ageing: Plan of Action (2020), available at <https://www.who.int/publications/m/item/decade-of-healthy-ageing-plan-of-action>.

years. Both older people and the environments in which they live are diverse, dynamic and changing, and interactions between the two hold incredible potential for enabling or constraining healthy ageing.¹⁴

- (b) *Combating ageism*: Ageism affects how we think, feel and act towards others and ourselves based on age. It imposes powerful barriers to the development of good policies and programmes for older and younger people and has profound negative consequences on older adults' health and well-being. The World Health Organization (WHO) is working with key partners on the Global Campaign to Combat Ageism which aims to change the narrative around age and ageing and helps create a world for all ages.¹⁵
- (c) *Providing integrated care*: Numerous physiological changes occur with increasing age. Older people require non-discriminatory access to good-quality essential health services that include prevention; promotion; curative, rehabilitative, palliative and end-of-life care; safe, affordable, effective, good-quality essential medicines and vaccines; dental care and health and assistive technologies, while ensuring that use of these services does not cause the user financial hardship.¹⁶
- (d) *Building long-term care systems*: Significant declines in physical and mental capacity can limit older people's ability to care for themselves and to participate in society. Older people continue to aspire for well-being and respect regardless of declines in physical and mental capacity. Long-term care systems enable older people, who experience significant declines in capacity, to receive the care and support that allow them to live a life commensurate with their basic rights, fundamental freedoms and human dignity. Access to rehabilitation, assistive technologies

¹⁴ <https://www.who.int/teams/social-determinants-of-health/demographic-change-and-healthy-ageing/age-friendly-environments>.

¹⁵ <https://www.who.int/teams/social-determinants-of-health/demographic-change-and-healthy-ageing/combating-ageism>.

¹⁶ <https://www.who.int/initiatives/decade-of-healthy-ageing>.

and supportive, inclusive environments can improve the situation; however, many people reach a point in their lives when they can no longer care for themselves without support and assistance. Access to good-quality long-term care is essential for such people to maintain their functional ability, enjoy basic human rights and live with dignity. These services can also help reduce the inappropriate use of acute healthcare services and help families avoid catastrophic care expenditures.¹⁷

The UN Decade of Healthy Ageing requires a whole-of-government and whole-of-society response. It includes collaborative multisectoral and multi-stakeholder partnering in its vision and in each of the above four areas for action to meet its commitment to bring about transformative change while building trust across generations by optimizing everyone's opportunities for healthy ageing.

An online knowledge exchange platform has been established to connect and convene the stakeholders who promote the four action areas at country level and those seeking information, guidance and capacity-building. This enables work on the four areas by

- (a) listening to diverse voices and enabling meaningful engagement of older people, family members, caregivers, young people and communities;
- (b) nurturing leadership and building capacity to take appropriate action integrated across sectors;
- (c) connecting various stakeholders around the world to share and learn from the experience of others; and
- (d) strengthening data, research and innovation to accelerate implementation.¹⁸

¹⁷ Ibid. | <https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/ageing-and-health/integrated-continuum-of-long-term-care>.

¹⁸ <https://www.who.int/activities/improving-understanding-measurement-and-monitoring-of-healthy-ageing>.

1.4 Policy Response to Ageing in India

Government of India's commitment to population ageing concerns is evident in some its laws and policies.

- (a) The National Social Assistance Programme for the poor is an outcome of the Directive Principles of the Indian Constitution (Articles 41–42), recognizing concurrent responsibility of the central and state governments in this regard.
- (b) India is a signatory to all the global conferences, initiatives on ageing as well as the Regional Plans of Action.
- (c) India formulated the National Policy on Older Persons (NPOP) in 1999, well ahead of the MIPAA (2002).

India's national response can be seen as evolving along with many multilateral initiatives under the aegis of the UN which has spearheaded global attention towards ageing concerns. The government also recognized that some of the key concerns of older citizens could be best addressed through partnerships with non-governmental organizations. India has significantly gained from the incremental global understanding of ageing issues, such as the 1982 Vienna International Plan of Action on Ageing, the UN Principles for Older Persons in 1991, and the Second World Assembly on Ageing in Madrid in 2002.

The formulation of NPOP has, in some ways, influenced the MIPAA. India had shared with other countries and international NGOs the serious lack of attention to ageing in the Millennium Development Goals. Today, the SDGs give special attention to ageing under the goal of Good Health and Well-Being (SDG 3). India's policy response to ageing has also benefitted from various UN conventions, resolutions and initiatives including the:

- (a) document on active ageing published by WHO;
- (b) January 2010 resolution of the Convention on the Elimination of All Forms of Discrimination against Women or older women;

India's national response can be seen as evolving along with many multilateral initiatives under the aegis of the UN which has spearheaded global attention towards ageing concerns.

The United Nations Population Fund (UNFPA), globally and in India, focuses on population ageing as part of its strategic plan for emerging population concerns.

- (c) United Nations Population Fund initiative of 'Building a Knowledge Base on Population Ageing in India' (BKPAI) to study the social-economic implications of ageing;
- (d) work by the International Labour Organization on income security and social pensions; and
- (e) data gathering efforts under the Longitudinal Ageing Study in India (LASI) and the WHO Study of Global AGEing and adult health (WHO SAGE) initiative in India.

India's ageing policy and programmes, along with the government response regarding the well-being of older persons, are discussed in Chapter 3.

1.5 Context and Focus of the Report

The United Nations Population Fund (UNFPA), globally and in India, focuses on population ageing as part of its strategic plan for emerging population concerns. While the developed countries had extensive databases on the demographic, social and economic conditions, health needs, and living arrangements of older persons, India hardly had any such disaggregated data despite several researchers attempting to extract relevant information from various national surveys commissioned for different purposes. Hence, UNFPA, India in collaboration with the Population Research Centre (PRC); Institute for Social and Economic Change (ISEC), Bangalore; Institute of Economic Growth (IEG), Delhi; and Tata Institute of Social Sciences (TISS), Mumbai, launched the BKPAI project during the VII Cycle of Cooperation with the Government of India (2008–12). The project focuses on research using secondary and primary data, results and analyses which can be used for further research, advocacy, policy dialogue and programme development for the well-being of older persons.

India Ageing Report 2017, published by UNFPA, looked at responses from the government and NGOs; gathered field-based information on selected initiatives that positively impacted the lives of older people; and documented good practices in care of older persons

that could be replicated on scale.¹⁹ The document included narratives of selected good practices in elder care and support as useful learning experiences. Based on the trends obtained from a sample survey conducted with UNFPA support, the report also estimates the demand for elder care services and makes suggestions for the way forward in four broad areas, namely, (a) enhancing policy and programme relevance; (b) creating a supportive environment; (c) capacity development; and (d) research. It served as a useful reference document for relevant stakeholders to develop programmes for ensuring good quality of life for older persons.

Building on the 2017 report, this report provides updated information on the conditions of older persons in the country based on the latest available data and attempts to map out the various efforts being undertaken as an 'institutional response' to step up the quality of elder care. It focuses on the responses from the government, community-based organizations and associations of older persons, efforts by the corporate houses under the corporate social responsibility (CSR) mandate, and measures taken for the care for older persons during the COVID-19 pandemic.

1.6 Organization of the Report

The report is divided into eight chapters. This introductory chapter gives an overview of the population ageing phenomenon and various international policy frameworks on ageing and also sets the context of the report.

Chapter 2 discusses the socio-demographic status, health, living arrangements and economic status of the elderly based on the latest round of national survey.²⁰

¹⁹ <https://india.unfpa.org/en/publications/caring-our-elders-early-responses-india-ageing-report-2017>.

²⁰ International Institute for Population Sciences, Mumbai, *Longitudinal Ageing Study in India: Wave 1, 2017-18, India Report*, available at https://lasi-india.org/public/documentation/LASI_India_Report_2020.pdf.

Chapter 3 explores India's ageing policy and programme landscape by compiling government response to population ageing and provides a snapshot of various ongoing schemes, concessions and programmes for older persons.

Chapter 4 showcases the efforts undertaken by community-based organizations and the associations of older persons for the welfare of their members and the challenges faced. An inventory of such efforts together with the challenges will be helpful for strengthening such community-led efforts for elder care.

Chapter 5 discusses the corporate social responsibility (CSR) efforts and initiatives undertaken by corporate houses towards supporting senior citizens. It is perhaps the first attempt to document CSR efforts and resources spent towards elder care.

Chapter 6 uses survey data to analyse the availability and utilization of various programmes and schemes for older persons. It presents information about the coverage of the schemes and provides directions for improvements.

In the wake of the unprecedented COVID-19 pandemic, it is important to document efforts undertaken by various voluntary organizations to take care of older persons, particularly during the nationwide lockdowns. Chapter 7 documents the care efforts undertaken to support senior citizens during the pandemic across the country, especially during the lockdowns, and highlights the need for better preparedness to assist vulnerable older persons in any type of humanitarian situations.

Chapter 8 sums up the findings and charts the way forward for enhancing the quality of life of older persons in the country.

Status of the Older Population in India

2

2.1 Introduction

Population ageing is an inevitable and irreversible demographic reality that is associated with welcome improvements in health and medical care. With longevity and declining fertility rates, the population of older persons (60 years and above) is globally growing faster than the general population.

Three key demographic changes—declining fertility, reduction in mortality and increasing survival at older ages—contribute to population ageing. They reflect a shift in the age structure from young to old. The demographic transition of declining fertility and mortality leads to an expanding bulge in the older cohorts, as compared to the younger. The old-age dependency in the population therefore gradually increases. The shift from a period of high mortality, short lives and large families to one with a longer life and fewer children is the hallmark of demographic transition. A top-heavy age structure means that the elderly has to depend upon incomes and revenues generated by a dwindling number of younger workers.

In general, ageing is defined in terms of chronological age with a cut-off at 60 or 65 years (in part because it broadly coincides with the age at retirement). However, in many developing countries, chronological age may have little to do with retirement as majority of the elderly are engaged in the informal sector for as long as they can work, with no specific retirement age. In such cases, the socially constructed meanings of age are more often significant, often defined by the roles assigned to older people or the loss of certain roles

that signify physical decline in old age.¹ In India, the cut-off age to define older persons is generally considered as 60 years.

This chapter presents a more updated profile of the elderly based on latest available data from Longitudinal Ageing Survey in India (LASI), 2017–18,² as a sequel to *India Ageing Report 2017* which had used the 2011 survey data of the United Nations Population Fund (UNFPA) “Building a Knowledge Base on Population Ageing in India” (BKPAI) project.³ In addition, data from the *Census of India, Population Projections by the Government of India (2011–2036)* and *World Population Prospects 2022* by United Nations Department of Economic and Social Affairs has also been used.

2.2 Population Ageing in South Asia and India

In Asia as a whole, the proportion of the elderly is expected to increase from 13.7 percent to 35.7 percent during 2022–2050.⁴ In East Asia, the proportion of the elderly is expected to be 39.2 percent by 2050. Japan (43.7 percent), the Republic of Korea (46.4 percent) and China (38.8 percent) may be expected to report the highest proportions of the elderly population by 2050. The South Asian Association for Regional Cooperation (SAARC) countries, however, are likely to

¹ M. Gorman, ‘Development and the Rights of Older People’, in J. Randel *et al.* (eds.) *The Ageing and Development Report: Poverty, Independence and the World’s Older People*, pp 3–21 (Earthscan Publications Ltd., London, 1999).

² Longitudinal Ageing Survey in India was conducted by International Institute for Population Sciences (IIPS), Mumbai, in collaboration with the National Programme for Health Care for Elderly (NPHCE), Ministry of Health & Family Welfare (MoHFW); Harvard T. H. Chan School of Public Health (HSPH); and the University of Southern California (USC). | IIPS, NPHCE, HSPH and USC, *Longitudinal Ageing Study in India (LASI) Wave 1, 2017 -18, India Report*, (International Institute for Population Sciences, Mumbai; National Programme for Health Care for Elderly, Ministry of Health & Family Welfare; Harvard T. H. Chan School of Public Health; and the University of Southern California, 2020), available at https://iipsindia.ac.in/sites/default/files/LASI_India_Report_2020_compressed.pdf.

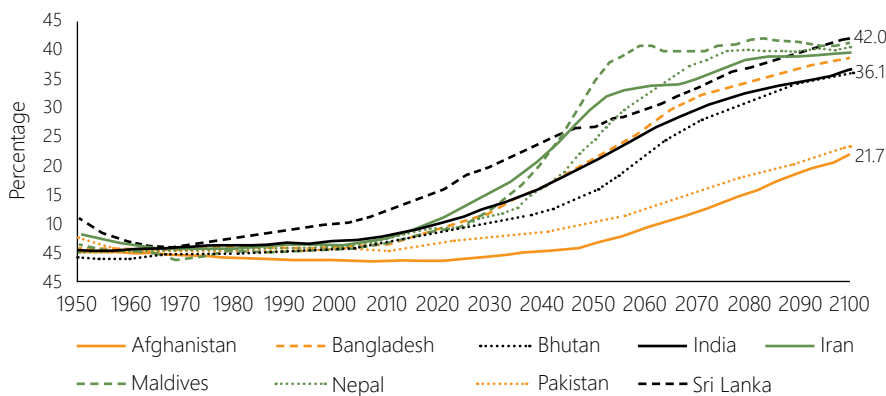
³ UNFPA. *Caring for Our Elders: Early Responses, India Ageing Report 2017* (United Nations Population Fund, New Delhi, 2017).

⁴ Department of Economic and Social Affairs, Population Division, *World Population Prospects 2022, Data Sources*, (United Nations, 2022), UN DESA/POP/2022/DC/NO. 9.

have only about 19.8 percent population above 60 years by 2050. Within the SAARC, Bangladesh (21.3 percent), Bhutan (23.8 percent), Maldives (34.1 percent) and Sri Lanka (27 percent) are estimated to overshoot the SAARC average for the statistic by 2050. While India is not expected to report more than 20 percent elderly by 2050, the absolute numbers will be very large.

Amongst South Asian countries, pace of ageing in India is moderate with the proportion of the aged increasing to 20 percent in 2050 and 36.1 percent in 2100 (Figure 2.1). *World Population Prospects 2022* projects that other bigger and stronger economies such as Japan, China, Indonesia and Viet Nam will be experiencing high to very high growth of the elderly population in the future which can go beyond 40 percent of their total population. By 2050, one in every five individuals will be an elderly in India.

Figure 2.1: Percentage of the elderly population in South Asian countries, 1950–2100



Note: Sri Lanka is the highest at 42.0 percent and Afghanistan is the lowest at 21.7 percent; India is at 36.1 percent.

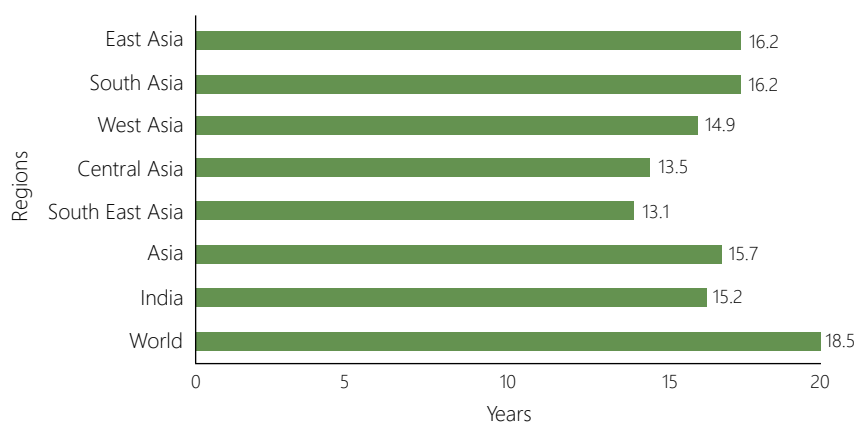
Source: Department of Economic and Social Affairs, Population Division, *World Economic Prospects (2022 Revision)*, (United Nations, 2022), available at <https://population.un.org/wpp/Publications/>.

Between 2010 and 2020, the doubling rate of the elderly in India was reported to be around 15 years, on a par with West Asia and the Asia average (Figure 2.2). South and East Asia are taking a year longer (that is, 16 years) for doubling of their elderly population whereas South East Asia is doubling most rapidly at 13 years.

Population ageing presents a challenge for the demographic, health and socio-economic setup of a nation. Asia is ageing at a faster pace than the world average with significant variations in the doubling time across countries within it.

In some developing countries, the old-age dependency ratio could more than double in 50 years, a phenomenon that was stretched over 150–200 years in the developed world. The rapid ageing of developing countries is not accompanied by the increases in personal incomes experienced in the developed world during its ageing process. Further, the governments of the rapidly ageing developing countries are slower in recognizing and responding to the demographic shift, largely due to competing development priorities.

Figure 2.2: Doubling time of the elderly population based on annual growth rate during 2010–2020



Source: Department of Economic and Social Affairs, Population Division, *World Population Prospects 2019*, (United Nations, 2019), available at <https://population.un.org/wpp/Download/Standard/Population/>.

2.3 Ageing in India: Levels and Trends

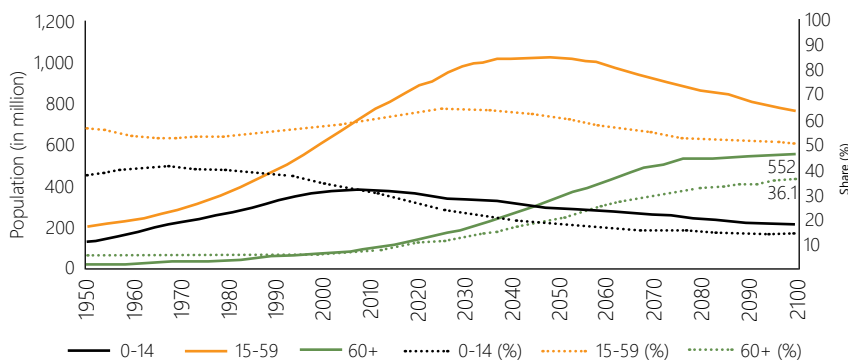
2.3.1 Prospects of the older population

The percentage of the elderly in India has been increasing swiftly in recent years, and the trend is likely to continue in the coming decades. The share of population over the age of 60 years is projected to increase from 10.5 percent in 2022 to 20.8 percent in 2050 (Figure 2.3). By the end of the century, the elderly will constitute over 36 percent of the total population of the country.

Sharp growth in the elderly population is observed from 2010 onwards along with a decline in the age group of below 15 years, indicating rapidity of ageing in India. Four years before 2050,

the population size of the elderly in India will be higher than the population size of children aged 0–14 years (Figure 2.3). By that time, the population share of 15–59 years will also see a dip. Undoubtedly, the relatively young India today will turn into a rapidly ageing society in the coming decades.

Figure 2.3: Size and share of population by age group, 1950–2100



Note:

Solid lines plotted along the primary y-axis (left) represent the absolute population.

Dotted lines plotted along the secondary y-axis (right) represent the share of the age group in the total population.

Source: Department of Economic and Social Affairs, Population Division, *World Economic Prospects (2022 Revision)*, (United Nations, 2022), available at <https://population.un.org/wpp/Publications/>.

2.3.2 State differentials

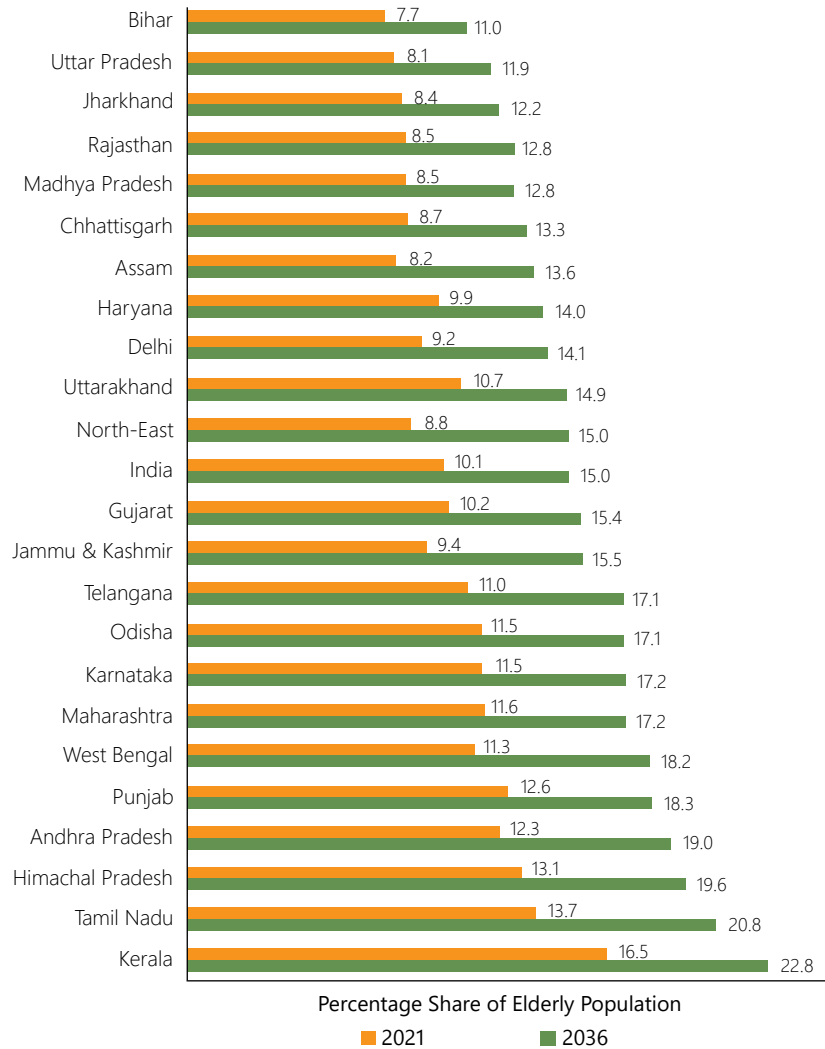
At the national level, the share of the elderly population is projected to increase from 10.1 percent in 2021 to 15 percent in 2036 (Figure 2.4). A distinguishing feature of ageing in India is the significant interstate variation in absolute levels and growth (and hence, share) of the elderly population, given the varying stages and pace of demographic transition across states. Consequently, there are considerable variations in the age structure of the population, including the ageing experience. Most of the states in the southern region and select northern states such as Himachal Pradesh and Punjab reported a higher share of the elderly population than the national average in 2021, a gap that is expected to widen by 2036. While states reporting higher fertility rates and lagging in demographic transition, such as Bihar and Uttar Pradesh, expect to

Elderly population in India is expanding at an unprecedented rate and may be expected to surpass the children’s population by mid-century.

Share of the elderly population would be substantial in most of the states in the coming decades with one in five persons being elderly in the southern states by 2036.

see an increase in the share of the elderly population between 2021 and 2036, the level will remain lower than the Indian average.

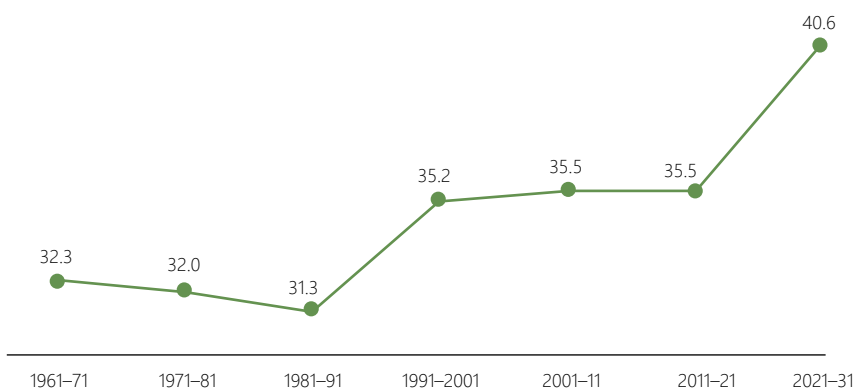
Figure 2.4: Projected share of the elderly population, India and states, 2021 versus 2036



Source: Ministry of Health and Family Welfare, *Population Projections for India and States 2011-36: Report on the Technical Group of Population Projections* (National Commission on Population, Ministry of Health and Family Welfare, Government of India, 2020), available at https://main.mohfw.gov.in/sites/default/files/Population%20Projection%20Report%202011-2036%20-%20upload_compressed_0.pdf.

The decadal growth of the elderly population in India declined slightly from 32 percent between 1961 and 1971 to 31 percent in 1981–1991 (Figure 2.5). Growth picked up pace during 1991–2001 (35 percent) and is projected to shoot to 41 percent between 2021 and 2031.

Figure 2.5: Decadal growth (%) of the elderly population, 1961–2031



Note: Projections beyond 2011 are based on data drawn from *Census of India 2011*.

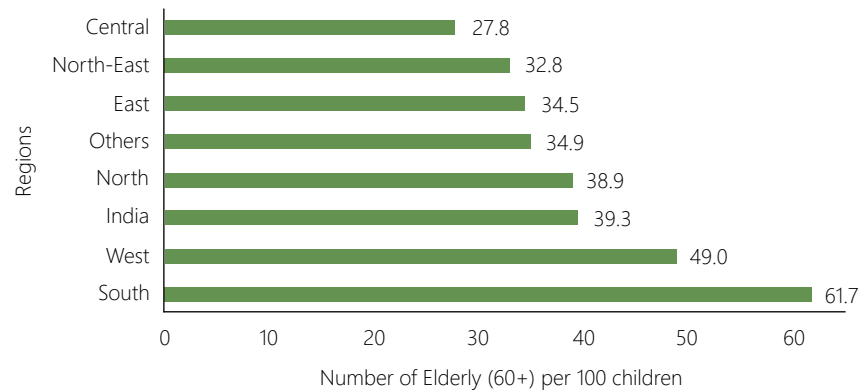
Source: ORGI. *Census of India 2011* (Office of Registrar General & Census Commissioner, Ministry of Home Affairs, Government of India, 2011).

2.3.3 Ageing index

The ageing index measures the number of elderly (60+ years) per 100 children population (below 15 years) and the index score increases as the population ages. There are 39 older persons per 100 children in India according to 2021 population estimates. States with a higher share of the elderly population (such as those in southern India) also show a higher score for an ageing index, indicative of the decline in fertility leading to a rising number of older persons as compared to children (Figure 2.6). Compared to southern and western India, central and north-eastern regions have the younger group of states as indicated by the ageing index.

India has witnessed moderate to high pace of decadal growth in elderly population since 1961. Evidently, the pace was slower before 2001 but is expected to increase sharply in coming decades.

Figure 2.6: Ageing index across regions in India, 2021



Notes:

North: Jammu and Kashmir, Himachal Pradesh, Punjab, Uttarakhand, Haryana Delhi, Rajasthan

West: Gujarat, Maharashtra

East: Bihar, West Bengal, Jharkhand, Odisha

Central: Uttar Pradesh, Chhattisgarh, Madhya Pradesh

North-East: Sikkim, Arunachal Pradesh, Nagaland, Manipur, Mizoram, Tripura, Meghalaya, Assam

South: Andhra Pradesh, Telangana, Karnataka, Kerala, Tamil Nadu

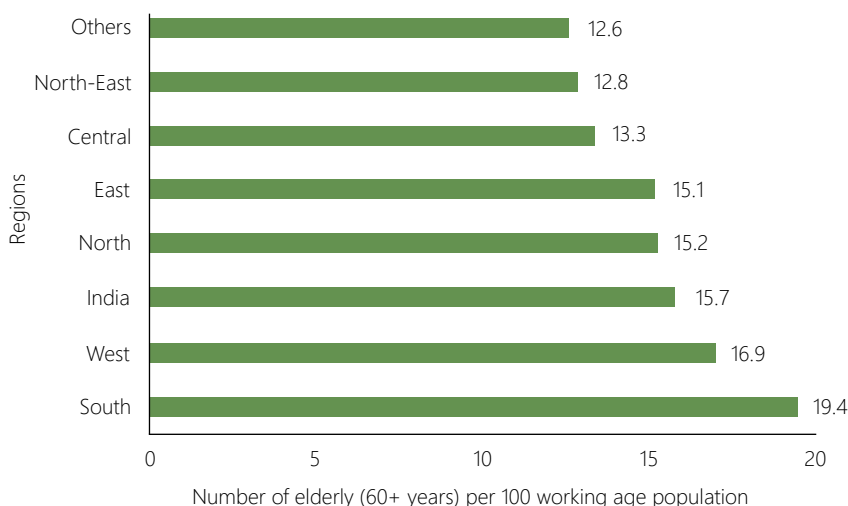
Others: Daman and Diu, Dadra and Nagar Haveli, Chandigarh, Lakshadweep, Puducherry, Andaman, Nicobar and Goa

Source: Ministry of Health and Family Welfare, *Population Projections for India and States 2011-36: Report on the Technical Group of Population Projections* (National Commission on Population, Ministry of Health and Family Welfare, Government of India, 2020), available at https://main.mohfw.gov.in/sites/default/files/Population%20Projection%20Report%202011-2036%20-%20upload_compressed_0.pdf.

2.3.4 Old-age dependency ratio

The old-age dependency ratio of a population represents the number of persons aged 60+ years per 100 persons in the 15–59 years (or working-age) group. The higher the ratio, the greater the old age-related dependency, reflecting higher levels of demand for care from immediate family. Population projections indicate that in 2021, there were 16 older persons per 100 working-age persons in India, with significant variations across regions (Figure 2.7). In line with the findings regarding the ageing index, in the southern region, the old-age dependency ratio was higher than the national average at around 20 as is true of western India at 17. Overall, Union Territories (13) and the north-eastern region (13) reflected lower old-age dependency ratios.

Figure 2.7: Old-age dependency ratio across regions, 2021



Notes:

North: Jammu and Kashmir, Himachal Pradesh, Punjab, Uttarakhand, Haryana, Delhi, Rajasthan

West: Gujarat, Maharashtra

East: Bihar, West Bengal, Jharkhand, Odisha

Central: Uttar Pradesh, Chhattisgarh, Madhya Pradesh

North-East: Sikkim, Arunachal Pradesh, Nagaland, Manipur, Mizoram, Tripura, Meghalaya, Assam

South: Andhra Pradesh, Telangana, Karnataka, Kerala, Tamil Nadu

Others: Daman and Diu, Dadra and Nagar Haveli, Chandigarh, Lakshadweep, Puducherry, Andaman, Nicobar and Goa

Source: Ministry of Health and Family Welfare, *Population Projections for India and States 2011-36: Report on the Technical Group of Population Projections* (National Commission on Population, Ministry of Health and Family Welfare, Government of India, 2020), available at https://main.mohfw.gov.in/sites/default/files/Population%20Projection%20Report%202011-2036%20-%20upload_compressed_0.pdf.

2.3.5 Life expectancy

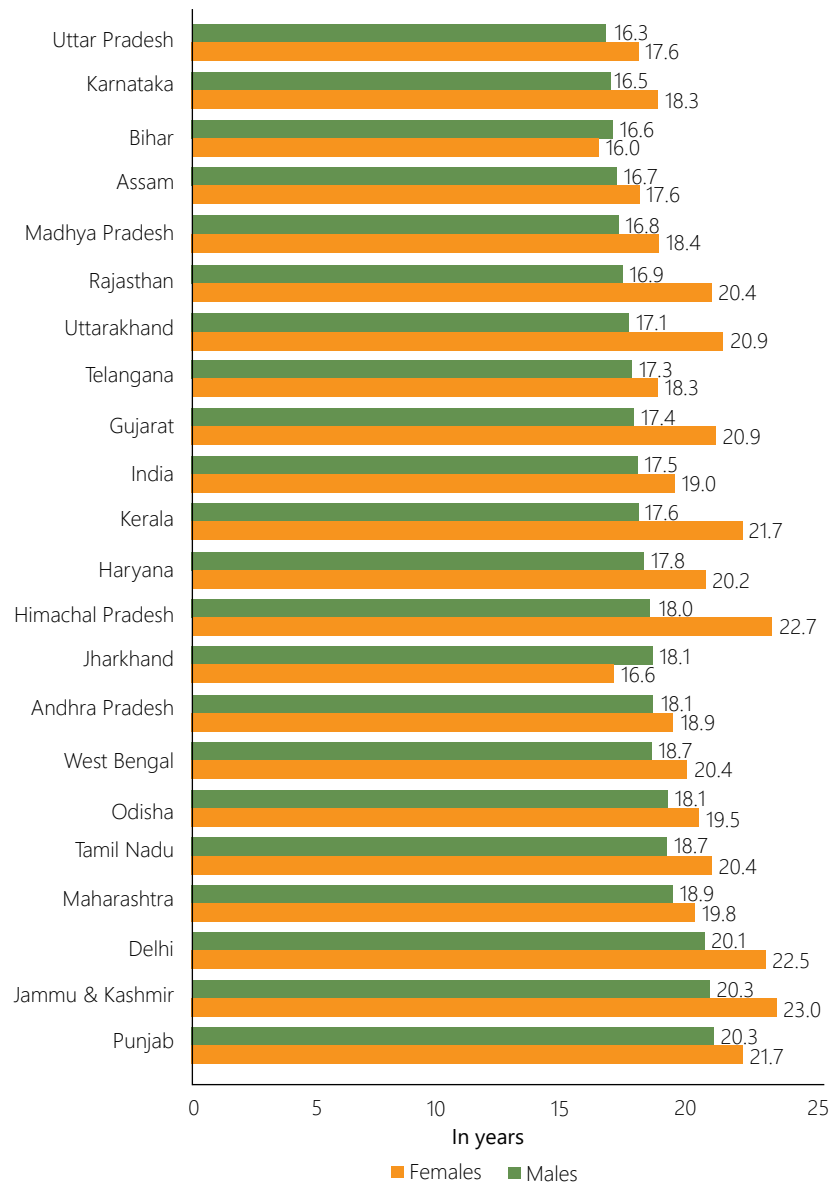
Life expectancy at 60 years is derived from life tables, which are constructed based on sex- and age-specific death rates. In India, the life tables are provided by the Office of the Registrar General & Census Commissioner using data from the Sample Registration System and are usually derived for a period of five years. The latest life tables are for the period 2015–2019.

Life expectancy at 60 years reflects the average number of years that a person of 60 years could expect to live, based on the sex- and age-specific death rates prevailing at the time (in the specific year that

Higher old-age dependency ratio indicates higher demand for support from the next generation in terms of caregiving, social and financial needs.

he/she attained 60 years of age), in the country or state of his/her residence. Similarly, life expectancy at 75 years reflects additional life years for those who attained the age of 75 years (again based on prevailing death rates for the sex, year and place).

Figure 2.8: Life expectancy at 60 years differentiated by sex across states, 2015–2019



Source: Office of the Registrar General & Census Commissioner, India, Sample Registration System-based 'Abridged Life Tables 2015-19', (Ministry of Home Affairs, Government of India, New Delhi, 2022).

At 60 years, a person in India may expect to live another 18.3 years, which is higher in case of females at 19 years as compared to males at 17.5 years. Feminization of ageing reflects the extra life years survived by elderly females (as compared to males) at the age of 60 years. For instance, in Himachal Pradesh (in northern India) and Kerala (in southern India), women at 60 years have a life expectancy of 23 and 22 years respectively which is 4 years greater than men at 60 years in these states (as compared to the national average differential of only 1.5 years) (Figure 2.8). Life expectancy of women at 60 years is greater than 20 years in states such as Rajasthan, Haryana, Gujarat, Uttarakhand, Kerala, Himachal Pradesh and the Union Territory of Jammu & Kashmir, raising concerns about their social and economic well-being.

In states where life expectancy at 75 years exceeds 10 years, programmes and policies to support a healthier life for the oldest of the old persons are clearly called for (Figure 2.9).

Figure 2.9: Life expectancy at 75 years across states, 2015–2019



Source: Office of the Registrar General & Census Commissioner, India, Sample Registration System-based 'Abridged Life Tables 2015-19', (Ministry of Home Affairs, Government of India, New Delhi, 2022).

Increasing life expectancy in the twilight years indicates a need for focus on inclusive health and social and economic well-being of older persons.

2.4 Challenges of an Ageing Population

Three aspects of ageing that create significant challenges are: (a) women living longer than men (feminization) resulting in higher levels of widowhood and associated socio-cultural and economic deprivations and dependencies; (b) high proportion of rural population among the elderly (ruralization); and (c) ageing of the aged persons.

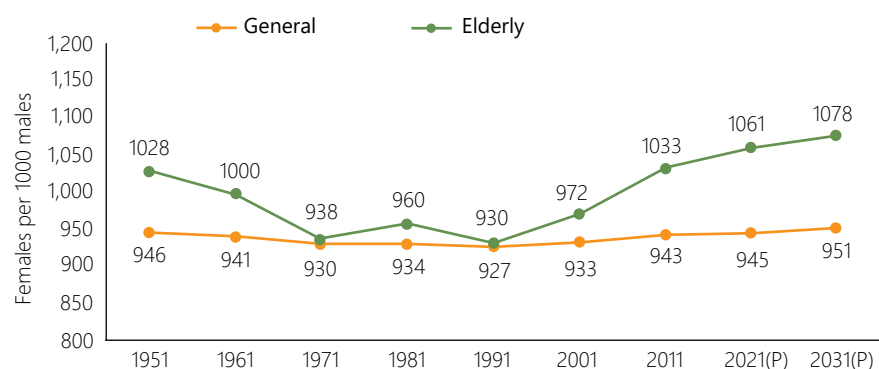
2.4.1 Feminization

Gender disparities exist at all ages but when women become old, the consequences become more acute. Poverty is inherently gendered in old age when older women are more likely to be widowed, living alone, with no income and with fewer assets of their own, and fully dependent on family for support.

Incidence of widowhood and higher life expectancy among older women are key demographic characteristics in India. Elderly widowed women are often alone with little support and also experience greater incidence of morbidities that are functionally restricting. A larger percentage of women among the oldest of the old signifies a higher imbalance in the demographic structure and entails additional resource pooling for associated support and care giving. Since 1991, the sex ratio (females per 1,000 males) among the elderly has been climbing steadily, while the sex ratio of the general population remains the same. A sex ratio of greater than 1,000 implies a larger number of elderly women than men, something that is not true for the general population (Figure 2.10).

Interregional variations in the elderly sex ratio are noteworthy. Between 2011 and 2021, the ratio increased in India as a whole and across all regions barring the Union Territories and western India. In the north-east and the east, while the ratio increased, it remained

Figure 2.10: Sex ratio of the general and elderly population, 1951–2031

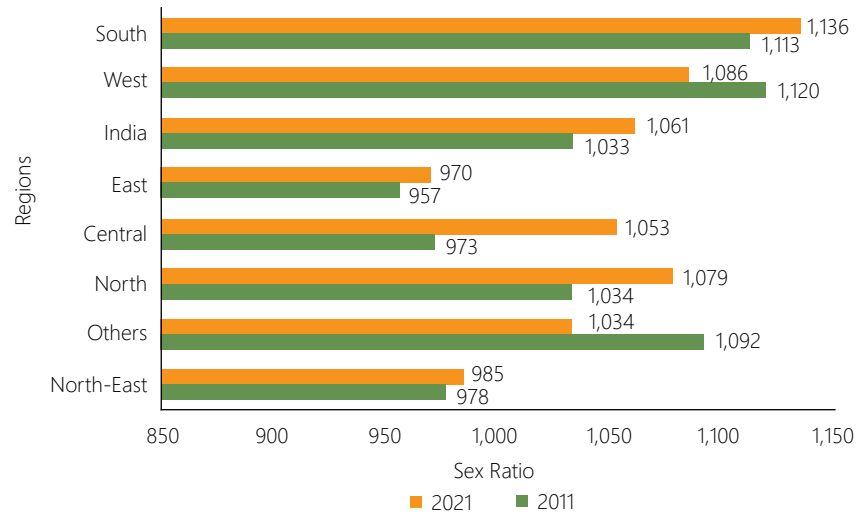


Abbreviation: P, Projected.

Sources: Office of the Registrar General and the Census Commissioner, India, *Census of India, 2011* (Ministry of Home Affairs, Government of India), available at <https://censusindia.gov.in/census.website/>. | Ministry of Health and Family Welfare, *Population Projections for India and States 2011-36: Report on the Technical Group of Population Projections* (National Commission on Population, Ministry of Health and Family Welfare, Government of India, 2020), available at https://main.mohfw.gov.in/sites/default/files/Population%20Projection%20Report%202011-2036%20-%20upload_compressed_0.pdf.

below 1,000 in both years, indicating that the men still outnumber the women in these regions even at 60+ years. This, however, is not true for the other regions (which has a bearing on the country's average). A case in point is central India where the sex ratio went from 973 in 2011 to 1,053 in 2021, implying that the women caught up with and outperformed the men in survival after 60 years over the decade (Figure 2.11).

Figure 2.11: Older women per 1,000 older men by region, 2011 versus 2021



Notes:

North: Jammu and Kashmir, Himachal Pradesh, Punjab, Uttarakhand, Haryana, Delhi, Rajasthan
 West: Gujarat, Maharashtra
 East: Bihar, West Bengal, Jharkhand, Odisha
 Central: Uttar Pradesh, Chhattisgarh, Madhya Pradesh
 North-East: Sikkim, Arunachal Pradesh, Nagaland, Manipur, Mizoram, Tripura, Meghalaya, Assam
 South: Andhra Pradesh, Telangana, Karnataka, Kerala, Tamil Nadu
 Others: Daman and Diu, Dadra and Nagar Haveli, Chandigarh, Lakshadweep, Puducherry, Andaman, Nicobar and Goa

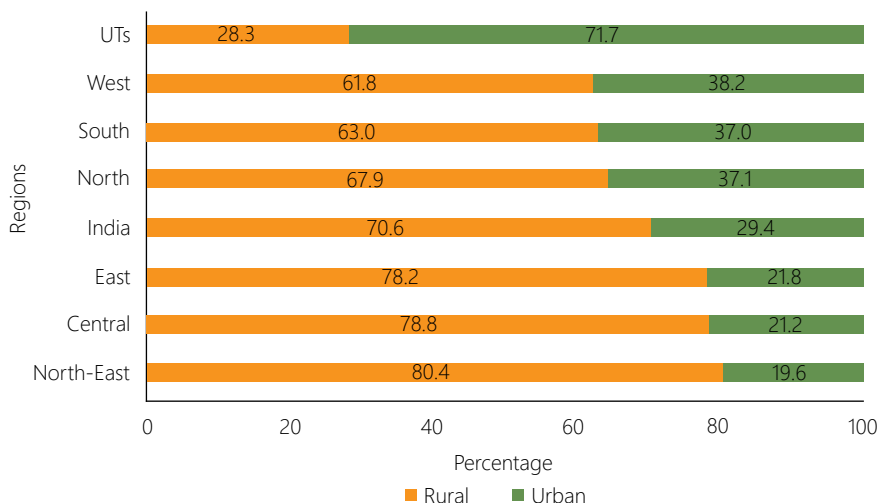
Sources: Office of the Registrar General and the Census Commissioner, India, *Census of India, 2011* (Ministry of Home Affairs, Government of India, 2011), available at <https://censusindia.gov.in/census.website/>. | Ministry of Health and Family Welfare, *Population Projections for India and States 2011-36: Report on the Technical Group of Population Projections* (National Commission on Population, Ministry of Health and Family Welfare, Government of India, 2020), available at https://main.mohfw.gov.in/sites/default/files/Population%20Projection%20Report%202011-2036%20-%20upload_compressed_0.pdf.

2.4.2 Ruralization

According to *Census of India 2011*, on an average, 71 percent of older persons live in rural areas, with significant interregional variation, ranging from 62–63 percent in the west and south to 78–80 percent in the east, north and north-east (Figure 2.12). A greater share of city dwellers in the total 60+ years’ population is seen only in the Union Territories (71.7 percent). Large parts of rural India are still remote with poor road and transport access. Income insecurity, lack of access

to adequate and quality healthcare and isolation are, therefore, more acute for the rural elderly than their urban counterparts.

Figure 2.12: Older population by area of residence across regions, 2011



Notes:

North: Jammu and Kashmir, Himachal Pradesh, Punjab, Uttarakhand, Haryana Delhi, Rajasthan

West: Gujarat, Maharashtra, Goa

East: Bihar, West Bengal, Jharkhand, Odisha

Central: Uttar Pradesh, Chhattisgarh, Madhya Pradesh

North-East: Sikkim, Arunachal Pradesh, Nagaland, Manipur, Mizoram, Tripura, Meghalaya, Assam

South: Andhra Pradesh, Telangana, Karnataka, Kerala, Tamil Nadu

UTs: Daman and Diu, Dadra and Nagar Haveli, Chandigarh, Lakshadweep, Puducherry, Andaman, Nicobar

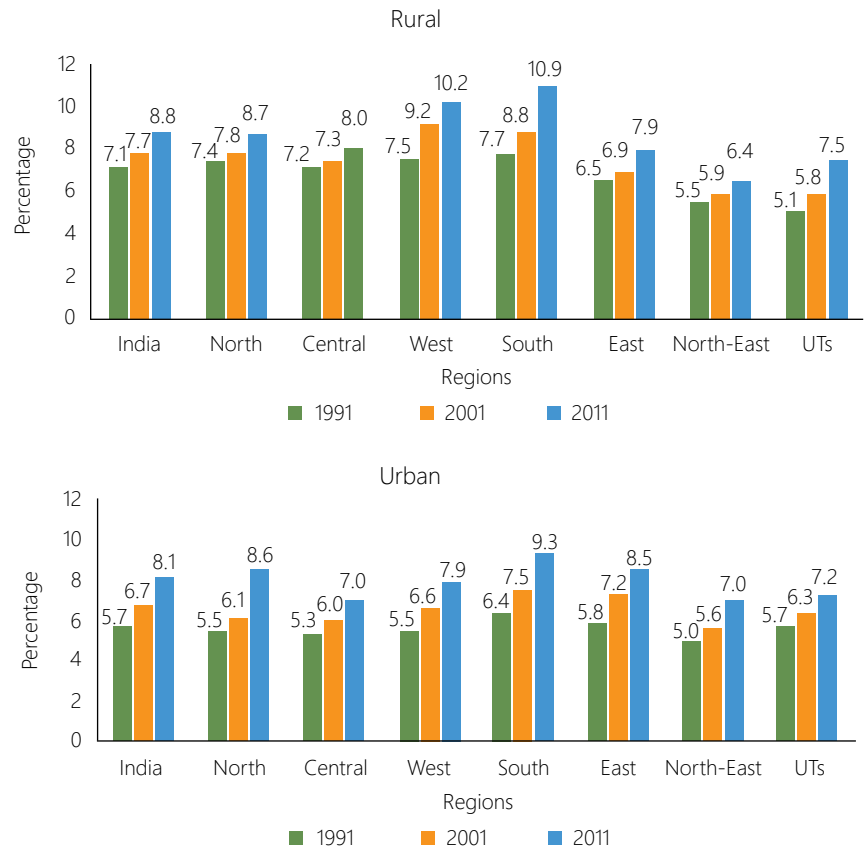
Abbreviation: UT, Union Territory.

Source: Office of the Registrar General and the Census Commissioner, India, *Census of India, 2011* (Ministry of Home Affairs, Government of India, 2011), available at <https://censusindia.gov.in/census.website/>.

In 2011, persons aged 60+ years comprised 8.8 percent of the total rural population and 8.1 percent of the total urban population (Figure 2.13). While the percentage of the elderly in the total population has increased in both rural and urban areas between 1991 and 2011, the rate of increase has been higher in urban (by 2.4 percentage points) than rural areas (by 1.7 percentage points). We have already seen that southern and western India have a higher percentage of older population than the rest of the country. Rural–

urban differentials indicate that ageing is more pronounced in rural areas in these regions with more than 10 percent of the rural population being 60+ years in 2011.

Figure 2.13: Share of the elderly in total population by region, rural versus urban, 1991, 2001 and 2011



Notes:

North: Jammu and Kashmir, Himachal Pradesh, Punjab, Uttarakhand, Haryana, Delhi, Rajasthan
 West: Gujarat, Maharashtra, Goa

East: Bihar, West Bengal, Jharkhand, Odisha

Central: Uttar Pradesh, Chhattisgarh, Madhya Pradesh

North-East: Sikkim, Arunachal Pradesh, Nagaland, Manipur, Mizoram, Tripura, Meghalaya, Assam

South: Andhra Pradesh, Telangana, Karnataka, Kerala, Tamil Nadu

UTs: Daman and Diu, Dadra and Nagar Haveli, Chandigarh, Lakshadweep, Puducherry, Andaman, Nicobar

For 1991 Census: India excludes Jammu and Kashmir; Uttarakhand in North, Chhattisgarh in Central, Telangana in South and Jharkhand in East are the part of their parent states.

Abbreviation: UT, Union Territory.

Source: Office of the Registrar General and the Census Commissioner, India, *Census of India, 2011* (Ministry of Home Affairs, Government of India, 2011), available at <https://censusindia.gov.in/census.website/>.

2.4.3 Ageing of the aged

During 2000–2022, the total population of the country grew by 34 percent, while the population of 60+ years grew by 103 percent. The population growth of older persons aged 80+ years has been even higher at 128 percent during the same period. Projections indicate that during 2022–2050, the overall population of India will grow by 18 percent only, while the older population will grow by 134 percent. During the same period, the population of persons aged 80+ years will grow 279 percent with a predominance of widowed and highly dependent very old women. The number of older women compared to the number of older men will progressively increase with advancing ages from 60 through 80 years and therefore, policies and programmes must especially focus on the special needs of these very old women.

A key characteristic of India's ageing process is the north–south dichotomy represented by the increasing size and share of the older population.

2.5 Socio-Demographic Status of the Older Population

This section draws upon the LASI survey 2018 to discuss marital status, living arrangements, income sources and economic dependency, and health conditions of the elderly in India.⁵ The LASI was a large-scale nation-wide survey-based scientific investigation of the health, economic, and social determinants and consequences of population ageing in India. The survey included 31,464 older persons (60+ years) from across 35 states and Union Territories.

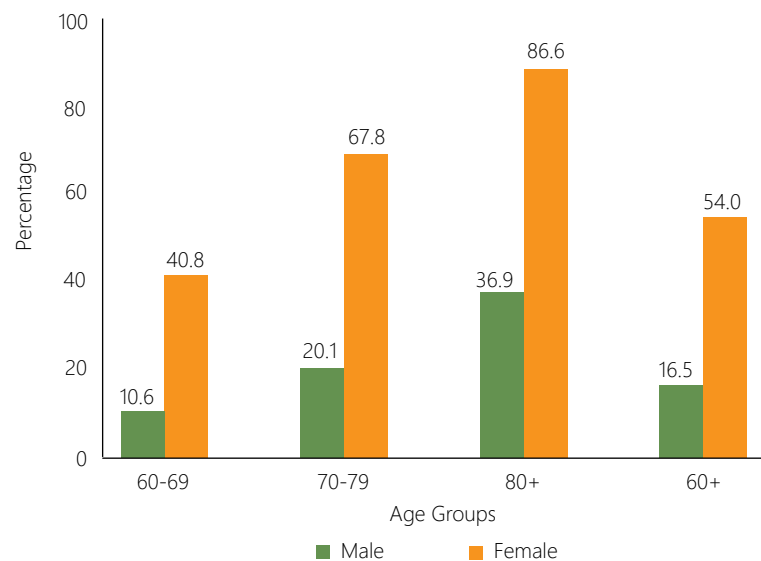
2.5.1 Marital status

The loss of one's spouse in old age adds significant vulnerability to the life of the surviving partner. The incidence of widowhood among older persons, therefore, is an important indicator of old-age vulnerability being experienced in a society. According to *Census of India 2011*, nearly

⁵ IIPS, NPHCE, HSPH and USC, *Longitudinal Ageing Study in India (LASI) Wave 1, 2017–18, India Report*, (International Institute for Population Sciences, Mumbai; National Programme for Health Care for Elderly, Ministry of Health & Family Welfare; Harvard T. H. Chan School of Public Health; and the University of Southern California, 2020), available at https://iipsindia.ac.in/sites/default/files/LASI_India_Report_2020_compressed.pdf.

66 percent of those over 60 years of age were 'currently married', 32 percent widowed and about 3 percent separated or divorced. However, gender differentials were significant with 82 percent of older men (as compared to 50 percent of older women) being currently married. Incidence of widowhood (that is, death of spouse) was, thus, much higher among women (48 percent) as compared to men (15 percent).⁶ Data from the LASI survey supports these findings with 54 percent of 60+ years of women being widowed as compared to 16 percent men (Figure 2.14). The gender differential in incidence of widowhood is seen to increase in higher age cohorts with 87 percent of 80+ years of women being widowed as opposed to only 37 percent men. Since women in India are more likely to be dependent on their spouses for financial security, they face greater adversities due to loss of spouse as compared to men. Lack of financial or material support for the elderly widowed is a matter of concern for future security and increased risk of deterioration in quality of life.

Figure 2.14: Widowhood among older persons, by age and sex, 2017/18



Source: Computed from individual level data of the *Longitudinal Ageing Study in India: Wave 1, 2017-18*, (International Institute for Population Sciences; National Programme for Health Care of the Elderly, Ministry of Health and Family Welfare, Government of India; Harvard T. H. Chan School of Public Health and the University of Southern California; 2020).

⁶ Office of the Registrar General and the Census Commissioner, India, *Census of India, 2011* (Ministry of Home Affairs, Government of India, 2011), available at <https://censusindia.gov.in/census.website/>.

More than half the 60+ years of women in India are widowed, with the proportion increasing significantly in higher age cohorts. Physical and financial well-being of elderly widowed women is therefore a key policy concern.

2.5.2 Living arrangements

The well-being of older persons can also greatly depend on who they live with, particularly in developing countries where older persons have little recourse to formal welfare systems. In the last few decades, change in education, consumer expenditure, marital status, intergenerational relationship and support have had a bearing on the choice of living arrangements in the pursuit of economic independence and privacy.⁷

Living arrangements among the elderly were not a matter of discussion in India till a few decades ago because their families were expected to take care of them. However, with the reduction in fertility and increased life expectancy at old ages, traditional living arrangements have come under significant strain. The disintegration of families started in the last few decades and has become a prominent phenomenon as the younger generation is migrating to urban areas for employment and better economic achievements. With declining informal social support systems, older persons (especially women) who live alone are likely to be more vulnerable than those who live with their families. While majority of the elderly are still living with their adult children in India, about one-fifth either live alone or only with the spouse and hence, must manage their material and physical needs on their own (Figure 2.15).

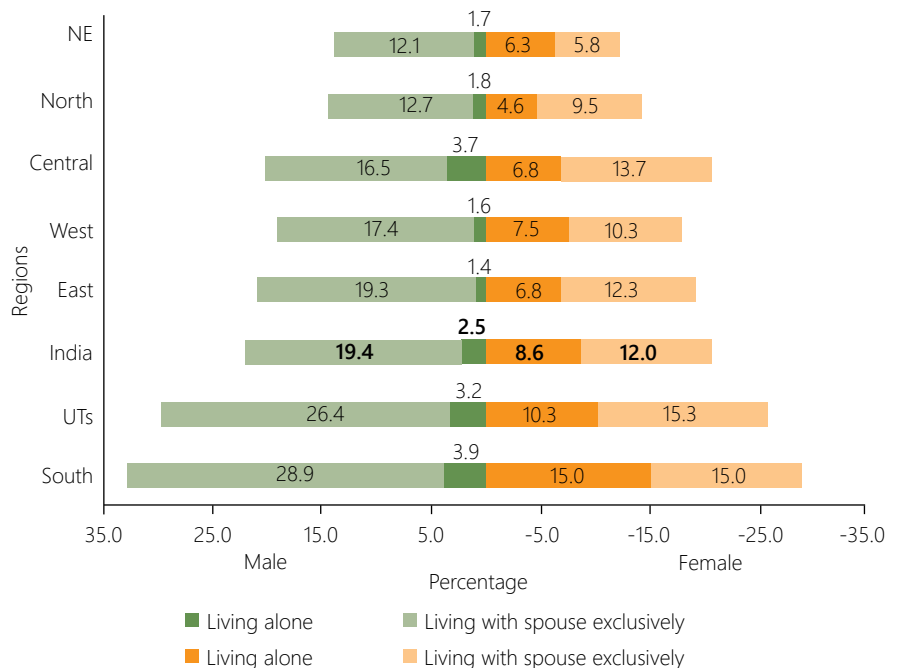
Around 2.5 percent of the elderly men and 8.6 percent of the elderly women were living alone in India according to the LASI survey. About one in five elderly men and one in eight elderly women lived exclusively with their spouse. The higher share of elderly men living exclusively with their spouse suggests a higher life expectancy

⁷ S. Kumar and K. A. Kumar, 'Living Arrangement and Economic Dependency among the Elderly in India: A Comparative Analysis of EAG and Non EAG States', *Ageing International*, vol. 44, pp. 352–370 (Springer, 2019), available at <https://doi.org/10.1007/s12126-019-9344-3>. | J. Bongaarts and Z. Zimmer, 'Living arrangements of older adults in the developing world: An analysis of demographic and health survey household surveys', *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, vol. 57 (3), pp. S145–S157 (Oxford Academic, Oxford University Press, 2002).

Living alone is a growing phenomenon among older females due to higher life expectancy and higher incidence of widowhood. Older men are more likely to be living exclusively with their spouse than alone in India.

among older women. This also indicates long spans of unsupported widowhood at the later ages. Among the older men, the percentage living alone is higher in southern (3.9 percent) and central regions (3.7 percent) as compared to the east, west and north. Share of elderly men living exclusively with their spouse was much higher in the Union Territories (26.4) and the south (28.9) than the rest of India. Over 15 percent of elderly women in south India were living alone

Figure 2.15: Living arrangements (by sex and across regions) of older persons not living with their adult children



Notes:

North: Jammu and Kashmir, Himachal Pradesh, Punjab, Uttarakhand, Haryana, Delhi, Rajasthan
 West: Gujarat, Maharashtra, Goa
 East: Bihar, West Bengal, Jharkhand, Odisha
 Central: Uttar Pradesh, Chhattisgarh, Madhya Pradesh
 North-East (NE): Sikkim, Arunachal Pradesh, Nagaland, Manipur, Mizoram, Tripura, Meghalaya, Assam
 South: Andhra Pradesh, Telangana, Karnataka, Kerala, Tamil Nadu
 Union Territories (UTs): Daman and Diu, Dadra and Nagar Haveli, Chandigarh, Lakshadweep, Puducherry, Andaman and Nicobar.

Source: Computed from individual level data of the *Longitudinal Ageing Study in India: Wave 1, 2017-18*, (International Institute for Population Sciences; National Programme for Health Care of the Elderly, Ministry of Health and Family Welfare, Government of India; Harvard T. H. Chan School of Public Health and the University of Southern California; 2020).

(as compared to 3.9 percent men) indicating higher vulnerabilities. In fact, the south is the only region where the percentage of elderly women living alone is even higher than the percentage living exclusively with their spouse (13.6 percent).

2.6 Economic Status

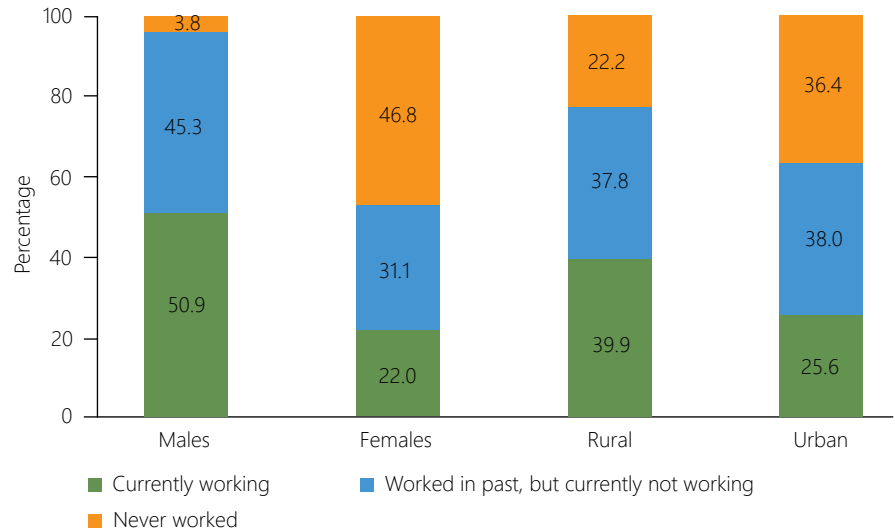
Income insecurity is one of the major causes of vulnerability in old age. In India, it is normative for families to take care of the needs of older persons, including economic and social needs. With the changing socio-economic, demographic and development scenario, financial security arising from personal income and asset ownership has become a major determinant of well-being of older persons. However, if income primarily accrues from their work, it is very likely that their dependence on work will increase with age.

2.6.1 Work participation

The definition of work used in the LASI survey is comprehensive and includes agricultural work, wages/salary, self-employed activities and unpaid family business work excluding one's own housework. Three mutually exclusive categories of work are defined: (a) currently working (worked at the time of the survey); (b) worked in the past for at least three months continuously at some point in their lifetime, but currently not working; and (c) never worked.

Nearly half the men aged 60+ years (50.9 percent) were currently working, while the work participation rate among older women was only at 22 percent (Figure 2.16). While only 4 percent older males reported that they had never worked in the past, 47 percent of the women did so—understandable in the Indian context. Work participation of older persons also varied by place of residence and a higher proportion of them reported currently working in rural areas (39.9 percent) than in urban areas (25.6 percent), indicating that the rural elderly continued to work in the agriculture sector beyond 60 years of age.

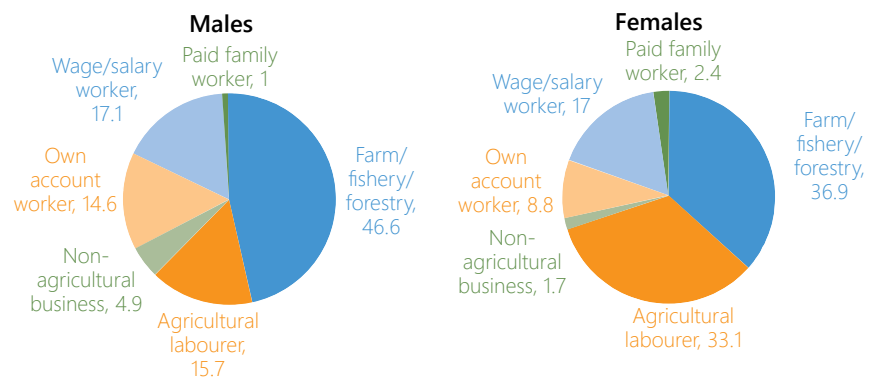
Figure 2.16: Percentage distribution of men and women aged above 60 years by work status and place of residence



Source: Computed from individual level data of the *Longitudinal Ageing Study in India: Wave 1, 2017-18*, (International Institute for Population Sciences; National Programme for Health Care of the Elderly, Ministry of Health and Family Welfare, Government of India; Harvard T. H. Chan School of Public Health and the University of Southern California; 2020).

Economic activities of currently working older persons were mostly in the informal and unorganized sectors. Around 47 percent of the older men and 37 percent of the older women were currently

Figure 2.17: Type of work of the 'currently working' older persons by sex



Source: Computed from individual level data of the *Longitudinal Ageing Study in India: Wave 1, 2017-18*, (International Institute for Population Sciences; National Programme for Health Care of the Elderly, Ministry of Health and Family Welfare, Government of India; Harvard T. H. Chan School of Public Health and the University of Southern California; 2020).

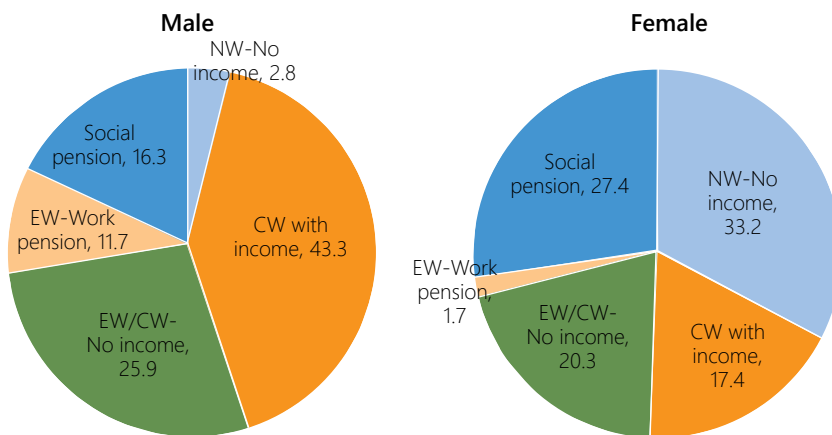
working in agriculture and/or allied activities (farm/fishery/forestry). In addition, 16 percent of men and 33 percent of women were engaged as agricultural labour (Figure 2.17). Only around 17 percent of older persons got wages or salaries for their economic participation.

2.6.2 Sources of income

Ageing is directly associated with economic dependency given loss of income coupled with increased healthcare expenditure. Low participation in the formal economy restricts access to fixed pension and increases economic insecurity.

The LASI survey indicates that around 33 percent of the older females have never worked and do not have any income (Figure 2.18). A larger percentage of the male elderly belongs to the category of having ever worked or currently working but earn

Figure 2.18: Sources of income among the older population by sex



Abbreviations: CW, currently working; EW, ever worked; NW, never worked.

Notes:

1. CW with income also includes elderly with multiple sources of income like wages/salaries, work-related pension or social pension.
2. EW-work pension also includes respondents with social pension apart from work pension.

Source: Computed from individual level data of the *Longitudinal Ageing Study in India: Wave 1, 2017-18*, (International Institute for Population Sciences; National Programme for Health Care of the Elderly, Ministry of Health and Family Welfare, Government of India; Harvard T. H. Chan School of Public Health and the University of Southern California; 2020).

no income (25.9 percent) as compared to females (20.3 percent). Higher proportion of the male elderly were currently working and earning income (43.3 percent) than their female counterparts (17.4 percent). In terms of pension, nearly 11 percent of elderly males received pension from their previous work and 16.3 percent were receiving social pension exclusively. In case of females, 27.4 percent were exclusively getting social pension while only 1.7 percent were getting pension from their previous work.

2.7 Health Status

Health is determined by several economic, social, psychological and physiological factors. Poor health and morbidity diminish the quality of life and well-being of the elderly while increasing psychological distress and perception of vulnerability.

Ageing is associated with poor health status due to chronic morbid conditions and degenerating physiological capacity. Fundamentally, it affects the functional capacities that are required to perform activities of daily living (ADL).⁸ Poor health status reflects a decline in functional capacity, poor perception about physical or mental status, socio-economic relevance of health, poor quality of healthcare access, etc. Based on the LASI survey data, this section discusses the prevalence of chronic morbidity among older population, nutritional status (measured by body mass index) and extent of disability and functional restrictions.

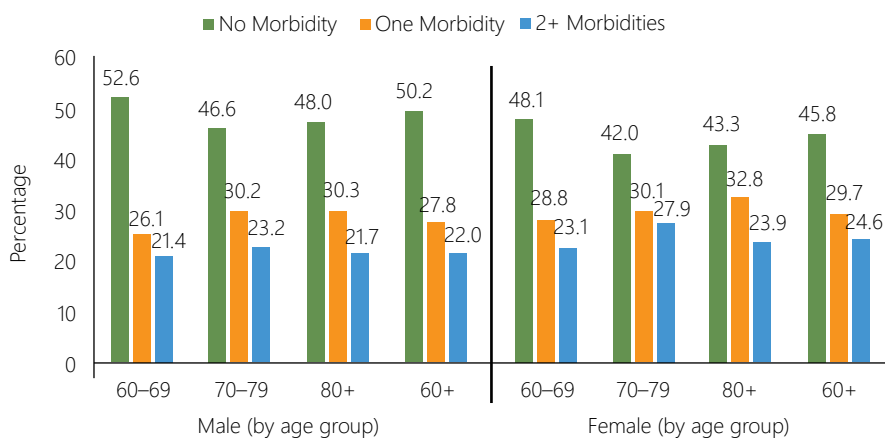
2.7.1 Prevalence of chronic morbidities

Poor outcome of health is reflected in the higher incidence of chronic diseases that impair the elderly and impede ADL. Chronic morbid conditions probed for in the LASI survey included hypertension, diabetes, cancer or malignant tumour, chronic lung diseases, chronic heart diseases, stroke, arthritis/osteoporosis, high cholesterol, and neurological conditions including psychiatric problems such as depression, Alzheimer's/dementia, unipolar/bipolar disorders,

⁸ Activities of daily living (ADL) are the basic tasks of everyday life such as feeding, bathing, dressing, mobility, use of the toilet and continence.

convulsions, Parkinson’s, etc. Prevalence of chronic morbid conditions was lower among the older men than women. Over 30 percent of the elderly women and 28 percent of the men suffered from one chronic morbid condition and nearly one fourth (across both sexes) suffered from more than two morbid conditions. With the increasing age, the share in such conditions gradually increased in the cohort (Figure 2.19).

Figure 2.19: Prevalence of chronic morbidities among the elderly, by age and sex



Source: Computed from individual level data of the *Longitudinal Ageing Study in India: Wave 1, 2017-18*, (International Institute for Population Sciences; National Programme for Health Care of the Elderly, Ministry of Health and Family Welfare, Government of India; Harvard T. H. Chan School of Public Health and the University of Southern California; 2020).

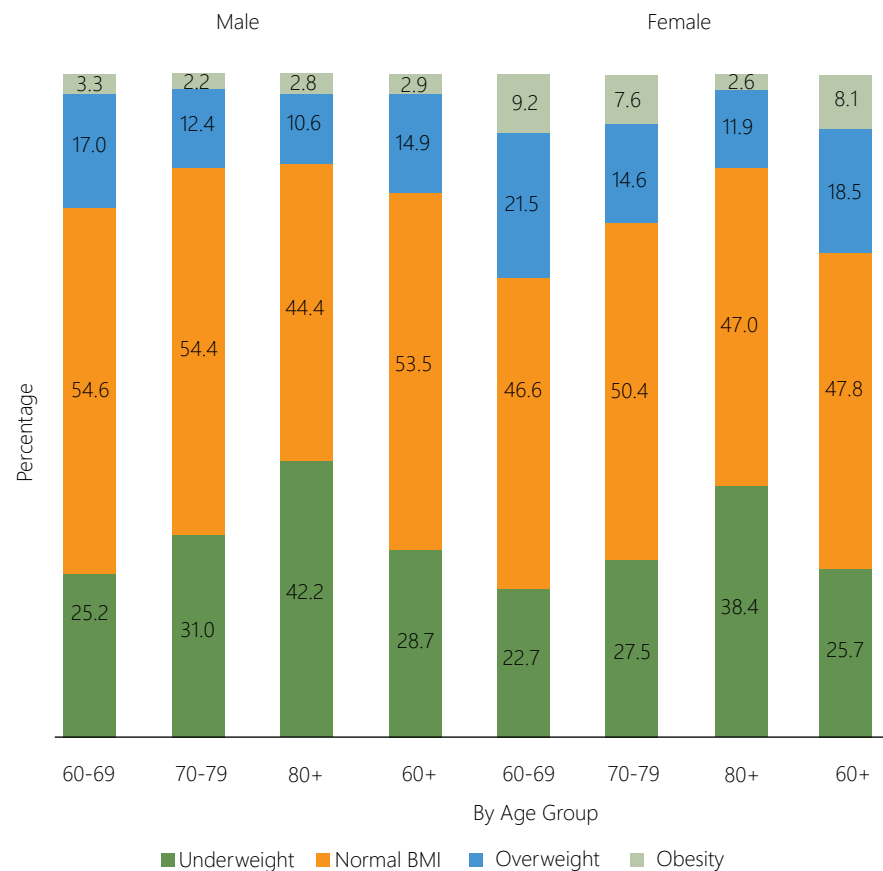
2.7.2 Nutritional status

Body mass index (BMI) is a well-established correlate of multi-morbidity and disability among older adults in the community and acute care settings.⁹ In India, 27.1 percent elderly were underweight, while 16.8 percent were overweight and 5.6 percent obese. With the increase in age, the incidence of underweight

⁹ Isaac Amankwaa et al., ‘Association between body mass index, multi-morbidity and activities of daily living among New Zealand nursing home older adults: a retrospective analysis of nationwide InterRAI data’, *BMC Geriatrics*, vol. 22(62), (Springer Nature, 2022), available at <https://doi.org/10.1186/s12877-021-02696-8>.

persons increased substantially among both men and women. Incidence of underweight men aged 60+ years was 28.7 percent and 25.7 percent of women aged 60+ years (Figure 2.20). The incidence of obesity was as high as 11.8 percent among the urban and 3.2 percent among the rural elderly.

Figure 2.20: Nutritional status of the population aged 60 years and above, by age and sex

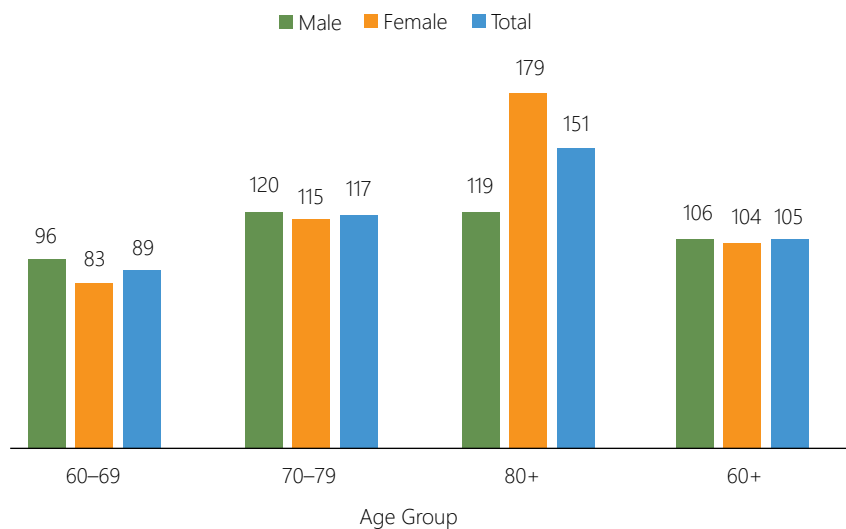


Source: Computed from individual level data of the *Longitudinal Ageing Study in India: Wave 1, 2017-18*, (International Institute for Population Sciences; National Programme for Health Care of the Elderly, Ministry of Health and Family Welfare, Government of India; Harvard T. H. Chan School of Public Health and the University of Southern California; 2020).

2.7.3 Extent of disability or impairments

With the increase in age, disability becomes a major concern, seriously limiting ADL and hence, increasing the caregiving burden. The LASI also surveyed impairments among older persons in India related to physical, mental, hearing, speech and visual capabilities. Women over 80 years reported a far higher incidence of impairments (179 per 1,000) than their male counterparts (119 per 1,000). Among the 60+ years, incidence of any impairment was found to be 105 per 1,000 population (Figure 2.21).

Figure 2.21: Prevalence of impairment among the elderly (per '000 population), by age and sex

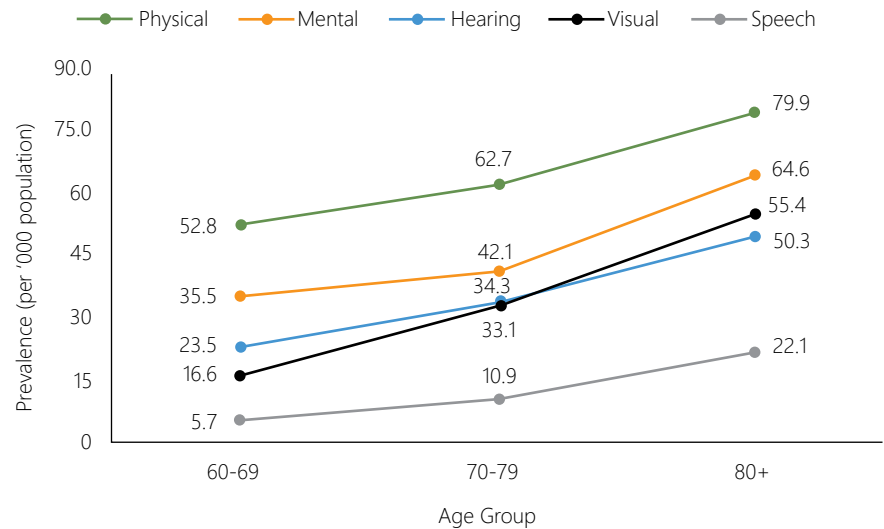


Note: Impairment includes any kind of physical, mental, hearing, visual, and speech difficulties.

Source: Computed from individual level data of the *Longitudinal Ageing Study in India: Wave 1, 2017-18*, (International Institute for Population Sciences; National Programme for Health Care of the Elderly, Ministry of Health and Family Welfare, Government of India; Harvard T. H. Chan School of Public Health and the University of Southern California; 2020).

Physical impairment was the most common among the elderly, followed by visual impairment, with impairment in speech being the least common (Figure 2.22).

Figure 2.22: Impairment by type and age group (per '000 population)

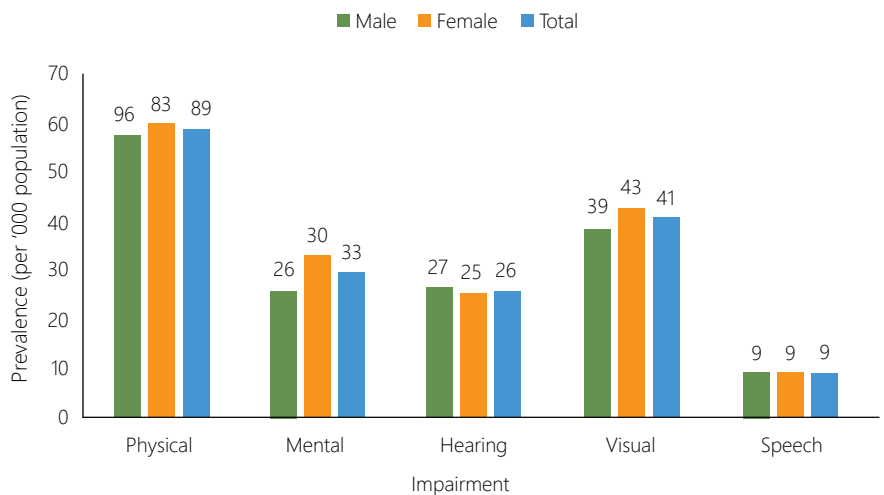


Source: Computed from individual level data of the *Longitudinal Ageing Study in India: Wave 1, 2017-18*, (International Institute for Population Sciences; National Programme for Health Care of the Elderly, Ministry of Health and Family Welfare, Government of India; Harvard T. H. Chan School of Public Health and the University of Southern California; 2020).

Physical impairment was the most common among the elderly, followed by visual impairment; with impairment in speech being the least common.

Incidence of physical, visual and mental impairment among 60+ years of women is higher than 60+ years of men (Figure 2.23).

Figure 2.23: Impairment by type and sex (per '000 population)



Source: Computed from individual level data of the *Longitudinal Ageing Study in India: Wave 1, 2017-18*, (International Institute for Population Sciences; National Programme for Health Care of the Elderly, Ministry of Health and Family Welfare, Government of India; Harvard T. H. Chan School of Public Health and the University of Southern California; 2020).

2.7.4 Functional restrictions

Vulnerability among older persons increases with the declining functional abilities. When they need assistance with ADL such as feeding, bathing, dressing, mobility, use of the toilet and continence, it increases care burden in the society.

The limitations imposed by chronic morbidity are measured through ADLs. The LASI survey canvassed a set of six questions regarding ADL including bathing, dressing, walking across the room, eating, getting in and out of bed, and visiting and using the toilet (including sitting down and getting up from it). One in five elderly suffered from at least one form of ADL limitations. The two most difficult activities were found to be getting in or out of bed and using toilets. The limitations of ADL increased with increasing age. On an average, limitations to perform any ADL were found to be higher for elderly women than elderly men in all age groups (Figures 2.24 a and b).

Figure 2.24a: Older women experiencing limitations in performing activities of daily living, by age

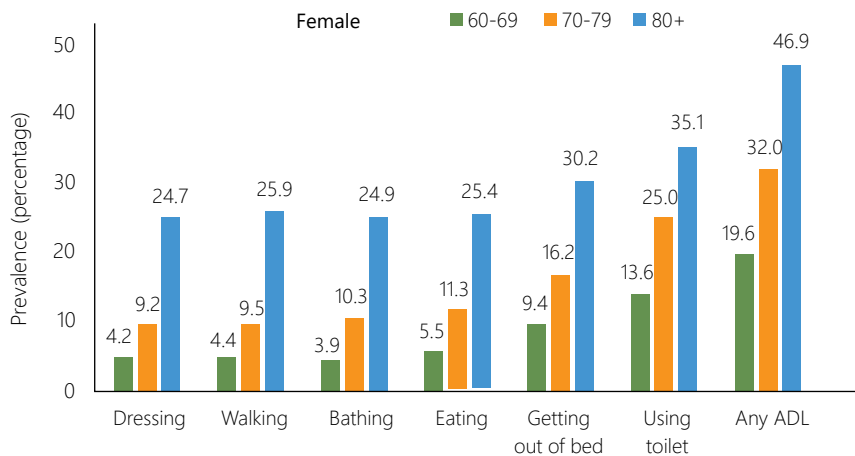
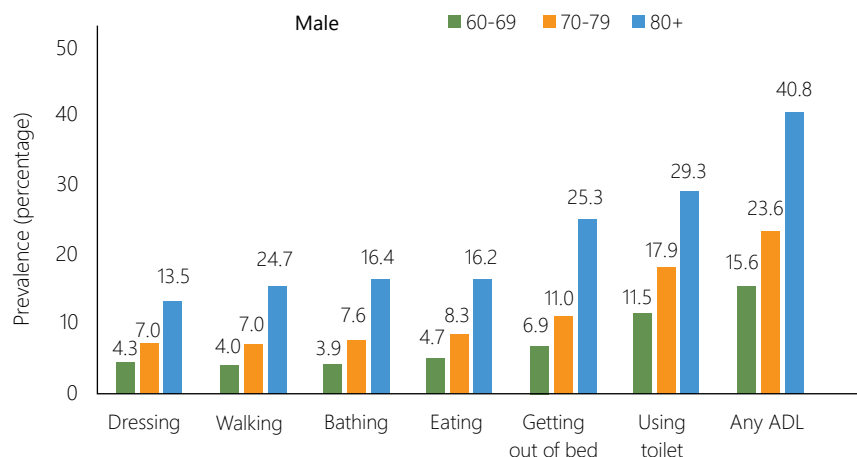


Figure 2.24b: Older men experiencing limitations in performing activities of daily living, by age



Source: Computed from individual level data of the *Longitudinal Ageing Study in India: Wave 1, 2017-18*, (International Institute for Population Sciences; National Programme for Health Care of the Elderly, Ministry of Health and Family Welfare, Government of India; Harvard T. H. Chan School of Public Health and the University of Southern California; 2020).

The ageing process brings with it deterioration of physical and mental capacities where the women are found to be at a greater disadvantage than the men though they outlive them. Physical and financial support and caring of older persons will be one of the most pertinent needs in the future.

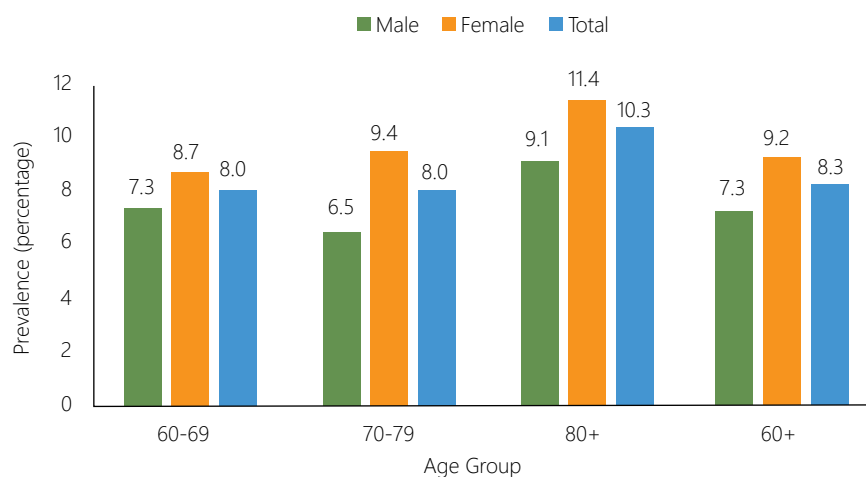
2.7.5 Use of assistive devices

The LASI survey also enquired about the use of assistive devices such as spectacles, hearing aids, dentures, walking sticks, wheelchairs, adjustable shower stools/commodores, back/neck collars, prosthesis and orthosis, etc., used by the elderly. The study found that only 44 percent were using assistive devices. The most used assistive devices among the elderly were spectacles (85.2 percent) and walking sticks (18.9 percent). The use of the assistive device increased with increasing age, among males, residing in urban areas, in higher wealth quintile and with higher educational levels. The LASI survey showed that of the total elderly reported to have a visual impairment, 23.8 percent were not using spectacles or contact lenses. Similarly, of the total elderly reported to have hearing impairment, around 91.7 percent were not using any hearing aid. This clearly showed an unmet need for assistive devices among the elderly.

2.7.6 Mental health

The LASI survey measured the incidence of depression (in the 12 months gone by) among respondents by administering the

Figure 2.25: Prevalence of depression among the elderly, by age and sex



Source: Computed from individual level data of the *Longitudinal Ageing Study in India: Wave 1, 2017-18*, (International Institute for Population Sciences; National Programme for Health Care of the Elderly, Ministry of Health and Family Welfare, Government of India; Harvard T. H. Chan School of Public Health and the University of Southern California; 2020).

Composite International Diagnostic Interview.¹⁰ Incidence of depression was seen to be rising with increasing age and was higher among elderly women than men (Figure 2.25).

2.8 Vulnerability among Older Population

Vulnerability refers to the analytical concept used initially in environmental science to study the human impact of natural calamities such as floods, droughts or earthquakes.¹¹ Different scholars have defined vulnerability in different ways contextualizing the relative importance. According to de Groot *et al.* (2019), vulnerability is closely related to the societal challenge of health inequalities and is also referred to as social disadvantage or deprivation (these terms

¹⁰ This 10-component scale is used to estimate the diagnostic symptoms-based prevalence of major depression. A score of more than 3 is considered to be major aspect of depression. For every 12 older persons in India, 1 suffers from major clinical depression.

¹¹ E. Schröder-Butterfill and R. Mariani, 'A framework for understanding old-age vulnerabilities', *Ageing & Society*, vol. 26(1), pp. 9–35 (Cambridge Core, Cambridge University Press, 2006).

Meaningful perspectives on the ageing process in India must look beyond demographic indicators to include the complex web of Indian social values, norms, culture, etc.

are used interchangeably).¹² Vulnerable populations are not affected by one set of risks only but by several risk factors.¹³

Meaningful perspectives on the ageing process in India must look beyond demographic indicators to include the complex web of Indian social values, norms, culture, etc. These aspects have a strong bearing on the vulnerability of the elderly which is conceptualized as an imbalance between their challenges and reserve capacities in terms of financial resources, family and social support.¹⁴ If vulnerabilities in critical aspects are not addressed adequately, quality of life suffers.

Understanding the spectrum of factors and determinants underlying vulnerability in old age is crucial to measuring the extent of disadvantages suffered by the elderly and creating a useful tool for policy formulators and programme implementers. Being closely linked to other determinants of multidimensional and multi-level old age vulnerabilities, this section discusses the state-wise indicators related to health and economic well-being of the elderly (see Annexe Table A2.1).

2.8.1 Vulnerability dimensions

Health-related dimensions of vulnerability

Health is important for ensuring behavioural responses of older people that enhance their well-being through participation in major

¹² N. de Groot *et al.*, 'Towards a universal concept of vulnerability: Broadening the evidence from the elderly to perinatal health using a Delphi approach', *PLoS One*, 14(2), e0212633 (20 February 2019), available at <https://doi.org/10.1371/journal.pone.0212633>.

¹³ L. Shi *et al.*, 'Enhancing the measurement of health disparities for vulnerable populations', *Journal of Public Health Management and Practice*, vol. 14 (suppl.), pp. 45–52 (Wolters Kluwer Health, 2008), available at <https://doi.org/10.1097/01.PHH.0000338386.59565.dc>.

¹⁴ E. Grundy, 'Ageing and vulnerable elderly people: European perspectives', *Ageing & Society*, vol. 26(1), pp. 105–134 (Cambridge Core, Cambridge University Press, 2006), available at <https://www.cambridge.org/core/journals/ageing-and-society/article/abs/ageing-and-vulnerable-elderly-people-european-perspectives/38FE71F6EC2FA12FBAFD30825B011E12>.

life events. Health-related vulnerability encompasses the probable risk of developing chronic and morbid conditions that reduce physiological and cognitive potential. Along with loss in physical performance, older persons are at high risk of losing memory and other sensory functions as age progresses. The elderly, when poor in health and/or finances, come to expect care and support from their children or near ones to manage ADL. Social and financial dependency on others due to decline in physical capacity and poor rate of literacy sometimes makes them feel neglected, deprived and depressed.

Ease of performing ADL is a key determinant of the degree of dependency that an elderly experiences.¹⁵ In India, nearly one-fifth of the elderly have at least one ADL limitation. Eleven (of 30) states and all union territories have a higher incidence of ADL-restricted elderly than the national average. The highest is in West Bengal (38.5 percent) followed by Goa (37.3 percent) and Maharashtra (35.6 percent). The northeastern states, Rajasthan and Haryana have the lowest levels of functionally disabled elderly.

Multi-morbidity is generally defined as occurrence of two or more chronic conditions.¹⁶ Older persons with multi-morbidity are at higher risk due to poor health, advanced age, cognitive impairment, limited health literacy along with co-morbidities such as depression or anxiety.¹⁷ Overall prevalence of multi-morbidity is 23.3 percent in

¹⁵ Restrictions experienced in performing ADL (in three months preceding the survey) were probed in terms of difficulty in dressing (including putting on footwear), walking across a room, bathing, eating, getting in or out of bed, using the toilet (including sitting on the toilet bowl or getting up from it). Those who reported difficulties in performing any of these six activities were considered to be functionally disabled.

¹⁶ Multi-morbidity includes the presence of two or more chronic diseases—hypertension, chronic heart diseases, stroke, any chronic lung disease, diabetes, cancer or malignancy, any bone/joint diseases, any neurological/psychiatric illness, high cholesterol.

¹⁷ WHO, Multimorbidity: Technical Series on Safer Primary Care, (Geneva: World Health Organization; 2016). Licence: CC BY-NC-SA 3.0 IGO. <https://apps.who.int/iris/bitstream/handle/10665/252275/9789241511650-eng.pdf>.

India, which ranged from 7.3 percent in Nagaland to 52.2 percent in Kerala. The reporting is relatively low in the central region of the country.

Economic dimension of vulnerability

Financial dependency of the elderly becomes more relevant in developing countries, where social pensions are insufficient to support them.¹⁸ Poverty among the elderly has been a consistent phenomenon in the developing world where much of the older population is deprived in terms of basic needs.¹⁹ Only a fraction of the elderly who were employed in the organized sector gets the benefits of a mandatory pension. In the absence of independent financial means, they are forced to fall back on their families, aggravating their economic vulnerability.²⁰

Level of poverty among the elderly may affect their quality of life and healthcare utilization. Overall, more than two-fifth of the elderly in India are in the poorest wealth quintile—ranging from 4.2 percent in Jammu and Kashmir and 5 percent in Punjab to 40.2 percent in Lakshadweep and 47 percent in Chhattisgarh. Further analysis of work, pension and income indicates that 18.7 percent elderly did not have any income. This proportion was above the national level among 17 states, which ranged from 19.3 percent in Uttarakhand to 42.4 percent in Lakshadweep.

¹⁸ M. Alam, 'Ageing, Old Age Income Security and Reforms: An Exploration of Indian Situation', *Economic and Political Weekly*, vol. 39(33), pp. 3731-3740 (2004).

¹⁹ N. Keyfitz and W. Flieger, *World Population Growth and Aging: Demographic Trends in the Late Twentieth Century*, (University of Chicago Press, Chicago, 1990).

²⁰ S. Kulkarni, S. Raju, and S. Bammidi, 'Social Security for the Elderly in India', *Building Knowledge Base on Ageing in India: Increased Awareness, Access and Quality of Elderly Services Thematic Paper*, 1 (2016). https://india.unfpa.org/sites/default/files/pub-pdf/ThematicPaper1_2.pdf.

Annexes to Chapter 2

TABLE A2.1: Dimensions of old age vulnerability in India and its states, 2017/18

	<i>Restriction to activities of daily living</i>	<i>Multi-morbidity</i>	<i>Poverty</i>	<i>No income</i>
Andaman and Nicobar	29.3	38.3	11.5	26.3
Andhra Pradesh	15.6	32.5	12.6	12.1
Arunachal Pradesh	12.9	13.0	16.8	42.2
Assam	19.6	16.1	23.4	26.5
Bihar	25.8	15.5	29.8	17.2
Chandigarh	20.6	41.0	6.9	30.5
Chhattisgarh	17.2	11.2	47.0	9.6
Dadra and Nagar Haveli	23.6	21.1	34.8	8.4
Daman and Diu	33.6	33.0	14.9	9.3
Delhi	23.9	31.2	18.3	25.2
Goa	37.3	38.8	6.1	25.2
Gujarat	24.5	25.8	17.0	12.0
Haryana	11.6	18.4	13.2	10.4
Himachal Pradesh	26.1	24.7	8.9	10.6
Jammu and Kashmir	21.2	35.3	4.2	38.9
Jharkhand	19.9	12.9	25.9	14.2
Karnataka	18.6	26.8	9.5	14.3
Kerala	22.7	52.2	17.1	24.7
Lakshadweep	22.9	39.6	40.2	42.4
Madhya Pradesh	27.3	14.0	20.8	14.1
Maharashtra	35.6	28.4	22.2	15.7
Manipur	10.6	15.4	7.7	7.8
Meghalaya	11.0	10.4	21.8	21.2
Mizoram	16.9	17.6	19.5	16.4
Nagaland	7.2	7.3	11.3	19.4

	<i>Restriction to activities of daily living</i>	<i>Multi-morbidity</i>	<i>Poverty</i>	<i>No income</i>
Odisha	19.4	17.2	34.6	17.3
Puducherry	14.4	36.2	31.6	15.0
Punjab	17.4	31.6	5.0	28.1
Rajasthan	7.5	20.4	20.5	11.4
Sikkim	23.5	22.3	22.1	31.3
Tamil Nadu	26.4	30.6	27.8	21.5
Telangana	14.6	30.7	15.8	11.0
Tripura	15.5	21.3	15.2	17.2
Uttar Pradesh	17.3	12.2	25.8	27.7
Uttarakhand	22.8	16.8	21.8	19.3
West Bengal	38.5	35.1	19.7	25.5
India	23.8	23.3	21.7	18.7

Source: IIPS, NPHCE, HSPH and USC, *Longitudinal Ageing Study in India (LASI) Wave 1, 2017–18, India Report*, (International Institute for Population Sciences, Mumbai; National Programme for Health Care for Elderly, Ministry of Health & Family Welfare; Harvard T. H. Chan School of Public Health; and the University of Southern California, 2020), available at https://iipsindia.ac.in/sites/default/files/LASI_India_Report_2020_compressed.pdf.

Response from Government

3

3.1 The Context

The Madrid International Plan of Action on Ageing (MIPAA), 2002 is a point of reference for policy and programme interventions and related institutional arrangements to address population ageing issues. It lays down three priority areas:

- (a) Mainstreaming ageing in public policy in general and poverty reduction strategies. In this context, eight priorities were identified:
 - (i) participation in society and development;
 - (ii) work and the ageing labour force;
 - (iii) rural development, migration and urbanization;
 - (iv) access to knowledge, education and training;
 - (v) intergenerational solidarity;
 - (vi) eradication of poverty;
 - (vii) income security, social protection/social security and poverty prevention; and
 - (viii) emergency situations.
- (b) Health and well-being among the elderly with a focus on:
 - (i) health and well-being;
 - (ii) access to healthcare;
 - (iii) HIV/AIDS;
 - (iv) mental health; and

- (v) disabilities during old age.
- (c) Enabling a supportive environment involving housing, living environment and care for the elderly, and generating favourable attitudes towards ageing without any “neglect, abuse and violence”.¹

With regard to national policies on population ageing and institutional arrangements, an interim review of progress shows significant inconsistency across countries.

The above priority areas would need institutional arrangements to:

- (a) integrate mandates of different ministries towards greater focus on resolving concerns pertaining to the elderly;
- (b) make reliable information available for policy formulation, monitoring and evaluation;
- (c) carry out research, including documenting and disseminating best practices and further assisting in implementing them; and
- (d) ensure adequate resource allocation for sector-specific policies to promote health and social protection.

An interim review of progress along these lines shows significant inconsistency across countries.² Among the sampled Asian countries, nine countries (Bangladesh, Cambodia, India, Indonesia, Lao PDR, Nepal, Philippines, Thailand and Viet Nam) had national policies on population ageing along with some institutional arrangements.

Apart from the MIPAA, the Sustainable Development Goals (SDGs), set by the United Nations General Assembly in 2015, also include goals that address the needs of senior citizens, mainly through the following:

- (a) SDG 1: eradicating poverty;
- (b) SDG 3: ensuring healthy lives and well-being at all ages;

¹ United Nations, Political Declaration and Madrid International Plan of Action on Ageing (New York, 2002), available at <https://www.un.org/esa/socdev/documents/ageing/MIPAA/political-declaration-en.pdf>.

² United Nations Population Fund and HelpAge International, *Overview of Available Policies and Legislation, Data and Research, and Institutional Arrangements Relating to Older Persons—Progress since Madrid* (New York, 2011).

- (c) SDG 5: promoting gender equality;
- (d) SDG 8: full and productive employment and decent work for all;
- (e) SDG 10: reducing inequalities among and within countries; and
- (f) SDG 11: making cities and human settlements inclusive, safe, resilient and sustainable.

The Indian Constitution mandates the well-being of senior citizens under Article 41, which states: "The State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want."

Under its Article 41, the Indian Constitution mandates the well-being of senior citizens.

India Ageing Report 2017, published by United Nations Population Fund (UNFPA), discusses some important demographic features of the elderly population, some of which are given below:

- (a) *Differentials across states*: Southern states like Kerala, Tamil Nadu and Karnataka, along with states like Himachal Pradesh, Maharashtra, Odisha and Punjab have a higher proportion of senior citizens (persons above 60 years of age) than states like Uttar Pradesh, Rajasthan, Madhya Pradesh, Bihar and Uttarakhand.
- (b) *The feminization of ageing*: According to Census 2011,³ the sex ratio among senior citizens was 1,033 females per 1,000 males with elderly women having a higher life expectancy than elderly men.
- (c) *Ruralization of elderly*: Census 2011 also highlighted that approximately 71 percent of the senior citizens lived in rural areas.
- (d) *More women aged 80 years and above*: During 2000–2050, the population aged 80 years and above is projected to grow

³ Census 2011 every where refers to the Census of India 2011 published by the Office of the Registrar General and Census Commissioner of India (Ministry of Home Affairs, Government of India).

700 percent, with pre-dominance of widows and highly dependent very old women.

- (e) *Decline in health status, income insecurity and compulsion to work:* Loss of spouse and consequent living arrangements increases dependency, and the inability to access social welfare benefits meant for them are some of the key problems faced by the elderly in India.

Financial security is a significant concern for senior citizens owing to loss of income and wealth during old age, leading to poverty and accompanying problems.

Over the years, Government of India has initiated several programmes to assist the elderly and mitigate their problems. Some of those initiatives are discussed in the next section.

3.2 Social Security and Welfare Schemes

Financial security is a significant concern for senior citizens owing to loss of income and wealth, leading to poverty and accompanying problems. This can be addressed through (a) social security schemes that are contributory and non-contributory or a mix of the two to achieve universal coverage and (b) a minimum set of tax-financed schemes that are available throughout the life cycle. Special measures tailored to meet the needs of certain disadvantaged groups are necessary to ensure sufficient coverage and enough benefits for all.

Table 3.1 lists some of the social security schemes for senior citizens in India.

TABLE 3.1 Social security schemes for senior citizens in India

S. No.	Scheme	Initiated by	Objectives	Year of Implementation
1.	Antodaya Anna Yojana	Department of Food and Public Distribution (Ministry of Consumer Affairs, Food and Public Distribution)	The scheme provides food grains at a highly subsidized rate (₹2 per kg for wheat and ₹3 per kg for rice) to widows/terminally ill persons/PwDs/persons aged 60 years and above.	2000
2.	Annapurna Scheme	Ministry of Rural Development	Persons aged 65 years and above, who are not receiving pension under the National Old Age Pension Scheme, get 10 kg foodgrains per person per month, free of cost.	2000/01

S. No.	Scheme	Initiated by	Objectives	Year of Implementation
3.	Pradhan Mantri Vaya Vandana Yojana	Ministry of Finance (Life Insurance Corporation of India)	The scheme was implemented through LIC of India. It provides pensioners aged 60 years and above survival (pension), death or maturity benefits during the policy term of 10 years with the assured return rate of 7.4 percent per annum for 2020/21, to be reset every year to the senior citizen subscriber. The scheme can be availed through a lump sum payment of the purchase price ranging from a minimum amount or ₹1,62,162, with a pension of ₹1,000 per month, to a maximum of ₹15,00,000, with a pension of ₹9,250 per month. Loan facility is available after completion of three policy years. The maximum loan that can be granted is 75% of the purchase price.	2003
4.	Varishtha Pension Bima Yojana	Ministry of Finance (Life Insurance Corporation of India)	The scheme provides pension to senior citizens through LIC of India in the form of immediate annuity during the pensioner's lifetime with the return of purchase price to the family/nominee on his/her death. The mode of payment of pension can be monthly, quarterly, half-yearly or yearly. The scheme has a lock-in period of 15 years, and the senior citizen can benefit from an (taxable) interest rate of 9 percent per annum for a period of 10 years. Investments are eligible for tax exemption under Section 80C of the Income Tax Act of 1961.	2003; revived in 2014
5.	Indira Gandhi National Old Age Pension Scheme (IGNOAPS)	Ministry of Rural Development	IGNOAPS is the extension of the National Old Age Pension Scheme, 1995. It is a non-contributory scheme that aims to benefit below-poverty-line (BPL) senior citizens, widows and those with disabilities through central government assistance of ₹200 per month to people in the 60–79 years age group and ₹500 to people above 80 years of age.	2007
6.	Indira Gandhi National Widow Pension Scheme	Ministry of Rural Development	The central government provides a monthly pension of ₹200 per beneficiary to BPL widows and state governments are also urged to provide the matching amount or more.	2009

S. No.	Scheme	Initiated by	Objectives	Year of Implementation
7.	Indira Gandhi National Disability Pension Scheme	Ministry of Rural Development	Central government provides ₹300 per month to persons with disabilities (PwDs) in poor households in the age group of 18–79 years and having 80 percent and above/multiple disabilities. The state government provides an additional ₹200 per month to each beneficiary.	2009
8.	Jeevan Pramaan	Ministry of Labour and Employment	The scheme allows senior citizens to digitally provide proof of his/her existence to authorities for continuity of pension every year instead of requiring to present himself/herself physically or through a Life Certificate issued by specified authorities.	2014
9.	Scheme for Financial Assistance for Veteran Artists	Ministry of Culture	Central government assistance of ₹6,000 as monthly allowance is given to artistes aged 60 years and above under this scheme, which was launched in 1961. The scheme was earlier known as Artistes Pension Scheme and Welfare Fund. On the death of the recipient, the financial assistance may be continued at the discretion of the central government after examining the dependents' financial condition. In case of death of the recipient, the spouse will receive lifetime benefits and dependents will receive till marriage or employment or up to the age of 21 years, whichever is earlier.	2014/15
10.	Atal Pension Yojana	Ministry of Finance (Pension Fund Regulatory and Development Authority)	The scheme aims to help unorganized sector workers save money as they earn and provides guaranteed return post retirement. Fixed pension for the subscribers ranging from ₹1,000 to ₹5,000, receivable at the age of 60 years, if s/he joins and contributes between the age of 18 and 40 years. The contribution levels increase if the subscriber joins late.	2015
11.	Pradhan Mantri Suraksha Bima Yojana		This scheme is a government-backed accident insurance scheme and is available to people in the age group 18–70 years with a bank account, who consent to enabling an auto-debit (₹12 per annum per member) on or before 31 May for the coverage period 1 June to 31 May on an annual renewal basis. A sum of ₹200,000 will be paid to the nominee in case of death. In case of irrecoverable loss of both eyes, or loss of use	2015

S. No.	Scheme	Initiated by	Objectives	Year of Implementation
			of both hands or feet, or loss of sight of one eye and loss of use of hand or foot, a sum of ₹200,000 will be paid to the subscriber. A sum of ₹100,000 will be paid in case of irrecoverable loss of sight of one eye or loss of use of one hand or foot.	
12.	Senior Citizens' Savings Scheme (SCSS)	Ministry of Finance (Department of Economic Affairs)	The main objective is to provide a regular income to those above 60 years of age. The main features of the scheme include tax benefits; safe investment; account transfer facility across the country; and higher interest rate of 8.2% per annum. The scheme requires a minimum deposit of ₹1,000 and the multiples thereof to the maximum of ₹3,000,000. An individual who is 60 plus on the date of opening of an account or an individual who is 55–59 years old and has retired [under superannuation, Voluntary Retirement Scheme (VRS) or Special VRS], can open an account. The tenure of the scheme is for 5 years, with premature withdrawal allowed under certain circumstances.	2019, amended in 2020

Sources:

1. Antodaya Anna Yojana: <https://dfpd.gov.in/pds-aay.htm>.
2. Annapurna Scheme <https://nsap.nic.in/Guidelines/Annapurna%20scheme%20guidelines%202000.pdf>.
3. Pradhan Mantri Vaya Vandana Yojana: https://licindia.in/getattachment/Products/Pension-Plans/Pradhan-Mantri-Vaya-Vandana-Yojana1/Sales-Brochure-Pradhan-Mantri-Vaya-Vandana-Yojana_English.pdf.aspx.
4. Varishtha Pension Bima Yojana: <https://financialservices.gov.in/insurance-divisions/Government-Sponsored-Socially-Oriented-Insurance-Schemes/Varishtha-Pension-Bima-Yojana#:~:text=Under%20the%20Scheme%20the%20subscribers,subsidy%20payment%20in%20the%20scheme>.
5. Indira Gandhi National Old Age Pension Scheme: <https://www.indiafilings.com/learn/indira-gandhi-national-old-age-pension-scheme-ignoaps/>.
6. Indira Gandhi National Widow Pension Scheme, Indira Gandhi National Disability Pension Scheme: https://nsap.nic.in/Guidelines/nsap_guidelines_oct2014.pdf.
7. Jeevan Pramaan: <https://www.india.gov.in/spotlight/jeevan-pramaan-digital-life-certificate-pensioners>.
8. Scheme for Financial Assistance for Veteran Artists: https://www.indiaculture.gov.in/sites/default/files/Schemes/OrderforSchemeForPensionandMedicalAidtoArtistesdated28.09.2017_26.10.2017.pdf | <https://www.indiaculture.gov.in/scheme-financial-assistance-veteran-artists#:~:text=5500%2F%2D%20per%20month%20per,should%20be%20at%20least%20Rs>.
9. Atal Pension Yojana: <https://www.india.gov.in/spotlight/atal-pension-yojana>.
10. Pradhan Mantri Suraksha Bima Yojana, <https://www.myscheme.gov.in/schemes/pmsby>
11. https://www.nsiindia.gov.in/InternalPage.aspx?Id_Pk=62.

In addition to social security schemes, the government also extends several concession and rebate schemes to senior citizens, including a microfinancing scheme providing concessional loans to small businesses.

Facilitating skilling and re-skilling of senior citizens and updating their technology skills helps them rejoin the workforce. The Ministry of Skill Development and Entrepreneurship has launched 'Skill Acquisition and Knowledge Awareness for Livelihood Promotion' (SANKALP), an easy-to-use online platform that allows pensioners to access opportunities for work and contribute to society. It also facilitates the organizations working in these areas to select appropriate skill and expertise from the available pool of volunteers.

3.3 Concession and Rebates

In addition to social security schemes, the government also extends several concession and rebate schemes to senior citizens, including a microfinancing scheme providing concessional loans to small businesses. Some such schemes are listed below.

Ministry of Railways

- Separate ticket counters for older persons at Passenger Reservation System Centres
- Provision of lower berth quota in air-conditioned and sleeper classes
- Wheelchairs and Yatri Mitra services available at railway stations for PwDs and elderly passengers

Before the COVID-19 pandemic, Ministry of Railways provided fare concessions for older persons (40 percent for men aged 60 years and above and 50 percent for women aged 58 years and above). However, these were withdrawn during the pandemic and have not been restored yet.

Ministry of Health and Family Welfare

- Several health schemes for central government offices' pensioners
- Facility to obtain medicines for chronic ailments for up to three months at a stretch

- Provision of separate queues for all elderly people in government hospitals
- Geriatric clinics in several government hospitals

Ministry of Finance

- Income tax exemption limit set at ₹300,000 per annum (p.a.) for senior citizens aged 60–80 years and ₹500,000 p.a. for super senior citizens (those above 80 years); this limit is set at ₹250,000 p.a. for ordinary citizens
- Exemption from e-filing of income tax return; super senior citizens can file their tax returns using Sahaj (ITR1) or Sugam (ITR4) forms
- Tax benefits of up to ₹50,000 available on interest income from deposits with banks, post office or cooperative banks
- Exemption from paying advance tax if senior citizens do not have any income from business or profession
- Standard deduction of ₹50,000 from pension income
- Income tax rebate of up to ₹100,000 for medical expenses for specified diseases for senior citizens (under Section 80DDB)
- Medical insurance premium paid up to ₹50,000 is exempt from income tax for senior citizens under section 80D
- No tax on reverse mortgage scheme for senior citizens
- Higher interest rates for savings accounts at national banks and tax benefits under Section 80C of the Income Tax Act
- Doorstep banking facilities for senior citizens aged more than 70 years and differently abled persons from 31 December 2017; banks were advised to make concerted efforts to offer certain basic banking services at the doorstep⁴

The government grants tax benefits to the elderly under Section 80C of the Income Tax Act.

⁴ The Reserve Bank of India issued instructions dated 9 November 2017 as part of Fourth Bi-monthly Monetary Policy Statement 2017–18 and further on 31 March 2020 on 'Doorstep Banking Facility for Senior Citizens and Differently abled Persons'. In view of the difficulties faced by senior citizens aged 70+ years and differently abled

The Maintenance and Welfare of Senior Citizens Act, 2007 is a key legislation for senior citizens that lays down measures for providing maintenance and support to elderly parents and senior citizens.

Ministry of Road Transport and Highways

- Reservation of two seats for senior citizens in the front row of the buses of the State Road Transport Undertakings
- Some state governments extend fare concession to senior citizens in the State Road Transport Undertaking buses
- Introduction of vehicles that are elderly friendly

Department of Telecommunication

- Registration of telephone connection under N-OYT Special Category, which is a priority category⁵
- MTNL gives 25 percent concession on installation and monthly rent of landline connections
- BSNL permits priority registration of telephone for senior citizens above 65 years without any charge

Ministry of Civil Aviation

In order to assist senior citizens, expectant mothers, passengers with disabilities, first time travellers, etc., the Ministry of Civil Aviation has instructed the airlines/airports to ensure provision of automated buggies (free of charge) for all such passengers in the terminal building to facilitate their access to boarding gates located beyond reasonable walking distance at all airports having annual aircraft movements of 50,000 or more. This free-of-charge facility may be extended to other needy passengers on demand basis.

Apart from the above, almost all banks, hospitals and courts extend special facilities for senior citizens, such as exclusive counters at

or infirm persons (having medically certified chronic illness or disability), including the visually impaired, banks were advised to make concerted effort to provide basic banking facilities, such as pick up of cash and instruments against receipt, delivery of cash against withdrawal from account, delivery of demand drafts, and submission of Know Your Customer documents and 'Life certificate' at the premises/residence of such customers.

⁵ N-OYT = Non-Own Your Telephone | https://www.bsnl.co.in/opencms/export/sites/default/BSNL/about_us/others/pdf/infomanual.pdf.

hospitals and banks for registration, special clinics and priority hearing of older persons' cases in courts.

3.4 Legislations Related to Older Persons

3.4.1 Maintenance and Welfare of Senior Citizens Act, 2007

A key legislation for senior citizens, the Maintenance and Welfare of Senior Citizens Act, 2007 lays down measures for providing maintenance and support to elderly parents and senior citizens that include:

- (a) Revocation of transfer of property by senior citizens in case of negligence by relatives.
- (b) Maintenance of parent/senior citizens by children/relatives are made obligatory and justiciable through tribunals for those who cannot maintain themselves through their earnings and property.
- (c) Provision of punishment for the abandonment of senior citizens.
- (d) Adequate medical facilities and security for senior citizens.
- (e) Establishment of old age homes for indigent senior citizens.

The Maintenance and Welfare of Senior Citizens (Amendment) Bill, 2019 proposes to include parents-in-law and grandparents (maternal and paternal) and expands the scope of the Act to include the provision of healthcare, safety and security for parents and senior citizens, allowing them to lead a life of dignity. The Bill also stipulates that maintenance may be claimed from stepchildren, adopted children, etc. It removes the upper limit of the maintenance amount and reduces the deadline for payment to 15 days from the passing of orders by the maintenance tribunal. The maintenance officer is responsible for ensuring compliance with orders on maintenance payments, acting as a liaison for senior citizens. The Bill also provides the right to the children and relatives to appeal against the orders.

3.4.2 National Policy on Older Persons, 1999

National Policy on Older Persons (NPOP), 1999 is regarded as the first policy that acknowledges population ageing and lays down a strategy

National Policy on Older Persons (NPOP), 1999 is regarded as the first policy that acknowledges population ageing and lays down a strategy to address the demographic change.

A Senior Citizens' Welfare Fund (SCWF) was established for providing financial assistance to schemes that promote financial security, healthcare and nutrition of senior citizens, as well as welfare of elderly widows and to support other innovative schemes directed towards welfare of senior citizens.

to address the demographic change. It attempted to provide a holistic support system to senior citizens, with emphasis on financial security, healthcare, shelter, education, welfare, protection against abuse and exploitation, and protection of life and property. It aimed to strengthen their legitimate place in society and help older persons to live the last phase of their life with purpose, dignity and peace. It was in pursuance of the UN General Assembly Resolution 47/5⁶ to observe 1999 as the International Year of Older Persons and maintain the constitutional rights of older persons.⁷

3.4.3 National Council of Senior Citizens

The NPOP suggested forming an advisory body for framing of policies and programmes for senior citizens. The central government then constituted the National Council for Older Persons (NCOP) in May 1999. This was later reconstituted as National Council for Senior Citizens with the Union Minister for Social Justice and Empowerment as chairperson and the Minister of State as the vice chairperson. The council also has ex-officio members (secretary and additional secretary of the MSJE; representatives of 14 central ministries, National Commission for Women and National Human Rights Commission); representatives of five state governments—one from each region: north, south, east, west and north-east; a representative of one Union Territory (nominated by the central government); the oldest member of the Lok Sabha and the oldest member of the Rajya Sabha; and five representatives (one each) of Senior Citizens Associations, Pensioners Associations, non-governmental organizations (NGOs) working for senior citizens, experts in the field of ageing and other related areas (nominated by the central government). Five senior citizens who have distinguished themselves in various fields are also nominated to the council by the central government.⁸

⁶ <https://www.un.org/development/desa/ageing/resources/international-year-of-older-persons-1999/resolution-475.html>.

⁷ Ministry of Social Justice and Empowerment, National Policy for Older Persons (Government of India, 1999).

⁸ Ministry of Social Justice and Empowerment, Notification of National Council of Senior Citizens (Government of India, 2016), available at <https://socialjustice.gov.in/writereaddata/UploadFile/Annexure-III%20-%20notification%20of%20NCSrC.pdf>.

3.4.4 Senior Citizens' Welfare Fund

A Senior Citizens' Welfare Fund (SCWF) was established in 2016 for providing financial assistance to schemes that promoted financial security, healthcare and nutrition of senior citizens, as well as welfare of elderly widows and also supported other innovative schemes directed towards welfare of senior citizens. The fund is comprised of the amounts available under the central government saving schemes that remain unclaimed for a period of seven years from the date of the account being declared inoperative.⁹

3.5 Programmes for the Elderly

3.5.1 Atal Vayo Abhyuday Yojana

Ministry of Social Justice and Empowerment launched the National Action Plan for Welfare of Senior Citizens (NAPSrC) in 2021 that included the previously launched Integrated Programme for the Older Persons (IPOP). Renamed as 'Atal Vayo Abhyuday Yojana' (AVYAY), this centrally sponsored umbrella scheme was designed with a vision to create "a society in which senior citizens live a healthy, happy, empowered, dignified and self-reliant life along with strong social and inter-generational bonding".¹⁰ The policy document includes the government's immediate plan of action regarding the welfare and well-being of senior citizens in the country.

The AVYAY scheme was formulated after deliberations with central ministries/departments and think tanks and after considering inputs received from the seven 'working groups' that were constituted for designing comprehensive initiatives under the scheme. The scope of AVYAY is to implement Section 19 (Establishment of old age homes) and Section 20 (Medical support for senior citizens) of the Maintenance and Welfare of Parents and Senior Citizens Act, 2007

⁹ Ministry of Social Justice and Empowerment, Senior Citizens' Welfare Fund: Annual Report for the Year 2020–21 (Government of India, 2016b), available at https://socialjustice.gov.in/writereaddata/UploadFile/ANNUAL_REPORT_2021_ENG.pdf.

¹⁰ Ministry of Social Justice and Empowerment, Atal Vayo Abhyuday Yojana (Government of India, 2021), available at <https://pib.gov.in/PressReleaselframePage.aspx?PRID=1844991>.

The Atal Vayo Abhyuday Yojana (AVYAY) was designed with a vision to create "a society in which senior citizens live a healthy, happy, empowered, dignified and self-reliant life along with strong social and inter-generational bonding".

and includes all possible affirmative actions that can be taken for the welfare and well-being of older persons.¹¹

The central government can implement these initiatives either independently or in collaboration with state governments and other implementing agencies including voluntary and non-voluntary organizations, trusts, charitable organizations, registered societies, any public body or organizations having legal status of its own and/or any other reputed organization that is to be approved by the MSJE.

The following sub-schemes are a part of AVYAY:

- (a) Health and shelter for senior citizens
 - (i) Integrated Programme for Senior Citizens (IPSRc)
 - (ii) State Action Plan for Senior Citizens (SAPSRc)
- (b) Rashtriya Vayoshri Yojana (RVY)
- (c) National helpline, awareness, training and capacity building
- (d) Promoting silver economy: equity participation in start-ups for elderly care

The scheme also includes a monitoring and oversight mechanism, as given below, to ensure efficient and effective implementation of the action plan.

- (a) A steering committee chaired by MSJE and including representatives from other ministries
- (b) A project management committee to monitor the implementation of sub-schemes on a monthly basis
- (c) A screening committee to recommend funding proposals

Each of the AVYAY sub-schemes are discussed in the following section.

¹¹ https://www.indiacode.nic.in/bitstream/123456789/6831/1/maintenance_and_welfare_of_parents_and_senior_citizens_act.pdf.

Health and shelter for senior citizens

(a) *Integrated Programme for Senior Citizens (IPSrC)*: The IPSrC is responsible for maintenance of senior citizen homes to improve the quality of life of senior citizens, especially indigent senior citizens, by providing basic amenities like shelter, food, medical care and entertainment opportunities, and by encouraging productive and active ageing.

Projects admissible for funding assistance under this scheme are:

- (i) Maintenance of senior citizens' homes for 25 beneficiaries including those under Sansad Adarsh Gram Yojana (SAGY) and to provide food, shelter and healthcare for a minimum of 25 destitute elderly/50 elderly women complying with minimum standards,
- (ii) Maintenance of continuous care homes and senior citizens' homes for at least 20 senior citizens afflicted with Alzheimer's disease/dementia who are seriously ill and require continuous nursing care.¹²
- (iii) Maintenance of mobile medical care units with a doctor, nurse, organizer and driver,
- (iv) Physiotherapy clinics for the elderly,
- (v) Maintenance of Regional Resource Training Centres (RRTCs) for research, monitoring and technical support, advocacy, networking and capacity building for effective delivery of services and intergenerational bonding, and
- (vi) Other activities that align with the objectives of the scheme, including implementation of the provisions of National Policy for Senior Citizens (NPSrC).

(b) *State Action Plan for Senior Citizens (SAPSrC)*: The main objective of SAPSrC is to develop programmes and initiatives that will provide skilling opportunities for senior citizens that will not only

The IPSrC is responsible for maintenance of senior citizen homes by providing basic amenities like shelter, food, medical care and entertainment opportunities, and by encouraging productive and active ageing.

¹² <https://socialjustice.gov.in/writereaddata/UploadFile/IPSrC%20English%20version.pdf>.

help them actively engage with and contribute to the society but also improve their quality of life.

The programmes admissible for funding assistance under the SAPSrC are:

- (i) Maintenance of 'mobile medicare units' to provide medical care to the senior citizens living in rural, isolated and backward areas, as well as in urban slums, where proper healthcare facilities are not available.
- (ii) Physiotherapy clinics for a minimum of 50 senior citizens per month. These clinics will be operational only in the district government hospitals and run by agencies that have a credible track record in implementing similar projects for the welfare of the elderly.
- (iii) Creation of a pool of trained geriatric caregivers wherein grant-in-aid is given to agencies that have proven track record in geriatric care along with conducting training for geriatric caregivers. These agencies should also be able to provide bedside assistance to the needy elderly as needed.
- (iv) Special drives to organize cataract surgeries for senior citizens as an effort to assist the National Programme for Control of Blindness & Visual Impairment. These surgeries will be carried out in all district government hospitals or at community health centres every year. The aim of this initiative is to have zero cataract blindness cases in a state in three years' time.

The Rashtriya Vayoshri Yojana provides physical aids and assisted living devices to below-poverty-line (BPL) senior citizens suffering from age-related disabilities and infirmities such as poor vision, hearing impairment, loss of teeth, and locomotor disability.

Rashtriya Vayoshri Yojana

This scheme provides physical aids and assisted living devices to below-poverty-line (BPL) senior citizens suffering from age-related disabilities and infirmities such as poor vision, hearing impairment, loss of teeth and locomotor disability. The free distribution of these aids will be commensurate with the extent of disability, and in case of multiple disabilities/infirmities, assistive devices will be provided to separately address each impairment type. This is a central sector

scheme funded by SCWF, and it stipulates that 30 percent of the beneficiaries in each district should be women.¹³

The Rashtriya Vayoshri Yojana has been revised from 1 April 2021. Under the revised scheme, the criteria of selection of beneficiaries have been extended to include not only BPL senior citizens but also those with monthly income of less than ₹15000 and those who suffer from age-related disabilities/infirmities.

National helpline (Elderline), awareness, training and capacity building
A toll-free national helpline number—14567—(Elderline) has been made fully operational in 26 states and Union Territories(UTs) during 2021–22. Registration of grievances, redressal of grievances and monitoring of the performance of states and UTs are being done through the portal to be developed for senior citizens.

Under training on geriatric and healthcare initiative, skilling youth will be important to add to the pool of elderly care givers through short-term and long-term training programmes. The National Institute of Social Defence (NISD) conducts short-term skilling programmes for bedside assistants and medium- to long-term trainings for geriatric care. Creating a pool of trained personnel who can run the senior citizen homes as per minimum standards and training to the staff of the project of senior citizens homes is another component.

Scheme for Awareness Generation and Capacity Building for Welfare of Senior Citizens focuses on spreading awareness in the society and among the senior citizens regarding:

- (a) the experiences and knowledge of senior citizens that can be tapped and passed on to the younger generations,
- (b) the right of senior citizens to lead a dignified life, and
- (c) the duties of the society and family members towards the senior citizens and the penalties that they can attract if these duties are not adhered to.

¹³ [https://www.india.gov.in/spotlight/rashtriya-vayoshri-yojana#:~:text=Rashtriya %20Vayoshri%20Yojana%20\(RVY\)%20is,funded%20by%20the%20Central%20Government.](https://www.india.gov.in/spotlight/rashtriya-vayoshri-yojana#:~:text=Rashtriya%20Vayoshri%20Yojana%20(RVY)%20is,funded%20by%20the%20Central%20Government.)

The government is committed towards providing innovative and out-of-the-box solutions for the commonly faced problems by promoting start-ups.

The types of awareness programmes are:

- (a) seminars/workshops/conferences at regional level on the issues relating to senior citizens through reputed organizations;
- (b) special campaigns to spread awareness on mental health issues;
- (c) awareness campaigns on all aspects such as provisions of MWPC Act and to promote positive attitude towards the vulnerabilities of senior citizens;
- (d) training and capacity building of communities/families on geriatric care; and
- (e) initiatives to distribute IEC¹⁴ material on self-care, nutritional needs and information on government schemes, etc.

Promoting silver economy: Equity participation in start-ups for elderly care

The government is committed towards providing innovative and out-of-the-box solutions for the commonly faced problems by promoting start-ups. Currently, there is a vacuum in comprehensively addressing the areas that concern the elderly like mental care, social connectivity, productive activity and product development for the elderly segment. A number of start-ups are showing interest in entering this area and providing the much-required services for the aged population.

The objectives are:

- (a) to call for, through a transparent process, innovative ideas for elderly care and promoting start-ups by providing equity support;
- (b) to encourage youth in the best higher educational institutions to think about the problems of the elderly and come out with innovative solutions; and
- (c) to encourage institutional banking set up to fund such ventures.

¹⁴ IEC = Information, Education and Communication.

Anubhav platform

The Department of Pension and Pensioner's Welfare initiated the Anubhav portal to recognize the contribution of retired government employees and to showcase the commendable work done during service. The Anubhav portal was launched in March 2015 for retiring government officials to leave a record of their experiences while in government service. It is envisaged that this culture of leaving notes by retirees will become the foundation stone of good governance and administrative reforms in the future. In order to encourage submission of write-ups by retired government servants, an annual award scheme was started in 2016.¹⁵ Such a repository of experiences would also serve as an excellent nation-building instrument.

3.6 Health Provisions

Declining health and disabilities of various forms are a significant concern for the elderly population. As the population ages, it becomes essential to ensure continued and equitable access to disease prevention, treatment and rehabilitation. Therefore, along with social and economic security, Government of India is also focusing on providing health security to senior citizens.

The Ministry of Health and Family Welfare launched National Programme for Health Care of the Elderly (NPHCE) during 2010/11 to provide accessible, affordable and high-quality long-term care services to the elderly people of India. The central and state governments have a 75:25 split in budget-sharing commitments.

Table 3.2 lists the various services provided under NPHE at various levels.

The Anubhav portal, where retiring government officials leave a record of their experiences upon retirement, is envisaged to become the foundation stone of good governance and administrative reforms in the future.

¹⁵ <https://pensionersportal.gov.in/anubhav/>.

TABLE 3.2: Packages of services made available at different levels under NPHCE

<i>S. no.</i>	<i>Level of services</i>	<i>Services available</i>
1.	Sub-centre	<ul style="list-style-type: none"> • Health education related to healthy ageing • Domiciliary visits by the rehabilitation worker for the homebound/bedridden elderly and counselling and training family members on their home-based care • Arrange suitable callipers and supportive devices from primary health centres (PHCs) for the elderly disabled persons to make them ambulatory • Linkage with other support groups and day-care centres operational in the area
2.	Primary Health Centre	<ul style="list-style-type: none"> • Weekly geriatric clinic run by a trained medical officer • Maintaining a record of the elderly using a standard format during their first visit • Conducting a routine health assessment of the elderly persons based on simple clinical examination relating to the eye, blood pressure, blood sugar, etc. • Provision of medicines and proper advice on chronic ailments • Public awareness of geriatrics' promotional, preventive and rehabilitative aspects during health and village sanitation day/camps • Referral for diseases needing further investigation and treatment to the community health centre (CHC) or the district hospital
3.	Community Health Centre	<ul style="list-style-type: none"> • First referral unit for the elderly from PHCs and sub-centres • Geriatric clinic for elderly persons twice a week • Rehabilitation unit for physiotherapy and counselling • Domiciliary visits by the rehabilitation worker for bedridden elderly and counselling the family members on their home-based care • Health promotion and prevention • Referral of complicated cases to district hospital/higher healthcare facility
4	District Hospital	<ul style="list-style-type: none"> • Geriatric clinic for regular dedicated out-patient services to the elderly • Facilities for laboratory investigations for diagnosis and provision of medicines for geriatric medical and health problems
		<ul style="list-style-type: none"> • Geriatric ward with at least 10 beds for in-patient care of the elderly • Existing specialization departments such as general medicine, orthopaedics, ophthalmology and ear–nose–throat will provide the various services needed by elderly patients • Provide services for the elderly patients referred by the CHCs/PHCs • Conducting camps for geriatric services in PHCs/CHCs and other sites • Referral services for severe cases to tertiary-level hospitals

S. no.	Level of services	Services available
5.	Regional Geriatric Centre	<ul style="list-style-type: none"> • Geriatric clinic (specialized out-patient department for the elderly) • Geriatric ward with at least 30 beds for in-patient care and dedicated beds for elderly patients in the various specialties, such as surgery, orthopaedics, psychiatry, urology, ophthalmology and neurology • Laboratory investigation required for the elderly with a special sample collection centre in the OPD block • Tertiary healthcare to the cases referred from medical colleges, district hospitals and below

Source: Department of Health and Family Welfare, Detailed Brief of National Programme for Health Care of the Elderly, Ministry of Health and Family Welfare, Government of India (2011), available at <https://main.mohfw.gov.in/organisation/Departments-of-Health-and-Family-Welfare/national-programme-health-care-elderly-nphce>.

NPHCE also supports the elderly during hospitalization and has set up two National Centres on Ageing—one each in Delhi and Chennai.

Health insurance of senior citizens is also a priority area for the government. Pradhan Mantri Jan Arogya Yojana (PMJAY), also referred to as Ayushman Bharat National Health Protection Scheme, is one of the largest government-funded senior citizen health insurance schemes, launched in 2018. It aims to provide free access to health insurance coverage for low-income earners across the country. The scheme provides a health cover of ₹500,000 per family per year for secondary and tertiary care hospitalization to over 107.4 million poor and vulnerable families (approximately 500 million beneficiaries) that form the bottom 40 percent of the Indian population. The households included are based on the deprivation and occupational criteria of Socio-Economic Caste Census 2011 for rural and urban areas respectively. It subsumed the then existing Rashtriya Swasthya Bima Yojana, which had been launched in 2008.

3.7 Institutional Strengthening

3.7.1 National Institute of Social Defence

The National Institute of Social Defence (NISD) is an autonomous body under MSJE. The Senior Citizen Division of NISD is involved in training and capacity-building activities to improve old age care by:

At present, the National Institute of Social Defence (NISD) offers a one-year post-graduate diploma in Integrated Geriatric Care and a certificate course on geriatric caregiving and primary caregiving.

- (a) developing a cadre of professionals for older persons' care and welfare;
- (b) providing scientific knowledge regarding geriatric care; and
- (c) generating skilled manpower in the family and community settings, among other objectives.

At present, they offer a one-year post-graduate diploma in Integrated Geriatric Care and a certificate course on geriatric caregiving and primary caregiving. They also conduct several training programmes and one-day programmes on themes such as geriatric counselling and management of dementia in schools, colleges, PRIs and residents' welfare associations and has organized several inter-generational bonding courses for youth as well as educationists.

One of NISD's critical roles is to facilitate the convergence of services of government and non-government sectors, both locally and at the national level. It is also the nodal agency for the senior citizen national helpline (ELDERLINE 14567) launched in 2021 in collaboration with state departments, NGOs, local senior citizen groups, voluntary groups, etc. The national helpline has two key components:

- (a) Connect the centre with officers who can understand issues of elderly; and
- (b) Connect with field support to provide help as necessary.

Helpline services offered to senior citizens include information, guidance, support and need-based intervention.

3.7.2 Regional Resource and Training Centres

Regional Resource and Training Centres (RRTC) were established under the revised IPOP in 2008 and are key nodal agencies for elder care under overall direction and supervision of MSJE, providing overall technical support and inputs on senior citizens programmes in their assigned states allocated by the ministry. The RRTCs are spread across the geographical regions of the

country, covering all the states and UTs. These centres carry out advocacy, awareness generation, training of stakeholders, database generation, inspections, monitoring, research and liaising with the state governments in the field of old age care. RRTCs are agencies through which MSJE and NISD reach out to the end beneficiary, that is, the senior citizens.

The various roles of the RRTCs include the following:

- (a) Support initiatives to build and strengthen intergenerational relationships particularly between children/youth and senior citizens and encourage active and productive ageing.
- (b) Act as a technical support group to the state government in preparing the state action plan, monitoring its implementation and evaluating the outcomes.
- (c) Liaise with district social welfare officers and expedite the state government recommendations on project proposals.
- (d) Prepare an annual action plan for their own activities which should include visits, capacity building programmes, monitoring and evaluation exercise.
- (e) Upload their field visits on the e-Anudaan portal along with photographs and their observation on a regular basis.
- (f) Monitor/Inspect projects being implemented by the Department of Social Justice and Empowerment (DSJE), as required from time to time, and carry out visits to projects under their jurisdiction at least twice in the financial year; these visits will be made by the respective RRTC¹⁶ during the months of April and October every year.

¹⁶ Anugraha, New Delhi; Calcutta Metropolitan Institute of Gerontology, Kolkata; Centre for the Study of Social Change, Mumbai; Heritage Foundation, Hyderabad; Integrated Rural Development and Educational Organization, Manipur; Jana Seva Foundation, Pune; National Resources Centre for Women Development, Bhubaneswar; and Nightingales Medical Trust, Bengaluru. See also https://socialjustice.gov.in/writereaddata/UploadFile/ANNUAL_REPORT_2021_ENG.pdf.

The Insurance Regulatory Development Authority (IRDA) formed a committee on health insurance for senior citizens to consider their special requirements and implemented various recommendations.

The Vayomithram project provides physical and mental healthcare and social healthcare for all senior citizens. The main objective of the project is to provide free healthcare to the elderly, including free medicines through mobile clinics, palliative care and help desk services.

The NISD reports on the performance of the RRTCs upon completion of assigned tasks/programmes to the DSJE on a half yearly basis in September and March every year.

3.7.3 Insurance Regulatory Development Authority

The mission of IRDA is to protect the interests of the policyholders and to regulate, promote and ensure orderly growth of the insurance industry and for matters connected therewith or incidental thereto. The organization is sensitive to the special needs of senior citizen policyholders and proactively laid down guidelines to cap the drastically rising hospitalization policy premiums by insurance companies. It formed a committee on health insurance for senior citizens to consider their special requirements and implemented various recommendations.

In 2009, the IRDA issued instructions regarding health insurance for senior citizens to the chief executive officers of all general health insurance companies which, inter alia, includes:

- (a) Allowing entry into health insurance schemes till 65 years of age.
- (b) Provision of transparency in the premium charged.
- (c) Reasons to be recorded for denial of any proposals on all health insurance products catering to senior citizens' needs.

3.8 State Programmes: Case Studies

This section briefly discusses the efforts of Government of Kerala to improve the life of the elderly in the state.

3.8.1 Vayomithram

This project was initiated by the Kerala Social Security Mission (KSSM), an independent autonomous organization under the Social Justice Department, and was implemented in six municipal corporations, 85 municipalities and one block in each district of the state.¹⁷ The project aims to provide healthcare and support including medical check-up and treatment through mobile clinics to the elderly aged 65 years

¹⁷ http://sjd.kerala.gov.in/scheme-info.php?scheme_id=MTA4c1Y4dXFSI3Z5.

and above. The project, based on a Canadian healthcare model for the elderly, was started in 2010/11 in 2 districts but was soon extended to 12 more districts, covering the entire state. KSSM implements this project jointly with Local Self Government Department.

Senior citizens aged 65 years and above and who are residents of Kerala can receive Vayomithram services. A monitoring committee tracks and reports on the project implementation every month. The monitoring committee comprises the state coordinator, standing committee chairpersons of the municipality/panchayat, welfare standing committee chairman, unit staff nurse, doctor and district coordinator.

Each project unit functions in a flexible manner, adapting to the needs of the local population and topography. Each panchayat unit has 20 clinics, and each municipal corporation/municipality unit has 24 clinics. However, these numbers can vary as per local needs such as population, number of beneficiaries and topography.

Funds for this project are provided by the state government through KSSM to all beneficiaries in the units covered by it. The project provides physical and mental healthcare and social healthcare for all senior citizens. The main objective of the project is to provide free healthcare to the elderly, including free medicines through mobile clinics, palliative care and help desk services. All medicines, manpower, materials and vehicles are provided by KSSM. Infrastructure, building, furniture, telephone and other facilities are provided by the municipality and panchayat.

The government provides ₹0.24 billion for the Vayomithram project annually. Each municipality and panchayat contributes 5 percent from its welfare fund to the project and block panchayats give 10 percent of their funds to this project. Every year, KSSM contributes ₹3 million–₹4 million to each unit, based on the number of beneficiaries and their needs. Since 2018, 50 percent of the funds is being contributed by the various municipalities and panchayats.

The Vayomithram project has resulted in an increased sense of self-esteem among the beneficiaries, especially the dependent elderly, because the programme provides medicines and other healthcare support.

A review of project outcomes shows an increased sense of self-esteem among the beneficiaries, especially the dependent elderly, because the project provides medicines and other healthcare support. There is no discrimination between rich or poor, and even the well-to-do who live a lonely life are covered. Many beneficiaries develop lasting friendships. Reviews highlight the following issues among others:

- (a) A decentralized management system would enhance quality of care.
- (b) Urban and rural components of the project need separate attention as issues are distinct.
- (c) A better computerized accounting system is needed.

These findings would prove useful as Government of Kerala plans to expand this project to all the villages in the state.

3.8.2 Pakal Veedu (Day Home) for the Elderly

This project started in 2002 with the aim to provide meaningful companionship to senior citizens during the daytime through day-care centres named Pakal Veedu; it was implemented under the 'Comprehensive Mental Health Programme' by the local self-government in Thrissur.

These centres have television, newspapers, books, music systems, chess and carom boards for the senior citizens along with a conference hall and clinic. Doctors visit the centre and provide necessary medical assistance; food and medicines are also provided free of cost. A panchayat representative visits the Pakal Veedu daily.

Pakal Veedu in Thrissur is one such centre where 25–30 beneficiaries regularly avail the benefits. The centre employs medical officers, one caretaker, two care providers, two cooks and one helper to look after the members during the day. The total expenditure for the Thrissur centre during 2017/18 was ₹0.65 million.

However, expansion and continuation of these day-care centres have been significantly hindered by lack of funds, building space and the COVID-19 pandemic.

3.9 Conclusion and Suggestions

India remains committed to taking all possible steps towards improving the quality of life of the elderly and protecting their rights and dignity through full implementation of the NPOP. However, there remains significant scope to improve the coverage of the scheme. It is also imperative to ensure that the benefits of the schemes reach the rural areas and also address the needs of elderly women.

Given below are some suggestions for better implementation of the programmes for older persons:

- (a) Awareness generation regarding the MWPSA Act, 2007 is critical. The interactions with various stakeholders in this field revealed a conspicuous lack of awareness regarding the legislation.
- (b) Senior citizens also lacked awareness about the various schemes and programmes meant for them. As a result, many eligible seniors do not avail the benefits of these programmes and schemes.
- (c) Though minimum standards have been formulated for government-supported old age homes, numerous private old age homes remain out of the purview of any form of scrutiny. Hence, these should also be brought under government monitoring, and a regulatory body can be set up for the same.
- (d) Elderly SHGs should be actively promoted and supported. The ESHGs should also be linked with the Livelihood Mission, wherein senior citizens may be provided with raw materials to make finished products for sale in the market.
- (e) Ensuring ageing in situ (at home) should be a priority. If senior citizens are admitted to old age home owing to short-term absence of supervision and companionship at home, they lose out on spending time with their families. Hence, crèche-like facilities or equipped day-care centres may be developed for them where they may stay for the duration that their family members are away. This will allow the senior citizens to spend time with their families once they return home.

4

Response from Community-Based Organizations

4.1 Introduction

The National Policy for Older Persons fully acknowledges that a more comprehensive response to the population ageing issue is possible only when government efforts are supplemented by contributions from civil society organizations, community-based organizations (CBOs), non-governmental organizations (NGOs) and the private sector. While many such organizations are already making significant efforts in this direction, this chapter attempts to capture contributions made by a few selected NGOs and CBOs in improving quality of elder care in terms of maintenance of old age homes and day care centres; support for senior citizens' associations; response to the daily needs of older persons; legal and medical assistance and awareness generation. A few selected CBOs formed by senior citizens themselves (elderly retirees and pensioners) are also discussed in this chapter. Due to resource constraints, the senior citizens' CBOs often restrict their services to members only but to gain adequate visibility at the higher levels, they work under umbrella agencies such as All India Senior Citizen's Confederation (AISCCON), Federation of Senior Citizens of Maharashtra (FESCOM), Indian Association of Retired Persons, Bharat Pensioners Samaj (BPS), etc. Some of the discussed organizations operate at national and state levels and some have an international presence as well.

This chapter presents findings based on primary data collected from the following organizations, some of which have been formed by elderly retirees or pensioners. Some of these organizations have pan-India operations while others are based in certain states.

- (a) All India Senior Citizen's Confederation (AISCCON)
- (b) International Longevity Centre–India (ILC–I)
- (c) Alzheimer's & Related Disorders Society of India (ARDSI)
- (d) Federation of Senior Citizens of Maharashtra (FESCOM)
- (e) Kerala Senior Citizen Service Council (SCSC)
- (f) Tamil Nadu Senior Citizens' Association (TANSECA)
- (g) Senior Citizens Council of Delhi (SCCD)
- (h) Bharat Pensioners Samaj (BPS)

Due to the COVID-19 pandemic, interviews were conducted online and sought to gather data on organizational structure, infrastructural facilities, profile of members, nature of activities, perceived strengths, weaknesses and future plans. Organization websites, annual reports and other documents were also reviewed to obtain additional information.

4.2 Activities

Community-based organizations design and implement programmes based on their vision, mission, objectives and mandate. An analysis of these shows the diverse nature of activities undertaken which include rights of the elderly, issues related to pension, individual cases of elder abuse, mental health and well-being, facilitating grievance redressal, digital and financial literacy programmes, and providing healthcare among other things. The CBOs also organize awareness programmes like seminars, workshops, conferences and meetings with experts on the rights of the elderly not only for the members but also for other older persons living in the community.

In addition to the above, the CBOs organize social activities such as birthday and festival celebrations, get-togethers, recreational

Community-based organizations design and implement awareness programmes like seminars, workshops, conferences and meetings with experts on the rights of the elderly not only for the members but also for other older persons living in the community.

Among other things, CBOs organize social activities such as birthday and festival celebrations, get-togethers, recreational activities, religious discourses, picnics, yoga sessions, educational lectures by experts, income generation programmes, counselling services and voluntary work to engage the elderly.

activities, religious discourses, picnics, yoga sessions, educational lectures by experts, income generation programmes, counselling services and voluntary work to engage the elderly. The activities are organized depending on the availability of financial resources, implementation expertise, etc. Some of these organizations were formed to address the specific issues of the elderly which became their mandate in the implementation of the programmes. For instance, BPS, with pensioners as members, organizes specific programmes like settling pension-related issues and providing legal aid; lectures on pre- and post-retirement concerns; and felicitations of their members. Similarly, ARDSI mainly focuses on dealing with dementia and Alzheimer's disease in older persons.

Some of the primary activities undertaken by these CBOs are discussed below.

4.2.1 Awareness generation

Senior citizens need to be aware of government policies, regulations, legal frameworks and various existing programmes and schemes exclusively meant for them. Increased awareness can empower them to know about their entitlements and enable better access to welfare programmes. Towards this end, CBOs organize several awareness programmes such as observing important days/months;¹ inviting experts to speak on specific issues; organizing theme-specific national and regional conferences/seminars/meetings;² and counselling. These and several other kinds of events are organized with the help of the community, corporates, local government, state-level federations and national-level organizations like HelpAge India. One such event is ILC-I's awards programme. The organization facilitates senior citizens' organizations for their contribution in the field of population

¹ Important days such as Elder Abuse Awareness Day (15 June); Alzheimer's Day (21 September); International Day of Older Persons (1 October), Republic Day, Environment Day, Foundation Day, Maharashtra Day, World Alzheimer's Month, etc.

² Examples of themes and topics: Maintenance of Parents and Senior Citizens Act, 2007; National Policy for Older Persons; and United Nations Principles for Older Persons, among others; other relevant policy and programme initiatives for the elderly, such as digital security, elder abuse, healthy ageing, etc.

ageing and inspires them to work for the welfare of the elderly. In addition, awards given to individuals acknowledge the efforts of senior citizens, who, despite many challenges, contribute to the development of society. Awards include the B. G. Deshmukh Jeevan Gaurav Puraskar to persons aged 70 years and above and the Anjani Mashelkar Inspiration Award to women aged 70 years and above.³

Such events help in building solidarity in the senior citizens' community and create better awareness of various issues related to ageing. They also help in advocacy and capacity development. As a follow-up, organizers of such events submit their unmet needs to the chief guests like ministers and political leaders. Most of the events are organized with active participation of their members in managing logistics, cultural activities, publicity and media coverage, fund raising, organizing souvenirs, preparing annual reports, etc. Such activities encourage older persons to interact with their peers on specific issues and contribute to the overall feeling of wellness while strengthening mental health and intergenerational bonds.

The CBOs also organize events for other sections of the society to spread awareness about elderly rights and health, but such organizations are few. For instance, ARDSI is one such organization that conducts awareness programmes for school children, college youth, and healthcare providers like ANMs⁴ and *anganwadi* workers.

Organizations like Kerala SCCD arrange exchange programmes for its members—senior citizens' groups from SCCD visit other countries such as Mauritius, Nepal and Bhutan on a reciprocal basis. These visits are organized through memoranda of understanding with senior citizens' associations of partner countries. Apart from being an excursion opportunity, such exchange programmes help the delegation to recognize issues faced by older persons in other countries and see the kinds of elder care facilities available in those countries.

³ Based on an interview with a representative of International Longevity Centre–India (ILC–I).

⁴ ANM = Auxiliary Nurse and Midwife.

The CBOs also organize events for other sections of the society to spread awareness about elderly rights and health, but such organizations are few.

Bharat Pensioners Samaj is one of the oldest organizations exclusively working for the rights of pensioners.

Most of these organizations have websites and regularly update them with information on various issues, programmes and schemes and highlight the different events that they organize for the elderly. They also prepare annual reports summarizing the different types of activities carried out through the year, along with statement of accounts, membership status and details about various programmes and schemes.

4.2.2 Financial support and security

Income insecurity is one of the primary reasons for increased dependency on children and others, and this vulnerability often leads to abuse and neglect. A large proportion of the elderly population is in the informal sector with no retirement age or pension benefits. Many CBOs play an important role in advocacy and protecting the rights of the elderly; in creating awareness, providing legal aid and counselling; and assisting in networking for employment opportunities.

Bharat Pensioners Samaj is one of the oldest organizations exclusively working for the rights of pensioners. The various services it provides include:

- (a) Assisting retired government employees in settling pension issues (if withheld or on experiencing harassment);
- (b) Acting as a pressure group in highlighting family pension issues for pensioners and their dependants;
- (c) Conducting regular awareness programmes on pension-related issues;
- (d) Organizing conferences on financial security at state, district and local levels; and
- (e) Assisting elderly persons who are not covered under health insurance schemes.

In the past, BPS has influenced various pay commissions to fix the pension amount for different levels of retirees. The organization

also intervenes and provides legal support if pensioners experience property disputes with family members.⁵

Kerala SCSC is another organization that creates awareness about various income-generation activities for its members. It helps resolve pension-related issues as well as facilitates access to various government old age pension schemes, especially for the elderly below poverty line (BPL) who are entitled to receive ₹1,400 as old age pension from the government. With the help of Kudumbashree,⁶ the organization connects the elderly with various government-sponsored livelihood schemes.

Tamil Nadu Senior Citizens' Association, through its sub-committee, seeks the help of pensioners' associations to support its members for pension-related problems. All India Senior Citizens' Confederation focuses its efforts on ensuring financial security of the elderly working in the unorganized sector.

Other federations like SCCD, FESCOM and ARDSI provide financial support for necessities such as food, clothes and medicines to the indigent elderly by raising donations from its members. The poor elderly suffering from dementia are provided free medicines worth up to ₹2,000 by ARDSI. Federation of Senior Citizens of Maharashtra also helps elderly widows by extending financial assistance for their daughters' marriages. International Longevity Centre–India conducts online training programmes on financial literacy for the elderly, teaches them to make online payments and supports members with free-of-charge guidebooks or user manuals.

⁵ Based on an interview with a representative of BPS.

⁶ Kudumbashree is a community-based poverty reduction and women's empowerment initiative with significant scope for direct and indirect benefits to the elderly by the Kerala Government. | United Nations Population Fund 2017. 'Caring for Our Elders: Early Responses', *India Ageing Report 2017*. (UNFPA, New Delhi, India).

4.2.3 Mental health and addressing elder abuse

Studies indicate many elderly persons experience mental health conditions such as cognitive decline, depression and dementia. The mental health concerns, especially among older persons, generally remain unidentified by healthcare professionals and the elderly themselves. As per a recent report of the Longitudinal Ageing Study of India (LASI), a higher percentage of the elderly aged 60 years and above (15 percent) are in the lowest 10th percentile of composite cognition score than older adults aged 45-59 years (6 percent), and nearly 30 percent of elderly persons have depressive symptoms.⁷

Organization such as ARDSI, BPS and SCCD focus on mental health issues and elder abuse specifically related to family, property disputes and loneliness.

The LASI report also states that mental health issues in India were closely related to education, age, gender, place of residence, widowhood, living arrangement and work status. Indian families traditionally follow the joint family system but in the recent years, living arrangements of older persons have changed and they are often left behind at their ancestral homes with little or no support as their children migrate to other cities and towns for employment. This has deeply affected the mental health of older persons.

Organization such as ARDSI, BPS and SCCD focus on mental health issues and elder abuse specifically related to family, property disputes and loneliness. They conduct regular awareness generation events and counselling sessions; provide advocacy support; facilitate medical and legal interventions; organize capacity-building activities and interactions with appropriate representatives to minimize mental health problems and elder abuse cases. They regularly counsel older persons experiencing harassment by their family members.

Alzheimer's & Related Disorders Society of India focuses on Alzheimer's and dementia patients and organizes mental health

⁷ IIPS, NPHCE, HSPH and USC, *Longitudinal Ageing Study in India (LASI) Wave 1, 2017 -18, India Report*, (International Institute for Population Sciences, Mumbai; National Programme for Health Care for Elderly, Ministry of Health & Family Welfare; Harvard T. H. Chan School of Public Health; and the University of Southern California, 2020), available at https://iipsindia.ac.in/sites/default/files/LASI_India_Report_2020_compressed.pdf.

clinics and day care centres for the elderly in 24 states. The organization also operates a helpline for the elderly with dementia along with awareness campaigns among communities, family members (primary caregivers) and security forces such as the police and traffic police to facilitate the identification of elderly persons wandering on the roads to protect them. It sensitizes and provides training to the health officials (doctors) and associated staff like paramedics, ANMs, *anganwadi* workers and community workers to identify and deal with elderly dementia patients and attempts to remove the stigma attached to it. It also provides necessary knowledge and expertise in preparing standard operating procedures for services like memory clinics, dementia support, full-time day care centres, staff training and in developing IEC materials for awareness generation related to dementia and Alzheimer's. It provides subscription-based memberships to family members of the elderly with mental health issues to avail appropriate services. Persons with dementia are not directly enrolled as members because of their medical condition, thereby their family members (the spouse, son or daughter-in-law) can contact ARDSI for counselling and other services. The organization is also the knowledge partner in Kerala State Initiative on Dementia. With the aim of establishing at least six memory clinics in every district, ARDSI is approaching various agencies for collaboration, supporting partner agencies with training and IEC materials. The organization feels that dementia is highly under-diagnosed, and these memory clinics will help recognize and diagnose the elderly living with dementia. These clinics will also support the elderly and their family right from the onset of symptoms to the advanced stages.⁸

Bharat Pensioners Samaj (BPS) conducts counselling sessions and workshops to prepare its members to deal with the retirement process, to manage life after retirement and increase participation in other activities to bring positive changes in society. These efforts are

⁸ Based on an interview with a representative of Alzheimer's & Related Disorders Society of India (ARDSI).

all meant to ensure that a retiree can smoothly adjust to family and community in the post-retirement life.

Senior Citizens Council of Delhi, too, intervenes to protect lonely senior citizens from humiliation and harassment by their children and others and helps resolve property-related issues. It actively organizes educational campaigns and assists the elderly who are abused by their children through the implementation of the Maintenance and Welfare of Parents and Senior Citizens Act, 2007, as applicable in Delhi. It acts as a pressure group and advocates on behalf of the abused elderly to take up their issues with the concerned authorities. It also plays a vital role in extending moral support and legal guidance to the victims of elder abuse, humiliation or neglect.

Kerala SCSC displays the state government helpline numbers on its website to assist the elderly with mental health problems or abuse. The TANSECA use press, print and electronic media such as a newsletter (*Linkage*), television and radio to spread awareness on mental health issues among elderly.

4.2.4 Digital literacy

Exposure to computers, internet and new modes of communication including email, WhatsApp and other social media is very important, particularly amongst the elderly. This requires regular training as technology gets updated frequently. Many CBOs have computer facilities and conduct such trainings as well as training on financial literacy such as operating an online bank account and carrying out online transactions. They also talk about the importance of digitization and motivate and teach the elderly to set up online accounts with secure passwords.

4.3 Policy Advocacy

Advocacy is increasingly being used by many CBOs to create a supportive environment for their efforts and to have a voice at the policy and decision-making levels by presenting evidence based on field research and on-ground experience. These efforts have often led to good visibility and support from the government.

Advocacy is increasingly being used by many CBOs to create a supportive environment for their efforts and to have a voice at the policy and decision-making levels by presenting evidence based on field research and on-ground experience.

All the CBOs discussed in this chapter have been effective in bringing the concerns and issues of older persons to the notice of relevant authorities and helped integrate their agenda into the planning and programming frameworks at the local level. While some CBOs gain membership in various committees that deal with the issues of the elderly at the national and international levels, others directly help the elderly with matters relating to law and social justice. These organizations are often invited to provide inputs in policy making and developing programme strategies.

Some noteworthy advocacy outcomes include increase in the interest rates for deposits of senior citizens⁹ (AISCCON) and travel concessions, subsidies in healthcare and financial support for the elderly (AISCCON and FESCOM). Bharat Pensioners Samaj played a role in bringing uniformity in healthcare services in CGHS, ECHS¹⁰ and Retired Employees Liberalized Health Scheme. To provide a suitable platform to its pensioners for raising their issues, BPS approached the Director of Pensions in 2007 and convinced him to start a pensioners' portal¹¹ that would provide all the necessary information related to pensions and procedures, along with daily updates. Later, the government started two additional initiatives—'Bhavishya' (counselling services for the elderly who are about to retire in six months' time) and 'Sankalp' (post-retirement career options and pension-related solutions).

Issues related to dementia and Alzheimer's were highlighted with the government by ARDSI through the Dementia India Strategy Report.¹² Based on the experiences gained through research studies and awareness programmes and campaigns, ARDSI drafted a plan

⁹ In India, the interest rate for fixed deposits for the elderly is higher than the non-elderly population.

¹⁰ CGHS = Central Government Health Scheme, ECHS = Ex-Servicemen Contributory Health Scheme.

¹¹ www.pensionersportal.gov.in.

¹² ARDSI, *Dementia India Strategy Report* (Alzheimer's and Related Disorders Society of India, New Delhi, 2018). <https://ardsi.org/pdf/Dementia%20India%20Strategy%20Report%202018.pdf>.

In recent years, many CBOs have realized that social network platforms are highly effective for pressurizing the government to act on issues.

to address dementia and submitted it to the Ministry of Health and Family Welfare, Government of India, to develop a 'National Policy on Dementia'. Dementia has been included in District Mental Health Programme under the Project Implementation Plan.¹³ The organization has also collaborated with Alzheimer's Disease International and World Dementia Council to execute related activities.

Organizations like AISCCON and ARDSI serve in different committees constituted by the Ministry of Social Justice and Empowerment and other concerned ministries. These organizations provide inputs for policy formulation and implementation of various programmes and schemes. They are also consulted when a review of the implementation of programmes and schemes meant for the elderly has to be undertaken and their inputs are taken into consideration by the concerned department/ministries.¹⁴ Along with the several noticeable advocacy activities, AISCCON also strongly pushed for the revision of the Senior Citizens Maintenance Act, 2007. Though the Act has been revised, it is yet to be passed by the Parliament.

Similarly, ILC-I is regularly represented in various committees constituted by the central and state governments and the National Human Rights Commission; it was part of the committees for the drafting of National Policy for Older Persons and providing inputs for the Madrid International Plan of Action on Ageing and Maharashtra Policy for Older Persons. The organization is also a satellite centre of the International Institute of Ageing (INIA), United Nations—Malta for the SAARC region.

In recent years, many CBOs have realized that social network platforms are highly effective for pressurizing the government to act on issues. Social media platforms like YouTube, Facebook, Twitter, etc. are used to present the concerns of older persons to the government, indicating that CBOs have started using social media effectively for their advocacy efforts too.

¹³ <https://www.alzint.org/news-events/news/recent-policy-development-around-dementia-in-india/>.

¹⁴ Based on an interview with a representative of All India Senior Citizens' Confederation.

4.4 Financial Resources

Most CBOs generate funds through membership fees and donations. The major sources of funding for AISCCON, with a pan-India membership of 2.2 million elderly persons, are donations from members and membership fees. The organization has utilized these funds to improve office infrastructure (construction, furniture, computers) and launched rehabilitation clinics and other facilities for its members. As a state-level organization, FESCOM collects membership fees and caters to the needs of several senior citizens' organizations in the state of Maharashtra.

The Kerala SCSC, which has a strong membership base, initially mobilized membership among the elderly through door-to-door visits. Gradually, publicity has helped increase membership to a considerable extent, and now senior citizens directly contact the organization's office seeking membership. There are various membership plans, the fees of which vary according to the plan chosen as well as the socio-economic background of the senior citizen. Donations received from its members are called 'working fund' and it is spent on core activities; 15 percent of this fund is given to the state committee and the rest goes to committees in various districts, units and mandals.¹⁵

Every pensioner is eligible to become a member of the BPS with the approval of the managing committee. The pensioners pay ₹2,500 to become a life member of the society and are entitled to receive the monthly journal, *Bharat Pensioner*, for the next 10 years. A pensioner can also pay an annual fee to become a BPS member and get a subscription of the journal. An affiliated body of pensioners pays an annual fee of ₹600 and uses BPS's platform to raise pensioners' issues. Membership fees can also be paid online on the organization's website.¹⁶ Membership also varies by jurisdiction and territory. Due to fewer number of pensioners, the membership fee is lower in

¹⁵ Based on an interview with a representative of Kerala Senior Citizen Service Council.

¹⁶ www.bps1955.in.

Some sources of funds for CBOs include grants from national and international organizations, service charges and CSR funds. Almost all the organizations receive money from one or several of these sources.

rural areas. At present, 541 associations along with 1,671 individual members are associated with the organization. The membership status is updated every month. The organization, which has been in operation for the past 65 years, believes that their membership numbers and donations increase because people have confidence in the mandate of BPS and the support it provides to all its members.¹⁷

Other sources of funds for CBOs include grants from national and international organizations, service charges and corporate social responsibility (CSR) funds. Almost all the organizations receive money from one or several of these sources. The ARDSI operates day care centres for the elderly, including 24x7 services for elderly dementia patients. The federation gets a regular amount of money in the form of service or monthly charges from the family members of the elderly for utilizing these services. It received a one-time grant from Tata Trusts for its activities. It also succeeded in getting a grant from a shipment firm which helped the federation to purchase sanitizers, gloves and other essential things to ensure safety of its members and staff at the centre during COVID-19.

The ILC-I gets its funding from both national and international sources. Given its status as a member of the global ILC organization, it regularly collaborates with organizations like INIA—Malta, other branches of ILC and government and non-governmental agencies in India. In addition, senior officials of the ILC also mobilize fundraising drives through their networks. The organization receives donations from the corporate sector, especially CSR funds. In addition to this, the registration fee received from the participants of the workshops and conferences also contribute to the organization's funds.

HelpAge funded the SCCD centre during the initial phase. Along with the membership fee, the SCCD receives a grant of ₹240,000 from the Delhi government every year. The BPS also receives grant-in-aid of ₹75,000 every year from the central government of India. Local corporations in Maharashtra sometimes donate to FESCOM to fund some of its specific activities.

¹⁷ Based on an interview with a BPS representative.

4.5 Research and Monitoring

Many CBOs contribute in different ways to build and utilize a knowledge base for planning and delivering services as per their action plans and standard operating procedures, and for capacity development through trainings and evidence-based advocacy. Many of them (FESCOM, BPS and TANSECA) also publish journals/newsletter, books and reports for their members and for wider circulation. Current and former senior officials of AISCCON, along with invited experts, author books on various ageing issues which are then published by the organization. The reports/newsletters/journals of the CBOs are generally published in the regional language and include information about the activities conducted by them. These are also displayed during various events and awareness campaigns and the information is also published on their websites and regularly updated.

Research studies primarily focus on mental health; living arrangements and its impact; rights of the elderly; caregiving and economic aspects, which are used for awareness generation and evidence-based advocacy. Some CBOs also conduct studies in collaboration with international and national organizations. However, a service-oriented CBO like FESCOM feels that research and documentation are low-priority activities for such organizations as they are considered to be “academic in nature”.¹⁸

Among the eight CBOs discussed in this chapter, ARDSI and ILC-I are research-based agencies carrying out multidimensional activities such as training, capacity building, provision of services and advocating on dementia and Alzheimer’s.

The ARDSI was established with a commitment to the cause of dementia and Alzheimer’s. It regularly carries out various studies on the different dimensions of the diseases. It recently conducted a research project entitled ‘Stride’ in collaboration with the National

The ARDSI was established with a commitment to the cause of dementia and Alzheimer’s. It regularly carries out various studies on the different dimensions of the diseases.

¹⁸ Based on an interview with a representative of Federation of Senior Citizens of Maharashtra.

Institute of Mental Health and Neuro Sciences, Bengaluru to assess the economic burden related to the caregiving aspects of people living with dementia and to understand the nature and extent of social stigma attached to these diseases. The organization brought out standard operating procedures for dementia care centres and a manual for health workers to learn about the warning signs of dementia and to identify a person with dementia. Organizations like ARDSI use research-based IEC materials such as brochures and pamphlets for their information dissemination and awareness generation campaigns.¹⁹

As a part of a global alliance, ILC-I emphasizes the importance of research in the field of ageing by regularly conducting studies on various ageing-related concerns and shares its findings in various seminars, conferences and workshops, both at national and international levels.

The senior members/executive committee members carry out quarterly or half-yearly review meetings to assess the progress of their activities and to take corrective measures for improvement as per planned achievement of activities and outcomes. Most of these CBOs invite experts in the field of ageing to help them assess their activities and progress. The annual reports and audited accounts are approved during annual general body meetings.

4.6 Challenges

Almost all CBOs face varied types of challenges while conducting their programmes. It is, therefore, worthwhile to examine these to find out if the challenges and hurdles can be mitigated, and thereby improve the effectiveness of these organizations, allowing them to execute their projects in a better and more efficient manner.

4.6.1 Pension-related issues and income security

There is no dedicated funding available for the care of older persons. The CBOs expressed a dire need for such allocations. They

¹⁹ Based on an interview with an ARDSI representative.

also highlighted the need to plan well in advance for some level of income security after retirement.

Mobilizing and sensitizing the officials involved in the pension disbursement process is extremely necessary. Officials should be sympathetic to the grievances of pensioners, especially those from the informal sector and poor communities.

4.6.2 Addressing mental health issues

Dementia and Alzheimer's disease are still considered a stigma in society. Hence, creating awareness and empathy on these issues within the community is one of the biggest challenges. The severity of these issues is appreciated only when an elderly person in the family suffers from dementia or Alzheimer's. Along with changing the attitudes of people, having a financial sustainability plan for programmes related to mental health is a challenge.

The CBOs organize trainings in geriatric care to build capacity among the younger generation to meet the rising demand for caregivers and the younger generation is very interested in participating in such trainings. Service-oriented agencies like ARDSI are forced to restrict admission to a limited number of dementia patients as the centres do not have adequate space and financial resources to provide services. Hence, financial sustainability is an essential aspect of mental healthcare for the elderly.

Educating the elderly about the importance of preparing a will instead of simply transferring their properties to their children is a difficult task. The existence of a will can safeguard against elderly abuse and ensure automatic transfer of property to the recipient upon the demise of the elderly person.

The shift from joint to nuclear family system has also led to an increase in mental health issues in older persons, and CBOs find it difficult to manage such large number of mental health cases. These organizations believe that there is a slow realization in the society about how the elderly contributed to and supported the joint family

Service-oriented agencies like ARDSI are forced to restrict admission to a limited number of dementia patients as the centres do not have adequate space and financial resources to provide services.

system, nurturing and mentoring the younger generation. Hence, they feel it is important to initiate efforts to retrieve the traditional value system that was spiritually and emotionally richer and more fulfilling.

4.6.3 Digital literacy

Convincing senior citizens to use digital platforms and providing the training and necessary gadgets for their daily use has been a challenge. This intensified during the COVID-19 pandemic when the elderly were forced to remain indoors. The CBOs have tried to connect with their members through emails and online meeting platforms such as Zoom and Hangout, encouraging them to use these platforms to the extent possible.

4.6.4 Effective advocacy

The government and CBOs need to work together to resolve the problems faced by older persons. This trusted partnership alone can increase effectiveness of schemes especially crafted for the benefit of the elderly. The third dimension is the community, which should also cooperate with and help all CBOs. This will build better synergy among the various stakeholders and help governments play a more supportive role. The CBOs meet with elected legislative and parliamentary representatives, bureaucrats and other policymakers and submit their demands but are often turned away citing fund-related constraints.

4.6.5 Financial stability

Expanding the membership base and collecting a membership fee from older persons who have meagre savings or earnings are additional challenges faced by CBOs. Also, many senior citizens are not readily willing to enrol owing to a lack of awareness about the activities and benefits of CBOs. Organizations such as AISCCON, FESCOM, TANSECA and Kerala SCSC that have a strong membership base at the grassroots level also expressed concerns about financial instability. They face challenges in convincing government authorities and other stakeholders to provide funds, recognition and other related support. Lack of financial stability hampers the execution of

Expanding the membership base and collecting a membership fee from older persons who have meagre savings or earnings are some of the challenges faced by CBOs.

regular activities as CBOs are forced to cut down on services and programmes.

Additionally, CBOs are unable to approach corporate houses for CSR funding as they lack the necessary expertise for preparing suitable fundraising proposals. Ageing is a low priority area for most corporates houses and CBOs state that this also affects funding prospects.

4.7 Conclusion

Although the number of CBOs has increased over the years, more such organizations are needed, particularly in the rural areas where an increasing proportion of the elderly population has little to no income security due to a severe lack of livelihood options and access to social welfare schemes. The National Policy for Older Persons recognized this even before the Madrid International Plan of Action on Ageing, 2002 made a plea for such support.

Key areas of support include allocation of funds and fund stability to stimulate growth of CBOs and envisaging a greater role for Panchayati Raj Institutions (PRIs) in monitoring the CBOs and helping them diagnose and cater to the needs of older persons in rural and disadvantaged communities. Significant points arise from this chapter that need to be pondered upon and resolved at the earliest, some of which are:

- (a) increasing avenues and sources of funding,
- (b) capacity-building of CBOs,
- (c) ensuring more active participation of the elderly in various agencies and organizations, and
- (d) creating income security for the elderly in the unorganized sector.

Apart from increasing the number of CBOs and expanding their reach and activities, this chapter also highlights the need to develop associated infrastructure such as construction of meeting places, procuring of training equipment for physiotherapy clinics and

CBO funding may not attract corporates, since it is difficult to measure results in relation to funds provided due to the very nature of the work.

developing suitable digital platforms for the elderly that can be accessed and used easily.

Besides government sources, there is a significant scope for the utilization of CSR funds for this purpose. However, CBO funding may not attract corporates, since it is difficult to measure results in relation to funds provided due to the very nature of the work. Hence, government support is needed to encourage corporate houses to support community-based initiatives despite issues of short-term measurability of achievements against expected results.

The Integrated Programme for Older Persons supported the creation of Regional Research and Training Centres (RRTCs) to stimulate and support growth and development of CBOs. This mandate to create RRTCs should be strengthened through the use of CSR funds. At a higher level, institutions like Tata Institute of Social Sciences and International Institute for Population Sciences can receive funding based on their proposals and help implement projects at the grassroots level. HelpAge India can also be given this responsibility as it aligns with their mandate very well.

Corporate Sector and the Welfare of Senior Citizens

5

5.1 Context

While the government has implemented several programmes and schemes for the welfare of senior citizens, given the increase in their numbers, the private sector too can play a major role in addressing their physical, social, economic and emotional vulnerabilities.

Under Schedule VII of the Companies Act, 2013 corporate entities are obliged to spend 2 percent of their net profits averaged over three preceding financial years for social development. The focus areas of such corporate social responsibility (CSR) spending have been revised periodically, one of the most recent additions being ageing issues where specific initiatives include developing vocational skills, initiating livelihood enhancement projects, setting up old age homes, day care centres and similar facilities, and benefits for armed forces veterans and war widows. With this amendment in force, the elderly can now hope for financial and technical support from the corporate sector as well to improve their lives and living conditions.

This chapter discusses how CSR funds are being utilized for the older population. It also analyzes the framework adopted by corporate firms on elder care, intervention models, and the impact being created. Annual reports and other related data maintained by corporate entities were studied for this purpose.

While exact figures on private investment into elder care and senior support are not available, the data on spending under CSR initiatives reveals some stark facts.¹ From 2014 to 2021, a total of ₹1259.6 billion was

¹ All CSR expenditure data in this chapter is drawn from the Ministry of Corporate Affairs, Government of India. See also, <https://csr.gov.in/content/csr/global/master/home/home.html>.

spent as CSR funds (Table A5.1). Of this, the education sector received ₹365.6 billion (29 percent), healthcare received ₹251.3 billion (20 percent), the rural development sector received ₹122.6 billion (9.7 percent) and environment and related areas received ₹77.6 billion (6.2 percent). Gender equality, women empowerment and homes for elderly women received relatively lower CSR funding. The increase in the total CSR spending from 2014 to 2021 has been phenomenal (182 percent in seven years). Share of private companies in CSR spending continues to dominate, rising from an average share of 79 percent in 2018–2020 to 82 percent in 2020/21.

5.2 Corporate Social Responsibility and Senior Citizens' Welfare

Since 2014, CSR spending on senior citizens' welfare (SCW) has remained less than 0.3 percent of total spends despite a 516 percent growth, from ₹89 million to ₹551 million, in the last seven years (Table 5.1). While the increase indicates a significant shift in corporate attention towards SCW, the miniscule share indicates that a lot more needs to be done to sensitize the corporate sector to the vulnerability of the older population and to encourage them to invest more.

TABLE 5.1: Share of CSR spending on senior citizens' welfare

Year	Total CSR spends (₹ billion)	CSR spends on SCW (₹ billion)	Percentage CSR spends on SCW
2014/15	100.6	0.09	0.09
2015/16	145.8	0.21	0.15
2016/17	143.4	0.28	0.19
2017/18	170.9	0.4	0.23
2018/19	201.7	0.44	0.22
2019/2024	8.9	0.52	0.21
2020/2124	8.6	0.55	0.22

Abbreviations: CSR, Corporate Social Responsibility; SCW, senior citizens' welfare.

Source: All CSR expenditure data in this chapter is drawn from the Ministry of Corporate Affairs, Government of India. See also, <https://csr.gov.in/content/csr/global/master/home/home.html>.

5.3 State-wise Investment of CSR Funds

Funding from corporate houses for SCW is mainly concentrated in five states—Uttar Pradesh, Maharashtra, Tamil Nadu, Delhi and Gujarat—reflecting the number of companies located in these states and their commitment towards SCW (Table 5.2).

TABLE 5.2: Leading states in CSR spending on senior citizens' welfare

Year	State	CSR funding (₹ million)
2014/15	Uttar Pradesh	24.6
	Maharashtra	12.8
	Tamil Nadu	7.4
	Delhi	6.8
	Gujarat	6.4
2015/16	Maharashtra	40.8
	Tamil Nadu	30.5
	Rest of India	26.6
	Uttar Pradesh	25.2
	Delhi	15.7
2016/17	Uttar Pradesh	80.1
	Tamil Nadu	42.2
	Maharashtra	29.4
	Rest of India	24.6
	Delhi	18.6
2017/18	Uttar Pradesh	58.7
	Tamil Nadu	53.5
	Maharashtra	48.1
	Delhi	32.4
	Gujarat	16.1
2018/19	Uttar Pradesh	79
	Rest of India	76.2
	Maharashtra	58.7
	Delhi	33.3
	West Bengal	22.5

Table A5.2 lists companies that are actively funding SCW projects through CSR initiatives. The data shows that barring Gail (India)

There are 14 broad development sectors categorized under CSR fund allocation. The SCW sector is placed under the category of 'Gender Equality, Women Empowerment, Old Age Homes, Reducing Inequalities'.

Limited, Shree Cement Limited and South India Corporation Limited, most firms have reduced CSR funding for SCW over time.

5.4 Nature of Interventions in Elder Care

There are 14 broad development sectors categorized under CSR fund allocation. The SCW sector is placed under the category of 'Gender Equality, Women Empowerment, Old Age Homes, Reducing Inequalities'. This broad categorization creates ambiguity, especially when project details and beneficiaries are not clearly articulated for elder care. While elder care is a low priority area for CSR spending, corporate houses that have invested in this sector have implemented a variety of projects in the following categories:

- (a) *Promoting ageing with joy*: Providing psychosocial support and counselling to senior citizens to promote active engagement and enhancing their social and cultural life as well as education.
- (b) *Integrated social assistance and health security*: Providing medical and safety services, home-based/hospice care, support stays, preventive healthcare and wheelchairs.
- (c) *Supporting and setting up old age homes*: Offering financial support and providing basic amenities such as blankets, food items and other maintenance support.
- (d) *Awareness campaigns*: Highlighting abuse against the elderly.

The National Policy on Senior Citizens clearly states that given the seriousness of population ageing in a largely agriculture-dependent country like India, a lot more resources would be needed to tackle the issue than what the government alone can allocate. Hence, the policy recognizes the importance of contributions made by non-governmental and community-based organizations (NGOs and CBOs) as well as the private sector. Larger outlays for SCW would need more partnerships with CSR initiatives and with this in mind, National Stock Exchange (NSE) Foundation and Tata Trusts have jointly collaborated with the Ministry of Social Justice to scale up the National Elder Help Line across all states in India. Similarly, many partners have come together to take forward the 'Digital Health'

intervention and enabled the government to pilot the model for adoption.

5.5 Corporate Sector Involvement in Elder Care: Case Studies

The CSR initiatives of Tata Trusts and NSE Foundation in the elder care sector have been multidimensional and holistic, and therefore, it is worthwhile to examine their work as case studies and draw useful lessons for motivating and providing direction to other corporate firms. The case studies present the organization profile, their rationale in choosing ageing issues as part of CSR activities, the core team involvement in initiating the activities, engagement with other stakeholders including government and non-governmental agencies, nature of activities, coverage of projects, profile of beneficiaries, monitoring and evaluation framework, and documentation.

5.5.1 CSR initiatives in elder care by Tata Trusts

Tata Trusts designed an intervention in 2017 to improve the quality of life and dignity of the elderly. This was piloted with two alternative approaches keeping sustainability considerations in mind. The two approaches included:

- (a) developing models to facilitate services to the urban and rural elderly through existing government schemes and engaging elderly members by setting up activity centres for healthy ageing and
- (b) setting up a central response system (helpline) with a disaggregated data structure at the backend that would enable any caller to get appropriated solutions to their issues.

Urban programme

Activity centres facilitated continuous engagement and promoted the concept of joyful ageing with inter-generational activities. They encouraged volunteerism among the elderly and their participation in community work. Tata Trusts, along with HelpAge India and other local organizations, initiated one such activity centre as a pilot project in September 2018 in partnership with

One of the members using this facility said, “It’s not that I was not social or was isolated from my family. I am the kind of a person who is always jovial and active but being part of a facility, which is exclusively dedicated for people of our age group, is a different and special experience altogether.”

the Government of Odisha. The centre started with 115 registered members who engaged in activities that included physiotherapy, yoga, health check-ups, health-and-awareness sessions, indoor games, community work, etc.

The centre used two scientific tools—SF-36 and CASP-19—for measuring the health and happiness index of members every six months.² Results of a study conducted for 27 members showed a significant improvement in the happiness and well-being of the members. The average standardized CASP-19 score of 76 at the time of registration increased to 83 after six months. Almost 60 percent of the members showed absolute improvement in their CASP-19 score. Similarly, 44 percent of the members showed improvement in health status based on SF-36 scoring.

In addition to the activity centre, the elderly across Bhubaneswar were engaged in niche programmes like storytelling and writing capturing their rich life experiences; curated trips for community engagement; digital literacy for upskilling; sensitization of school children towards the elderly as part of ecosystem building; and reaching out to the elderly in the slums through health camps. The intervention in the slums gave an opportunity to the senior volunteers to contribute to society.

Building partnerships is an important part of programmes at the activity centre as well as for conducting city-wide programmes. The

² The 36-Item Short Form Health Survey questionnaire (SF-36) is a very popular instrument for evaluating health-related quality of life. It’s a set of generic, coherent and easily administered quality-of-life measures. These measures rely upon patient self-reporting and are now widely utilized by managed care organizations for routine monitoring and assessment of care outcomes in adult patients. The SF-36 consists of eight scaled scores wherein the lower the score the greater the disability indicated and vice versa. The CASP-19 is a quality-of-life assessment test comprising four domains: Control, Autonomy, Self-Realization and Pleasure. This tool was initially developed for the population aged 65–75 years. Its design scale covers some pivotal aspects of life pertaining to physical activity, human behaviour and self-awareness. It is a quick, effective, multidimensional instrument with equally good psychometric properties.

Government of Odisha has also initiated the creation of an integrated centre at BMC Mall (Bhubaneswar) which will include services for the elderly. This was conceptualized jointly with the Tata Trusts team and design inputs were provided. Successful operationalization of this centre holds the potential for a public–private partnership.

Leveraging the learning and experience from the Bhubaneswar activity centre, Tata Trusts initiated a similar project in Hyderabad in collaboration with Andhra Mahila Sabha (DDMS) in 2019 with support from Tata Advance Systems Limited for human resources.

The pandemic changed the lives of senior citizens and exacerbated some key concerns experienced by them daily. With the isolation and loneliness, they became more prone to anxiety and fear and other mental health issues, adversely affecting their overall health and well-being. There was a pressing need to provide support and engage the elderly during these uncertain times. With the closing of the physical centres during lockdowns, the programme to keep the elderly engaged and ensure their physical and mental well-being was taken online.

Based on the results of digital readiness survey and with the vision of establishing an elder-centric ecosystem through virtual support, the Elder Care team at Tata Trusts initiated a virtual programme in Bhubaneswar and Hyderabad in April 2020.

The virtual engagement programme consisted of three main interventions:

- (a) *Engagement activities*: WhatsApp group/other online chat groups were used to conduct activities focusing on health and fitness, recreation, cognitive alertness, etc.
- (b) *Engagement and learning*: Interactive platforms such as Google Meet, Zoom, Microsoft and Teams were used to conduct interactive sessions and webinars on relevant issues.
- (c) *Digital literacy*: Training and guidance were provided to participants on learning applications and using online interactive platforms.

The pandemic changed the lives of senior citizens and exacerbated some key concerns experienced by them daily. With the isolation and loneliness, they became more prone to anxiety and fear and other mental health issues, adversely affecting their overall health and well-being.

Other interventions included connecting with the elderly on the phone at regular intervals and e-advisory services for physiotherapy, emotional counselling and e-volunteer programmes.

Rural programme

In 2018, a comprehensive elder care programme was initiated in Mul block, Chandrapur district in Maharashtra to facilitate the implementation of the National Program for the Healthcare of Elderly (NPHCE) as a pilot initiative in partnership with the Public Health Department of the Government of Maharashtra and Janseva Pratishtan, the implementing agency. The programme was subsequently expanded to all the blocks of Chandrapur district in 2019. A similar project was initiated in Yadgir, Karnataka, in collaboration with the Government of Karnataka and Kalike (an initiative of Tata Trusts).

The objectives of these programmes were to strengthen the health services delivery for the elderly; running dedicated weekly geriatric clinics at primary health centres (PHCs) and capacity building of human resources in the healthcare system on conducting comprehensive geriatric assessment and clinical assessment. As per the NPHCE guidelines, a health card was introduced to help the staff record their observations in a standardized and systematic way during the geriatric assessments for better diagnosis and treatment. This developed awareness about seeking proper healthcare among the elderly.

In addition, activity centres were established in association with gram panchayats to improve the mental and physical well-being of the elderly and to address issues of loneliness and depression. Senior citizens were also invited to participate in physical activities such as yoga, recreational games, awareness sessions and bonding sessions with local school children. These centres operated three to four days a week for two to three hours a day and were run by volunteers with help from Accredited Social Health Activist (ASHA) workers. In some places, these centres were converted into health and wellness centres where the designated community health officer conducted

activities for the elderly and organized special yoga sessions as part of the wellness component.

The Chandrapur model was showcased by the Government of Maharashtra and Tata Trusts at the Best, Innovative and Replicable Practices Summit, 2019 organized by the Government of India and was highlighted under the Ayushman Bharat Yojana.³ The central government was keen to expand this project to five other districts in the state and released funds under the 2019–2020 Program Implementation Plan for the same. The state government is planning to start activity centres in all health and wellness centres in these five districts along with weekly geriatric clinics at the PHCs.

Based on the success of the Chandrapur model, NSE Foundation agreed to partner on a similar programme in the Nandurbar district along with Collectives for Integrated Livelihoods Initiative, another Tata Trusts initiative. This was a good example showcasing the collaborative efforts of various CSR organizations, state governments and the central government to create a working and scalable model.

Elder Spring Response System: Helpline for the elderly

An assessment of the existing helplines in the country showed that a dedicated helpline for senior citizens, including those in the rural areas, was much needed to address their diverse issues. The Elder Spring Response System with a toll-free number (14567) was established and the programme was implemented by Vijayavahini Charitable Foundation (supported by Tata Trusts) in Telangana.

The response system operated through a 'connect centre' and a field team. Senior citizens as well as anyone who wanted to volunteer with the programme could make use of the service through the toll-free number. The initial set of services rolled out included talking to the elderly and counselling them, providing information pertaining to

Based on the success of the Chandrapur model, the NSE Foundation agreed to partner on a similar programme in the Nandurbar district along with Collectives for Integrated Livelihoods Initiative, another Tata Trusts initiative.

³ MOHFW, *We Care: Good, Replicable and Innovative Practices*, (Ministry of Health and Family Welfare, Government of India, 2019). https://nhm.gov.in/New_Updates_2018/Innovation_summit/6th/We-care-Coffetable-book.pdf.

The Ministry of Social Justice and Empowerment (MOSJE) took cognizance of the impact of the helpline in Telangana and decided to expand the programme nationally.

elder care, guidance on legal and pension-related issues and field support for the homeless elderly and victims of abuse.

Four different categories of services were offered through the response system:

- (a) *Information* on old age homes, care givers, day care centres, elder-friendly products, hospitals, diagnostic centres, etc.
- (b) *Guidance* on legal issues (property, land litigations with either family or others), abuse (kith and kin or others, including employers), writing or changing will, pensions, provident fund-related issues or social security pension, etc.
- (c) *Emotional support* to reduce loneliness, to seek support if depressed, psychological support, etc.
- (d) *Field intervention* including:
 - (i) care for homeless or abused elders,
 - (ii) accommodation in partner old age homes after due medical attention, following a well-defined process, and
 - (iii) emotional and procedural support to elders in abuse and maintenance-related cases.

The Ministry of Social Justice and Empowerment (MOSJE) took cognizance of the impact of the helpline in Telangana and decided to expand the programme nationally.

Lessons learned

Through these three pilot interventions, Tata Trusts tried to showcase the process of addressing the needs of the elderly in urban and rural areas. All three initiatives have the potential for scaling up for greater impact in improving the quality of lives of the elderly by collaborating with different CSRs and state governments.

Hesitancy in collaborating with the central or state government efforts restricts the possibilities for creating better models of service delivery. However, trying to communicate and align with the vision of

some government schemes can have positive fallouts in the longer term for senior citizens in rural areas as well where private sector players in the elder care space do not reach.

5.5.2 CSR initiatives in elder care by National Stock Exchange Foundation

National Stock Exchange Foundation (NSEF) undertakes CSR activities of the National Stock Exchange of India Limited and its subsidiaries (NSE Group), with a broad vision of enhancing the well-being of underprivileged and marginalized communities. The NSEF strives to improve the quality of life of its identified beneficiaries, thereby creating inclusive societies, while meeting the social and environmental responsibilities of NSE Group.

The NSEF's aim of CSR interventions with the elderly population is to ensure an overarching and supportive ecosystem while ensuring access to social, economic and health security in the most backward aspirational districts, with a special focus on vulnerable communities including elderly women.

Starting in 2015 with small programmes focusing on health and wellness for the elderly in the urban slums of Dharavi and Jogeshwari in Mumbai, NSEF has designed and implemented projects that integrate social, health and economic needs of the elderly in vulnerable locations of the country, particularly in the states of Bihar (Supaul), Maharashtra (Nandurbar, Yavatmal), Tamil Nadu (Ramanathapuram), Telangana (Yadadri), West Bengal (Birbhum) and Rajasthan (Karauli). Local partners and agencies include HelpAge India, ISAP, Karuna Trust, COECOEDCON, Gravis, etc., to ensure enhanced collaborative understanding and intensive impact.

The NSEF adopts a transformative approach to elder care that is strategic, participatory, evidence-based, localized and focused on impact, learning and reflection. Based on its detailed understanding of the elderly segments and review studies from the field, NSEF discovered that not all elders are retired 'from any activity' and are willing to take responsibility and ownership of their growth. Hence,

The objective of social inclusion is to promote a cohesive and sustainable ecosystem for social security for elders in rural areas.

the model that NSEF has curated and follows is the 'Empowerment of the elderly by the elderly'.

The model represents a continuous journey to empowerment which indicates that elders are empowered only when they are socially included, have access to improved healthcare and attain financial independence.

The critical anchor of this model are the localized institutions that elders are formed into and operate out of that also serve as instruments of knowledge and technology dissemination and hubs of production, collectivization and commerce. The model nurtures these institutions by addressing their issues of care, social cohesion, health inclusion and economic security.

Social inclusion

The objective of social inclusion is to promote a cohesive and sustainable ecosystem for social security for elders in rural areas. The model promotes social cohesion by developing stronger interconnected groups of elders called elderly self-help groups (ESHGs), federating them and facilitating support to other disadvantaged elders. Once the elders are collectivized into ESHGs, the groups are provided the following services:

- (a) *Training and capacity building*: The elders are provided with the requisite information, knowledge, tools, skills, etc., pertaining to rights, healthcare and finance. The focus is on developing and engaging elder care community professionals and community resource persons who in turn service the elders and institutions for the elderly. The model uses various participatory tools and innovative digital techniques to disseminate key messages to elders.
- (b) *Access to social security schemes*: One of the key deliverables of social inclusion is enhancing access of elders to social security schemes, including identity, pension, health and livelihood schemes. The NSEF engages with specialist technical agencies to enhance access to various central and state government schemes.

- (c) *Strengthening elder groups through cohesive activities:* The NSEF believes that it is important to integrate its elder care interventions into the social fabric of the society and hence, facilitates many community-wide activities. The underlying emphasis is on the 'elder for elder' concept where elders are trained and empowered to collectively take responsibility for and address issues. These interventions have a two fold agenda—to make visible the concerns of elders with the wider community and to foster intergenerational dialogue.

Health access

The programme facilitates adequate access to healthcare and palliative care, focusing mainly on vision and mobility challenges to enhance active participation of the elderly in community life. The NSEF and its partners converge with state health missions at field and district levels to enhance access of elders to health services. Food, nutrition and health security is further promoted through local institutions like *anganwadis*, women and elders' institutions and healthcare centres. The key activities undertaken are described below:

- (a) *Provision of vision and mobility-related aids to the elderly:* The NSEF collaborates with technical agencies to provide intraocular lenses (for cataract surgeries) and polycentric knee braces for elders in the community. The needy are identified through participatory processes and then referred to the specialist camps for services. The important combination of vision and mobility aids assists elders in being active in the community for a longer period and also lifts their morale.
- (b) *Multi-specialty health camps:* The NSEF collaborates with the local health system to facilitate multi-specialty health camps at the community level. The disciplines are mapped to the corresponding needs of the elderly in the villages to ensure coherence. While NSEF covers the costs, it is the elderly that manage the operations and the logistics. This fosters a sense

NSE Foundation collaborates with the local health system to facilitate multi-specialty health camps at the community level. The disciplines are mapped to corresponding needs of the elderly in the villages to ensure coherence.

of belonging and ownership amongst the elders while also promoting their health-seeking behaviour.

- (c) *Village-level accredited clinics for primary and palliative care*: A corollary and a sustainable intervention to the above includes the village-level clinics for accessing basic healthcare services. It also segues into the palliative care services which are elder-led but supported by younger para-health professionals. Volunteers are trained on crucial health issues for the elderly to become first responders, sometimes providing very crucial home-based palliative care for the most vulnerable/unwell elderly.

Financial inclusion

The programme moves beyond basic banking services to build capacities of elders in using/accessing technology-based mainstream financial tools and services and supporting elders in building individual and collective livelihoods while increasing their bankability. Conversely, it engages with financial institutions to introduce elder-friendly policies and offer age-appropriate services. As part of the financial inclusion, the programme facilitates:

- (a) *Strengthening financial health of ESHGs*: The programme promotes regular savings, thrift and lending activities in ESHGs by following the Pancha Sutra indicators of financial discipline (meetings, savings, inter-lending, repayment and record keeping). Community mobilizers build capacities of the elders to have good financial practices. They also educate them on ways to leverage joint savings for their emergent needs. The NSEF projects help the elders establish bank linkages through account opening and leveraging financial schemes and subsidies.
- (b) *Developing business acumen of ESHGs*: The model is cognizant of the requirement of resources for capacity building of groups. Hence, there are concerted efforts by NSEF and its implementation partners for training, exposure, immersion and capacity building of elders, community professionals, including programme staff, concerned government officials, NGOs, panchayat functionaries and other stakeholders.

- (c) *Deployment of seed capital:* The adherence to Pancha Sutras develops enormous bonding, mutual trust and support among group members. Every ESHG is graded to capture the adherence to Pancha Sutras and to identify the weak spots in their functioning. The grading determines the credit worthiness of the group which aids in the next step of release of seed capital, a revolving fund provided to ESHGs for further deployment to individual members as loans to aid set up of individual livelihoods. The revolving fund acts as a catalytic capital for leveraging repeat bank finance and other bank linkages.
- (d) *Federation of ESHGs and launch of collectivized livelihoods:* The ESHGs are further collectivized and clustered into federations at block and district levels. The federation works on a 'I produce and I consume' model on two to three core livelihood activities. The federation enables collectivization of production services and enables access to market linkages at scale, thereby promoting better scalability and success of livelihood intervention, developing their business plans for micro enterprises and creating market linkages.
- (e) *Group re-grading:* Re-grading of the groups is usually taken up after 9–12 months have elapsed to provide enough time for all groups to match up. Sapt Sutra is a value-add, when, after a significant time of maturity and functioning, the two concepts of community social responsibility or reaching out to other needy in the community and that of social (development) action are introduced.
- (f) *Deployment of vulnerability reduction fund and promotion of collective livelihoods:* Federations are supported through vulnerability reduction fund to mitigate vulnerabilities and promote collective livelihood enterprises.

Every ESHG is graded to capture the adherence to Pancha Sutras and to identify the weak spots in their functioning. The grading determines the credit worthiness of the group which aids in the next step of release of seed capital.

Monitoring and evaluation of projects

The NSEF uses a results-based approach to monitor progress of all its social investment programmes, with assessments involving quantitative and qualitative indicators. Long-term outcome indicators

The project locations are selected after deliberations to demonstrate strategic interventions in distinctive demographic and situational scenarios present in the different states of India.

are aligned to national priorities and goals, and benchmarks are identified. Each thematic intervention also has identified output indicators which are tracked on a quarterly/annual basis for progress. Performance assessment is enhanced through the systematic monitoring of indicators. The emphasis is on the active application of monitoring and evaluation findings for the continuous improvement of strategies, programmes and other activities.

Area of intervention, partnerships and outreach

The project locations have been selected after deliberations to demonstrate strategic interventions in distinctive demographic and situational scenarios present in the different states of India. One critical reason for working in these varied locations and geographies is to establish the proof of concept and scale while addressing the amplified multiple vulnerabilities of the elderly, specifically women, through quality healthcare, economic security and social support mechanisms. The selected project locations are representative of present-day rural India denoted by high vulnerability to out-migration, floods and droughts, social backwardness and other debilitating factors that create a large pool of vulnerable elderly.

Localization of the model

The approach built upon the original model of social–health–economic empowerment has been suitably adapted and implementation strategies have been devised in the context of additional vulnerabilities in difficult terrains. The projects seek to establish the regime of community care and the elder-for-elder concept through the formation and strengthening of ESHGs to lead elders towards a dignified life. The project approach and localization nuances have been detailed below.

- (a) *Project Shraddha* was initiated to foster comprehensive and sustainable interventions for financial, emotional, social and health support to underprivileged senior citizens across India. Elderly inclusion is enabled through ESHGs and their higher order federations at the village and cluster levels. Additionally,

given the relative lack of primary healthcare access in rural areas, especially for the elderly, a community-managed module for healthcare to manage chronic ailments with palliative care for the bed-ridden and destitute elderly is institutionalized within the village itself.

- (b) *Project Clean (Climate and Livelihood Enhancement and Nutrition)* is the first project of its kind where ESHGs have participated on the environment and livelihoods front. The key idea was to improve livelihood and supplementary earning through the plantation of fruit-bearing trees. It was expected that by planting trees, there would be an increase in water catchment and enhanced soil quality. The project facilitated the setup of liquid manure units, not only to help in better growth of the trees but also utilize cow dung and other plant wastes in the production of manure. Each village has two to three liquid manure units to provide organic fertilizers to plants, which help survival and aid faster growth. The project was unique as it melded simultaneous participation of the elderly as collectives in contributing both labour and time for plantation, maintenance and monitoring.
- (c) *Project Aalambana* was envisaged to carry forward the positive lessons from Project Shraddha into more difficult geographies of aspirational districts. The project also encompasses digital inclusion of elders through common service centres where they will be provided training on digital literacy. As a long-term plan, these centres will be set up by the elders for the elders.
- (d) *Project Samarthyaa* is being implemented in one of the most backward aspirational districts of the country, Nandurbar. Under the livelihood promotion component for elders, the project has explored localized interventions, such as organic farming of chia seeds and quinoa which fetch a better market price, and food processing and poultry, which will be easy to implement and scale. The project has also started a brand under which the elderly groups can brand and sell their products. Under healthcare, the project has set up mobile medical units with weekly time slots

Project Clean (Climate and Livelihood Enhancement and Nutrition) is the first project of its kind where ESHGs have participated on the environment and livelihoods front. The key idea was to improve livelihood and supplementary earning through the plantation of fruit-bearing trees.

for elders. The project also focuses on equipping them with information on better health, nutrition and referrals for quality specialty care.

- (e) *Project Samrakshana* adapts the elder-for-elder network approach to build resilience and works on threefold issues of social, health and economic inclusion of elders. The uniqueness of this project is the focus on health access through general health, dental and Siddha health camps. The project has also set up wellness centres for elders, guided by the Ayushman Bharat guidelines by Government of India.
- (f) *Project Sustainable Livelihood in Agri-allied Business* focuses on upskilling elders and providing entrepreneurial placement support to the elderly. The project has focused on enabling elders to receive additional income while taking care of their family through activities such as beekeeping and neem oil processing. The project covers 500 elders while guaranteeing a monthly income of around ₹7,000 per person. The project is also working on providing market linkages for the produce.
- (g) *Project Comprehensive Elderly Care Programme* focuses on setting up dedicated healthcare access for the elderly and taking a systematic approach in coordination with local authorities. The project works in accordance with the government programme on setting up geriatric clinics at primary health centres on a weekly basis. The project covers 2,200 elders in Nandurbar.
- (h) *Project Urban Elder Care* was rolled out in Mumbai (Dharavi, Jogeshwari, Sewree and other lower income and slum pockets) in association with Dignity Foundation and Family Welfare Agency. The interventions catered to a cumulative number of around 51,000 elders. Elder enrichment centres were set up to provide needs-based services such as social, recreational, educational and care of destitute community members. Counselling of elder individuals and family members was taken up to address issues of mental health, loneliness and abuse.

Approach to convergence, collaboration and sustainability

The NSEF aspires to create a sustainable and unified ecosystem for elders through multidimensional and multi-stakeholder engagement with the government, youth and wider community. The projects have established positive community accountabilities and are concentrating on conjoint accountabilities with the wider ecosystem to enhance the quality of results and segue in long lasting and sustainable impact.

The model is also aligned with NITI Aayog's aspirational district programme for health and nutrition, financial inclusion, skill development and basic infrastructure. This provides impetus to NSEF to be a strong partner in actualizing the government's vision for state-driven development, focusing on the key districts and act as a catalyst for development. Besides this, the model builds convergence with government programmes and collaborates with various stakeholders to reach the last mile and deliver programmes effectively on the ground. The model is cognizant of the wide diaspora of the country and, as such, NSEF works largely with the poorest elderly of the country. This ensures that the projects prioritize last mile connectivity and follow the motto of 'leaving no one behind'.

Annexes to Chapter 5

TABLE A5.1: Sector-wise expenditure on corporate social responsibility initiatives (2014–2021)

S. No.	Development sector	Amount spent (₹ billion)							Cumulative (in ₹ billion)
		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	
1.	Art and Culture	1.2	1.2	3.1	4.0	2.3	9.3	4.8	25.8
2.	Conservation of Natural Resources	0.5	0.5	1.2	2.3	1.7	1.6	0.9	8.6
3.	Environmental Sustainability	7.7	8.0	10.8	13.0	13.6	14.7	9.8	77.6
4.	Slum Area Development	1.0	0.1	0.5	0.4	0.5	0.4	0.8	3.7
5.	Socio-Economic Inequalities	0.4	0.8	1.5	1.6	1.7	2.2	1.2	9.2
6.	Agro Forestry	0.2	0.6	0.4	0.7	0.7	0.7	0.2	3.4
7.	Senior Citizens' Welfare	0.1	0.2	0.3	0.4	0.5	0.5	0.6	2.5
8.	Setting Up Orphanage	0.1	0.2	0.2	0.4	0.1	0.4	0.2	1.4
9.	Other Central Government Funds	2.8	3.3	4.2	2.9	7.3	9.3	15.4	45.3
10.	Special Education	0.4	1.3	1.7	1.4	1.9	2.0	2.0	10.6
11.	Prime Minister's National Relief Fund	2.3	2.2	1.6	2.0	3.2	8.0	16.6	35.8
12.	Swachh Bharat Kosh	1.1	3.3	1.8	2.7	1.0	0.5	1.6	12.0
13.	Training to Promote Sports	0.6	1.4	1.8	2.9	3.1	3.0	2.4	15.2
14.	Clean Ganga Fund	0.1	0.3	0.2	0.3	0.1	0.1	0.1	1.3
15.	Gender Equality	0.6	0.7	0.7	0.2	0.5	0.8	0.4	4.0
16.	Healthcare	18.5	25.7	24.9	27.8	36.1	48.9	69.5	251.3
17.	Poverty, Eradicating Hunger, Malnutrition	2.8	12.5	6.1	8.1	11.9	11.5	12.4	65.2
18.	Animal Welfare	0.2	0.7	0.8	0.6	1.0	1.1	1.9	6.2
19.	Technology Incubators	0.1	0.3	0.2	0.2	0.3	0.5	0.6	2.2
20.	Livelihood Enhancement Projects	2.8	3.9	5.2	8.3	9.1	10.8	8.0	48.0

S. No.	Development sector	Amount spent (₹ billion)							Cumulative (in ₹ billion)
		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	
21.	Rural Development Projects	10.6	13.8	15.6	17.2	24.3	22.9	18.2	122.6
22.	Safe Drinking Water	1.0	1.8	1.5	2.2	2.3	2.5	2.0	13.3
23.	Women Empowerment	0.7	1.2	1.4	2.5	2.4	2.6	1.9	12.7
24.	Education	25.9	40.6	45.1	57.6	60.9	71.6	63.9	365.7
25.	Not Mentioned	13.4	10.5	3.9	0.2	0.9	5.0	2.8	36.7
26.	Sanitation	3.0	6.3	4.2	4.6	5.1	5.2	3.3	31.7
27.	Setting Up Homes and Hostels for Women	0.1	0.3	0.6	0.7	0.6	0.5	0.4	3.2
28.	Vocational Skills	2.8	3.4	3.7	5.5	8.0	11.7	6.3	41.4
29.	Armed Forces, Veterans, War Widows/ Dependents	0.1	0.1	0.4	0.3	0.9	0.6	0.8	3.2
	TOTAL	100.7	145.2	143.5	171.0	201.7	248.9	248.7	1259.6

Source: All CSR expenditure data in this chapter is drawn from the Ministry of Corporate Affairs, Government of India. See also, <https://csr.gov.in/content/csr/global/master/home/home.html>.

TABLE A5.2: Companies focusing on senior citizens' welfare through CSR activities

<p>Kothari Products Limited 2014–2017: 100% CSR funds spent on SCW 2017–2019: No CSR expenditure incurred 2019/20: CSR funds diverted to other projects</p>
<p>International Tractors Limited 2015–2019: Overall 10% of CSR funds spent on SCW However, since 2016, the share of CSR funds invested in elder care has been dropping.</p>
<p>Gail (India) Limited 2015–2019: Less than 1% of CSR funds spent on SCW. However, since 2018, funds spent on SCW have been rising and in 2019/20, about 2.4% of CSR funds were spent on SCW.</p>
<p>SBI Card Services Private Limited 2017–2019: Over 10% CSR spent on SCW 2019/20: CSR funds spent on SCW dropped to 8.6%</p>
<p>Shree Cement Limited 2014–2018: Less than 5% of CSR spent on SCW 2018–2020: Over 10% of CSR spent on SCW</p>
<p>Balaji Telefilms Limited 2014–2020: Over 20% of CSR spent on SCW (except in 2016/17 when it was 15%) 2019/20: CSR spent on SCW dropped by 22%.</p>
<p>South India Corporation Limited 2015–2019: 100% of CSR funds have been spent on SCW. Data beyond 2019 is not available.</p>
<p>Bharti Airtel Limited Since 2014, less than 2% CSR funds have been spent on SCW 2019/20: There was a 0.17% drop in CSR funds spent on SCW</p>
<p>National Stock Exchange of India Limited 2014–2017: Over 15% of CSR funds spent on SCW 2017–2020: Less than 10% of CSR funds spent on SCW</p>
<p>Navneet Education Limited 2014/15 & 2016/17: Over 10% of CSR spent on SCW 2017–2020: No CSR funds spent on SCW</p>

Abbreviations: CSR, corporate social responsibility; SCW, senior citizen's welfare.

Note: These firms are spending CSR funds specifically under the SCW head. Other organizations may be spending on related activities benefiting the general population, including the elderly, but none of them are specifically targeting seniors.

Source: All CSR expenditure data in this chapter is drawn from the Ministry of Corporate Affairs, Government of India. See also, <https://csr.gov.in/content/csr/global/master/home/home.html>.

6

Reach and Utilization of Social Security Schemes and Healthcare by Older Persons

Ageing is an inevitable demographic consequence of increased longevity largely due to the advancement in medical sciences. From this perspective, ageing represents progress and development in society. However, when accompanied by physical and mental health problems, poverty, and dependence on others, policy measures are needed to mitigate such problems faced by older persons. Decline in social and economic status and loss of income or poor financial support from their families cumulatively affect the lives and living conditions of the elderly. Healthcare expenditure tends to increase and often families perceive the elderly as burdensome, leading to their social isolation. Access to geriatric healthcare is, therefore, a necessary contributor to the overall well-being of the elderly who often lack awareness about their entitlements and the various government schemes and benefits specially meant to provide them with social security.

Social security schemes play an important role in addressing income vulnerability among older persons and to support their well-being. Information regarding awareness of, access to and utilization of these long-standing schemes is important to understand their efficacy and to suggest measures to improve their implementation.

The three key government schemes for the elderly are the Indira Gandhi National Old Age Pension Scheme (IGNOAPS), Indira Gandhi National Widow

Pension Scheme (IGNWPS) and Annapurna Scheme. In addition, the Maintenance and Welfare of Parents and Senior Citizens Act (MWPC), 2007 allows older persons to claim maintenance from their children. The schemes and MWPC Act have been discussed in chapter 3.

This chapter focuses on the reach and utilization of the government's social security schemes and healthcare by the elderly based on the Longitudinal Ageing Survey of India (LASI).¹ Working in conjunction with other surveys such as Health and Retirement Study,² LASI collected information from persons aged above 45 years and residing in households. The LASI survey followed a multistage stratified area probability cluster sampling design for 30 states and 6 Union Territories (UTs) in India. It covered 43,584 households with 73,396 individuals aged 45 years and above, among which 31,902 were aged 60 years and above.

6.1 Knowledge of Social Security Schemes and Maintenance and Welfare of Parents and Senior Citizens Act (MWPC), 2007

The elderly in India have low awareness about the various social security schemes designed for them. A little more than half of the elderly (55 percent) are aware of the old-age pension scheme (IGNOAPS); 44 percent about the widow pension scheme (IGNWPS); and 12 percent about the Annapurna Scheme. Figure 6.1 presents the percentage of persons aged 60 years and above who are aware of the various social security schemes, according to their background characteristics.³ A higher proportion of rural elderly

¹ IIPS, NPHCE, HSPH and USC, *Longitudinal Ageing Study in India (LASI) Wave 1, 2017-18, India Report*, (International Institute for Population Sciences, Mumbai; National Programme for Health Care for Elderly, Ministry of Health & Family Welfare; Harvard T. H. Chan School of Public Health; and the University of Southern California, 2020), available at https://iipsindia.ac.in/sites/default/files/LASI_India_Report_2020_compressed.pdf.

² <https://hrsonline.isr.umich.edu/>.

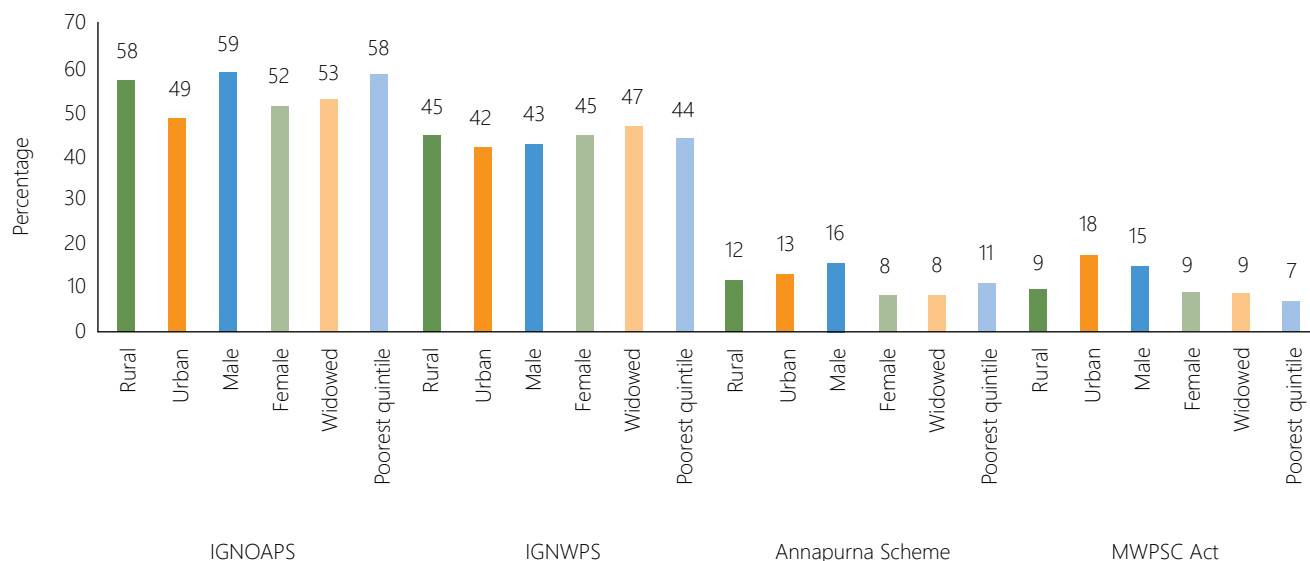
³ 'Background characteristics', in context of this report, refers to area of residence (urban/rural), sex of the individual (male/female), marital status (married/single/widowed, etc.) and income.

(57.6 percent) is aware of IGNOAPS than their urban counterparts (48.6 percent). Almost equal percentage of rural (45 percent) and urban (42 percent) elderly are aware of IGNWPS. Awareness about the Annapurna Scheme, though overall quite low, is marginally higher among the urban elderly (13 percent) than among those in the rural areas (12 percent). Awareness of IGNOAPS is lower amongst elderly women (52 percent) than elderly men (59 percent), while a slightly higher proportion of elderly women knew of IGNWPS (45 percent) than elderly men (43 percent). Only 47 percent of widowed elderly knew about IGNWPS. The awareness of Annapurna Scheme among male elderly is about two times higher (16 percent) than the female elderly (8 percent). As per the monthly per capita expenditure (MPCE) quintile, among the poorest elderly (bottom 20th percentile), 59 percent knew about IGNOAPS, 44 percent were aware of IGNWPS and only 11 percent knew about the Annapurna Scheme.

In comparison to the awareness of social security schemes, the awareness of MWPS Act is relatively very low. A little less than 12 percent of elderly people had any knowledge regarding MWPS Act—only 15 percent of elderly men and 9 percent of elderly women knew about the Act. Also, awareness about the Act was higher in urban areas (18 percent) as compared to the rural areas (9 percent). The widowed elderly and those belonging to the poorest MPCE quintile had the least knowledge about the Act (9 percent and 7 percent, respectively).

Awareness of IGNOAPS and IGNWPS is higher amongst the elderly in Haryana, Himachal Pradesh, Bihar, Jharkhand, Odisha, Assam, and in the UT of Dadra & Nagar Haveli. However, awareness regarding IGNWPS is as low as 6 percent in Arunachal Pradesh and 7 percent in Tripura. Annapurna scheme is better known in Chandigarh, Himachal Pradesh, Bihar, Chhattisgarh, Odisha and Assam while awareness of MWPS Act is higher in Chandigarh, Madhya Pradesh, Assam and Tripura.

Figure 6.1: Percentage of the elderly (aged 60 years and above) with awareness of social security schemes and MWPC Act



Abbreviations: IGNOAPS, Indira Gandhi National Old Age Pension Scheme; IGNWPS, Indira Gandhi National Widow Pension scheme; MWPC Act, Maintenance and Welfare of Parents and Senior Citizens Act.

Source: Computed from individual level data of the *Longitudinal Ageing Study in India: Wave 1, 2017-18*, (International Institute for Population Sciences; National Programme for Health Care of the Elderly, Ministry of Health and Family Welfare, Government of India; Harvard T. H. Chan School of Public Health and the University of Southern California; 2020).

TABLE 6.1: Percentage of the elderly (aged 60 years and above) with awareness of social security schemes and MWPC Act across states and Union Territories

States/Union Territories	Indira Gandhi National Old Age Pension Scheme	Indira Gandhi National Widow Pension Scheme	Annapurna Scheme	MWPC Act, 2007
India	55.0	44.0	12.0	11.7
North				
Chandigarh	51.0	46.8	18.5	23.3
Delhi	54.3	28.3	4.7	12.9
Haryana	78.4	67.6	8.4	6.6
Himachal Pradesh	77.1	70.2	15.0	7.1
Jammu & Kashmir	61.5	50.5	1.3	7.8
Punjab	62.5	40.4	4.3	2.6
Rajasthan	75.7	49.4	11.8	10.5
Uttarakhand	58.7	52.0	11.3	7.9
Central				
Chhattisgarh	62.5	47.7	20.0	6.3

<i>States/Union Territories</i>	<i>Indira Gandhi National Old Age Pension Scheme</i>	<i>Indira Gandhi National Widow Pension Scheme</i>	<i>Annapurna Scheme</i>	<i>MWPSC Act, 2007</i>
Madhya Pradesh	49.7	34.0	7.8	14.4
Uttar Pradesh	48.0	43.4	6.9	4.3
East				
Bihar	81.8	58.6	23.2	10.2
Jharkhand	77.7	67.6	17.0	4.3
Odisha	74.4	66.6	31.5	11.3
West Bengal	40.9	37.2	11.2	16.7
North East				
Arunachal Pradesh	18.3	5.6	1.3	2.0
Assam	83.6	61.5	30.2	44.3
Manipur	67.0	36.9	6.6	10.7
Meghalaya	39.6	11.3	0.0	6.6
Mizoram	62.5	31.0	0.8	14.0
Nagaland	40.5	18.5	6.9	0.7
Sikkim	42.9	9.8	0.4	14.0
Tripura	46.7	6.9	0.6	17.6
West				
Dadra & Nagar Havel	78.3	66.9	11.2	19.2
Daman & Diu	69.2	40.7	5.9	12.1
Goa	35.7	17.6	2.5	22.0
Gujarat	34.8	46.9	8.3	12.7
Maharashtra	29.6	28.8	5.8	10.7
South				
Andaman & Nicobar Islands	34.6	10.2	0.4	5.7
Andhra Pradesh	54.5	45.1	5.7	7.8
Karnataka	57.6	28.6	4.3	10.0
Kerala	67.6	58.2	13.4	19.4
Lakshadweep	51.5	49.2	7.4	11.5
Puducherry	65.9	46.0	22.1	46.4
Tamil Nadu	69.4	56.9	26.9	23.7
Telangana	35.3	27.8	5.2	4.9

Abbreviation: MWPSC Act, Maintenance and Welfare of Parents and Senior Citizens Act.

Source: Computed from individual level data, *Longitudinal Ageing Study in India, Wave-1*.

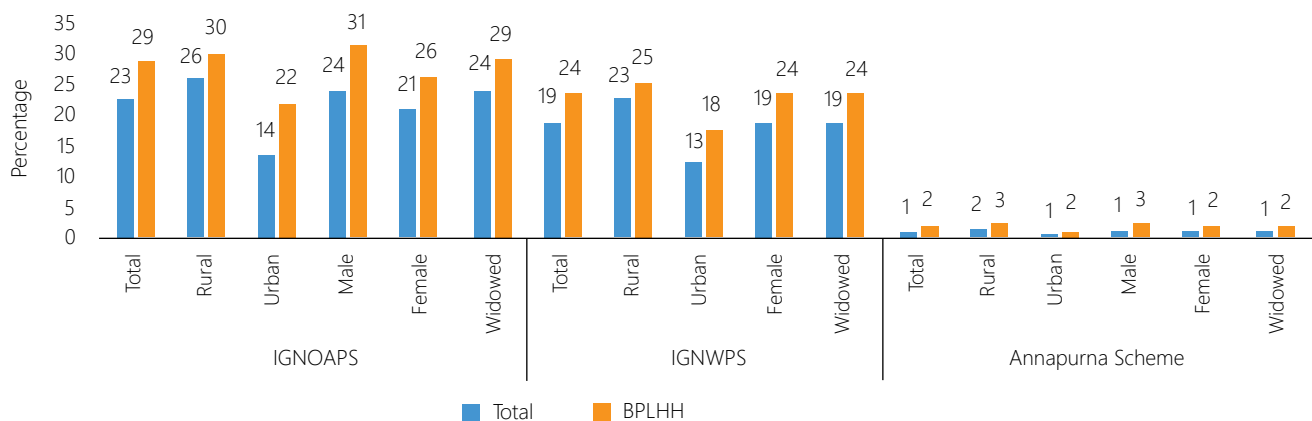
6.2 Utilization of Social Security Schemes

Often, despite awareness of the schemes, older persons are unable to access or utilize them effectively, and the LASI report reveals significant gaps in knowledge of and access to social security schemes by the elderly. It is, therefore, important to understand the actual utilization of these schemes alongside awareness levels.

Figure 6.2 presents the percentage of persons aged 60 years and above who benefit from the various social security schemes according to their background characteristics. About a third of the rural elderly (30 percent) from below-poverty-line (BPL) households receive benefits from IGNOAPS. Amongst the elderly BPL widows, only 24 percent receive the widow pension. The percentage of the elderly receiving these benefits are lower in urban areas than in rural areas. The utilization of Annapurna scheme is substantially low across all sections of the elderly.

The awareness and utilization of the social security schemes vary significantly across states and UTs. Higher coverage of IGNOAPS was found in Rajasthan (68.9 percent), Haryana (60.1 percent) and Tripura

Figure 6.2: Percentage of the elderly who benefit from various social security schemes



Note: Data for IGWPS calculated for widowed women only.

Abbreviations: IGNOAPS, Indira Gandhi National Old Age Pension Scheme; IGWPS, Indira Gandhi National Widow Pension scheme.

Source: Computed from individual level data, *Longitudinal Ageing Study in India, Wave-1* (same as Figure 6.1).

(54.1 percent) among BPL households. In the southern states, where ageing is more pronounced, only Karnataka showed a somewhat higher coverage (48.2 percent) while a third of the BPL elderly availed this scheme in Andhra Pradesh and Kerala; only a fourth of the ageing population from BPL households received IGNOAPS benefits in Telangana. Himachal Pradesh, despite having a higher proportion of elderly population, had only 28 percent coverage of the old-age pension scheme. Surprisingly, a very small percentage of older persons availed benefits under IGNOAPS in Tamil Nadu (13 percent) and Maharashtra (4 percent). The coverage was somewhat higher in most of the UTs. The highest coverage of IGNOAPS was found in Andhra Pradesh wherein 51 percent of the widowed elderly received pension, followed by Himachal Pradesh and Telangana with around 41 percent coverage. Maharashtra (9.6 percent) and Tamil Nadu (6 percent) again showed a very low coverage of this scheme among elderly women from BPL households. The utilization of Annapurna Scheme was higher in Chhattisgarh, Bihar and Assam.

TABLE 6.2: Percentage of the elderly who received benefits under various social security schemes across states and Union Territories

States/Union Territories	Indira Gandhi National Old Age Pension Scheme		Indira Gandhi National Widow Pension Scheme		Annapurna Scheme	
	BPL HH	Total	BPL HH	Total	BPL HH	Total
India	28.7	22.6	23.7	19.2	2.3	1.3
North						
Chandigarh	41.2	12.7	29.9	25.5	0.0	0.0
Delhi	43.1	29.4	44.2	23.0	0.6	0.2
Haryana	60.1	53.0	39.3	46.6	0.0	0.1
Himachal Pradesh	28.0	19.3	41.6	23.6	0.0	0.0
Jammu & Kashmir	35.2	22.7	42.7	29.1	0.0	0.0
Punjab	54.8	35.9	20.9	16.1	0.0	0.7
Rajasthan	68.9	51.9	32.5	22.7	4.5	1.6
Uttarakhand	30.2	21.2	37.3	25.9	0.8	0.4
Central						
Chhattisgarh	32.3	27.5	35.8	31.5	10.7	8.3
Madhya Pradesh	43.7	28.5	36.2	25.6	3.0	1.8

States/Union Territories	Indira Gandhi National Old Age Pension Scheme		Indira Gandhi National Widow Pension Scheme		Annapurna Scheme	
	BPL HH	Total	BPL HH	Total	BPL HH	Total
Uttar Pradesh	15.2	11.5	20.0	18.2	0.6	0.3
East						
Bihar	46.1	36.7	17.1	18.1	5.7	3.6
Jharkhand	34.9	27.5	30.3	31.7	2.3	1.3
Odisha	42.1	35.7	41.1	38.4	2.7	1.7
West Bengal	18.8	12.7	22.8	18.9	0.0	0.0
North East						
Arunachal Pradesh	4.9	4.6	2.3	2.1	0.0	0.0
Assam	29.2	21.7	3.7	2.7	5.4	4.0
Manipur	23.9	19.4	2.4	1.9	0.1	0.1
Meghalaya	37.4	30.9	7.2	5.9	0.0	0.0
Mizoram	28.8	19.3	0.0	0.0	0.0	0.0
Nagaland	18.0	15.2	2.2	2.8	0.0	0.0
Sikkim	38.9	38.0	5.1	12.7	0.0	0.0
Tripura	54.1	41.8	15.1	13.3	0.0	0.0
West						
Dadra & Nagar Havel	41.2	33.7	41.1	28.1	0.0	0.0
Daman & Diu	51.2	43.4	47.2	32.8	0.0	0.0
Goa	37.7	25.5	19.5	14.7	0.5	0.2
Gujarat	11.5	6.0	6.0	6.6	0.0	0.1
Maharashtra	4.3	3.3	9.6	8.0	0.1	0.1
South						
Andaman & Nicobar Islands	29.0	31.2	14.6	23.0	0.0	0.0
Andhra Pradesh	34.2	30.7	51.0	45.7	0.4	0.3
Karnataka	48.2	38.1	26.5	18.1	0.2	0.1
Kerala	34.7	27.9	35.3	27.2	0.2	0.1
Lakshadweep	9.3	6.9	25.8	23.8	1.9	0.7
Puducherry	53.0	44.7	16.8	17.3	2.3	1.3
Tamil Nadu	13.0	13.3	6.1	6.6	7.0	5.4
Telangana	24.8	21.2	41.3	38.9	0.1	0.2

Note: Data for IGWPS calculated for widowed women only.

Abbreviations: BPL HH, Below-Poverty-Line Household; IGNOAPS, Indira Gandhi National Old Age Pension Scheme; IGWPS, Indira Gandhi National Widow Pension scheme.

Source: Computed from individual level data, *Longitudinal Ageing Study in India, Wave-1*.

6.3 Reasons for Not Availing the Benefits

Enrolment for the various social security schemes involves multiple administrative procedures including extensive documentation, and physical presence at the offices to get the work done. The elderly are often unable to carry out these mandatory requirements because of physical infirmities, lack of technical understanding and inadequate communication skills. The reasons for not utilizing the social security schemes also explored in the LASI survey ranged across—‘no need’, ‘not eligible or not applicable’, ‘do not have the proper documents’, ‘not yet applied’, ‘process of getting benefits is cumbersome’, and ‘other reasons’. Table 6.3 shows that more than a third (35 percent) of the elderly men report that the process of getting benefits is cumbersome. However, a quarter of the elderly men (26 percent) have not applied for an old-age pension. For IGWPS, 10 percent of the elderly widows said that they do not need this pension, and 47 percent of the elderly widows are not eligible for it.

TABLE 6.3: Percentage distribution of the elderly (aged 60 years and above) in below-poverty-line households not utilizing the social security, by reasons and according to sex

Reasons	Indira Gandhi National Old Age Pension Scheme		Indira Gandhi National Widow Pension Scheme	Annapurna Scheme	
	Men	Women	Women	Men	Women
No need	7.2	5.9	10.3	12.1	8.7
Not eligible	19.9	22.5	47.4	38.4	46.3
Not having documents	8.3	6.9	5.2	10.5	8.6
Not yet applied	25.6	24.5	14.9	19.9	17.3
Process is cumbersome	35.1	36.5	20.0	18.4	18.3
Other reasons	3.8	3.7	2.2	0.6	0.8

Source: Computed from individual level data, *Longitudinal Ageing Study in India, Wave-1*.

The survey also included questions about the types of problems usually faced by the elderly in receiving the benefits. Among the BPL elderly who received old-age pension, 28.3 percent faced delays, 27.5 percent had to give bribes and 25.7 percent reported that their paperwork was incomplete. Among elderly women receiving widow

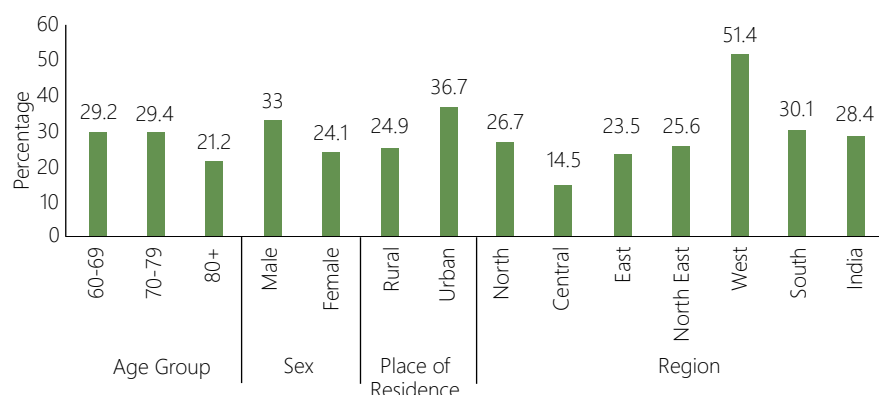
Non-receipt of the funds is another problem faced by the elderly enrolled in these major schemes.

pension, 35.7 percent reported delays in receiving the pension, 30.7 percent had to give bribes, 16.3 percent either had incomplete paperwork or found the paperwork cumbersome, and 10.4 percent stated that their applications were rejected. Non-receipt of the funds is another problem faced by the elderly enrolled in these major schemes. Some of the reasons cited for not utilizing the Annapurna Scheme among elderly men and women were 'not eligible', 'not yet applied' or 'process is cumbersome'.

6.4 Knowledge and Utilization of Concessions for the Elderly

The utilization of various concession schemes meant for older persons is very low. Figure 6.3 presents the percentage of the elderly who were aware of any government concession by their background characteristics. Only 28.4 percent of the elderly were aware of any concessions across the country. This was higher amongst the elderly in urban (36.7 percent) than in rural areas (24.9 percent) and elderly men were better aware (32.9 percent) than elderly women (24.1 percent). Highest proportion of awareness was observed in West India (51.4 percent) followed by South (30.1 percent), North (26.7 percent), North East (25.6 percent) and East (23.5 percent). Central India was the least aware of these concessions (14.5 percent).

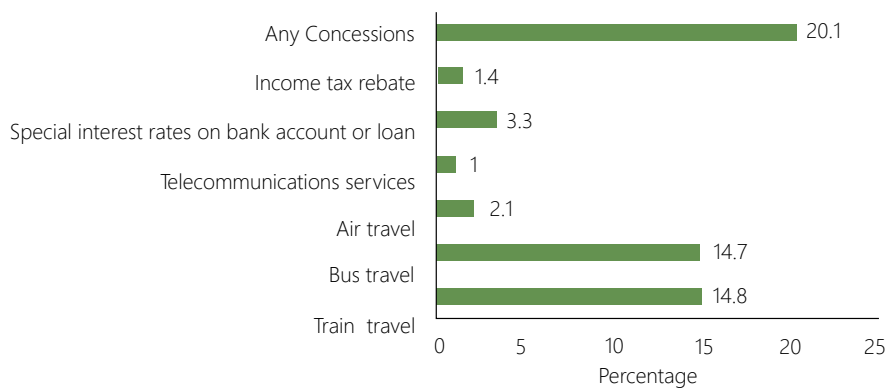
Figure 6.3: Awareness of any concessions given by government by different background characteristics and regions



Source: Computed from individual level data, *Longitudinal Ageing Study in India, Wave-1* (same as Figure 6.1).

Nearly one-third of the elderly availed any type of concessions. About 15 percent of the elderly have availed concessions for train and bus travel (Figure 6.4). This is higher in urban (23 percent) than in rural areas (11 percent). Utilization of concession on train travel is higher among elderly men (17 percent) than elderly women (12 percent). Utilization of bus travel concession is also higher in urban areas (20 percent) than in rural areas (12 percent), and it is higher among elderly men (16 percent) than elderly women (14 percent).

Figure 6.4: Different types of concessions availed by the elderly

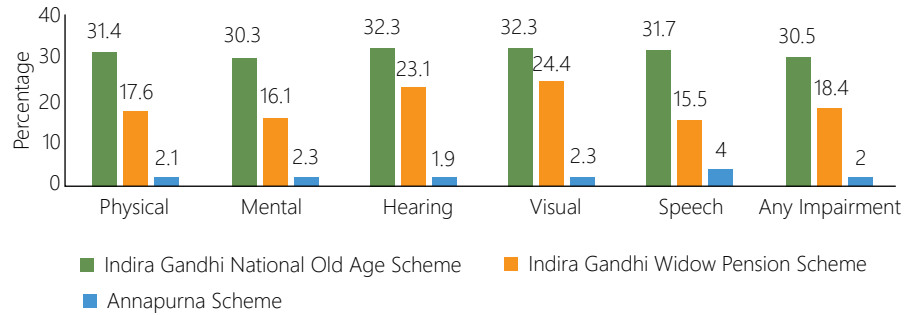


Source: Computed from individual level data, *Longitudinal Ageing Study in India, Wave-1* (same as Figure 6.1).

6.5 Access to Programmes for Older Persons with Disability

Figure 6.5 shows the utilization of social security schemes by types of impairments among the elderly. Utilization of IGNOAPS was the maximum among the elderly with disabilities (Figure 6.5). Around 32 percent of the elderly with hearing and vision impairments availed the social insurance scheme. Of the total elderly population, around 2.5 percent have hearing impairment and 3.7 percent have vision impairment. The widowed elderly with disabilities accessed IGNOAPS to a much lesser extent—the widow pension scheme was utilized by those with physical impairment (17.6 percent), mental impairment (16.1 percent), hearing impairment (23.1 percent) and vision impairment (24 percent).

Figure 6.5: Utilization of social security schemes by types of impairments among the elderly



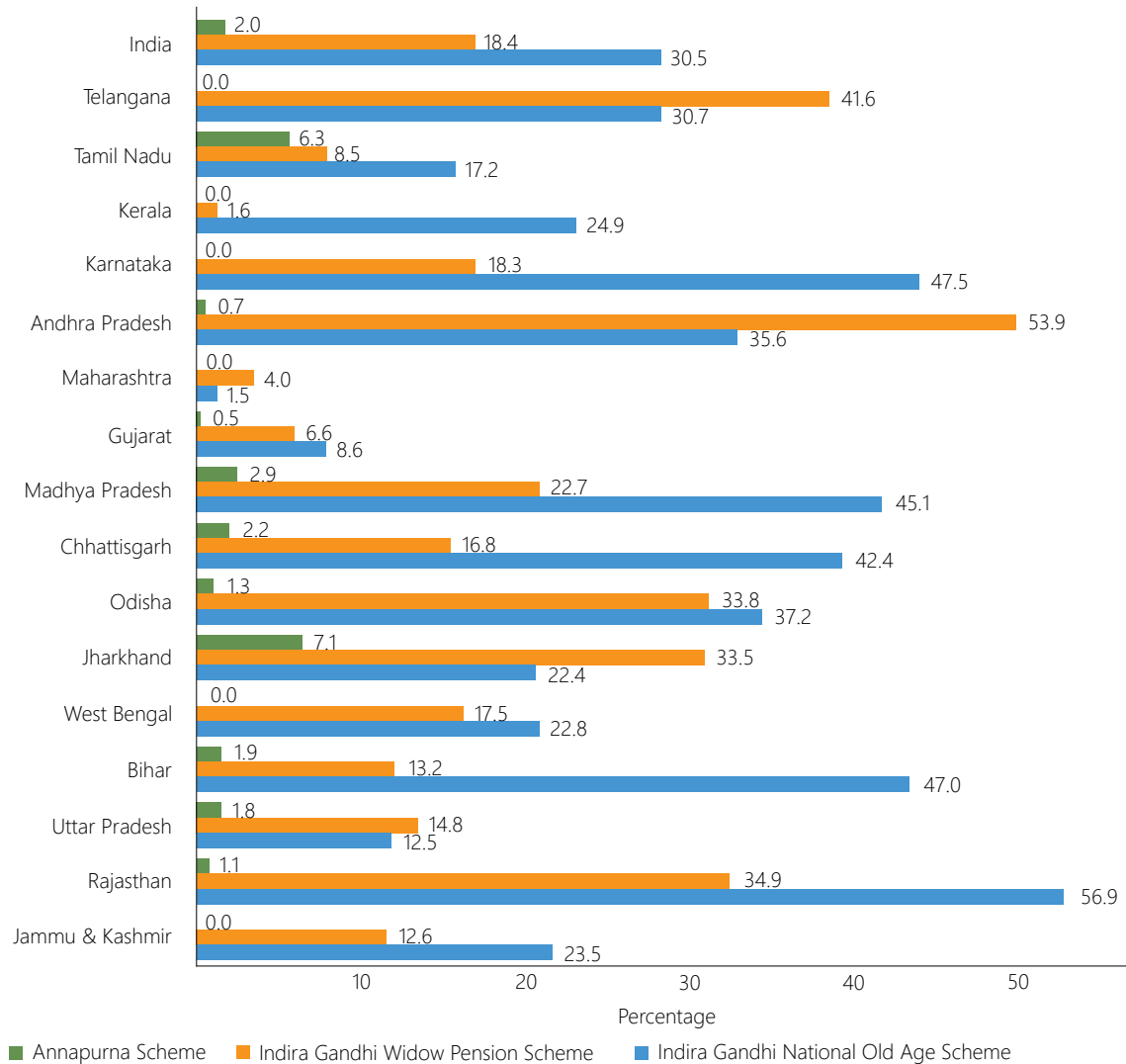
Note: Data for IGWPS calculated for widowed women only.

Source: Computed from individual level data, *Longitudinal Ageing Study in India, Wave-1* (same as Figure 6.1).

There was a substantial variation in the access to social security schemes across states for the elderly with any impairment (Figure 6.6). Rajasthan, Bihar, Karnataka and Madhya Pradesh showed higher access to IGNOAPS. Maharashtra, Gujarat, Uttar Pradesh and Kerala are some of the states with lower access to the old age pension scheme. A higher proportion of the widowed elderly with impairments accessed IGWPS in the states of Jharkhand, Telangana, Andhra Pradesh and Odisha. It should be noted that only those states that had a sufficient sample of the elderly with disabilities were included in this specific aspect of the analysis.

While the overall utilization of Annapurna Scheme among the elderly with any impairment was very low, within that limitation, Jharkhand (7.1 percent) and Tamil Nadu (6.3 percent) showed the highest utilization.

Figure 6.6: Utilization of social security schemes among the elderly with any impairment across states and Union Territories



Note: Data for IGWPS calculated for widowed women only.

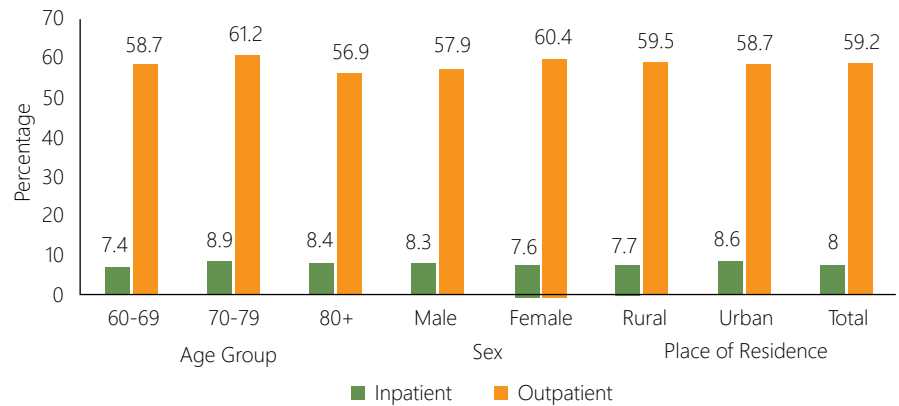
Source: Computed from individual level data, *Longitudinal Ageing Study in India, Wave-1* (same as Figure 6.1).

6.6 Access to Healthcare Facilities

Healthcare utilization among the elderly varied substantially between in-patient and out-patient care (Figure 6.7). Around 8 percent of the elderly accessed in-patient care and 59 percent accessed out-patient

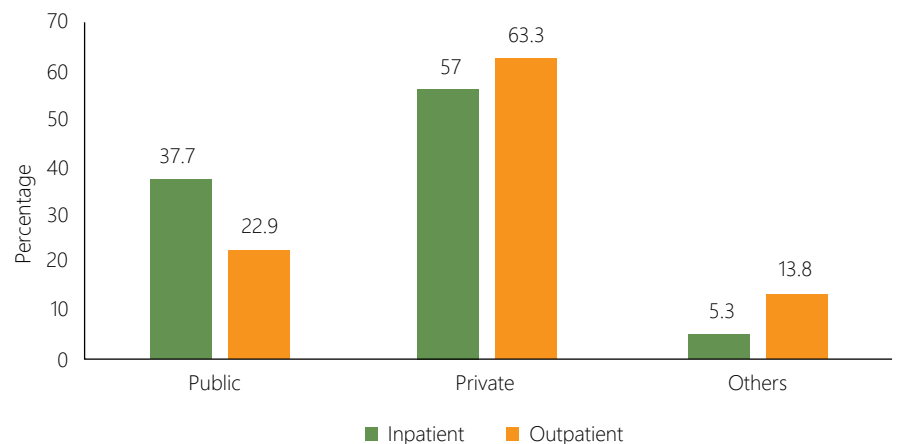
care in the 12 months preceding the survey. Of the elderly availing in-patient care, 37.7 percent accessed public facilities and 57 percent accessed private facilities. Of the elderly availing out-patient care, 22.9 percent accessed public facilities and 63.3 percent accessed private facilities (Figure 6.8).

Figure 6.7: In-patient and out-patient care accessed by the elderly in the 12 months preceding the survey



Source: Computed from individual level data, *Longitudinal Ageing Study in India, Wave-1* (same as Figure 6.1).

Figure 6.8: Percentage distribution of the elderly who received in-patient and out-patient care in the 12 months preceding the survey by type of health facilities



Note: 'Others' include health camps, mobile healthcare units, pharmacies, and home visits.

Source: Computed from individual level data, *Longitudinal Ageing Study in India, Wave-1* (same as Figure 6.1).

The main reason for visiting a health facility for in-patient care was found to be sickness (89.7 percent). Treatment for illness and medical check-ups for the elderly who were under observation or routine check-ups were the most common reasons for accessing out-patient care among the elderly. Hospitalization for fever/pyrexia of unknown cause, gastroenteritis, heart-related issues, breathing problems, ophthalmic surgery, abdominal surgery, diabetes or related complications, and stroke were the top ten reasons for accessing in-patient care. The top ten reasons for accessing out-patient care were fever/pyrexia of unknown cause, chronic pain in joints/arthritis, high blood pressure, generalized pain, diabetes or related complications, breathing problems, problems with eyes, heart-related issues, gastroenteritis, and injuries or accidents.

The elderly suffering from chronic morbid conditions require long-term healthcare services. The enormous burden of healthcare depletes savings, leading to distress financing and debts. Some of the major sources for financing in-patient- and out-patient-related health expenditure are personal income, income at the household-level (other than personal income), savings and contributions from relatives or friends. For in-patient care at private facilities, funding is mainly drawn from savings, loans and contribution from relatives or friends.

6.7 Access to Health Insurance

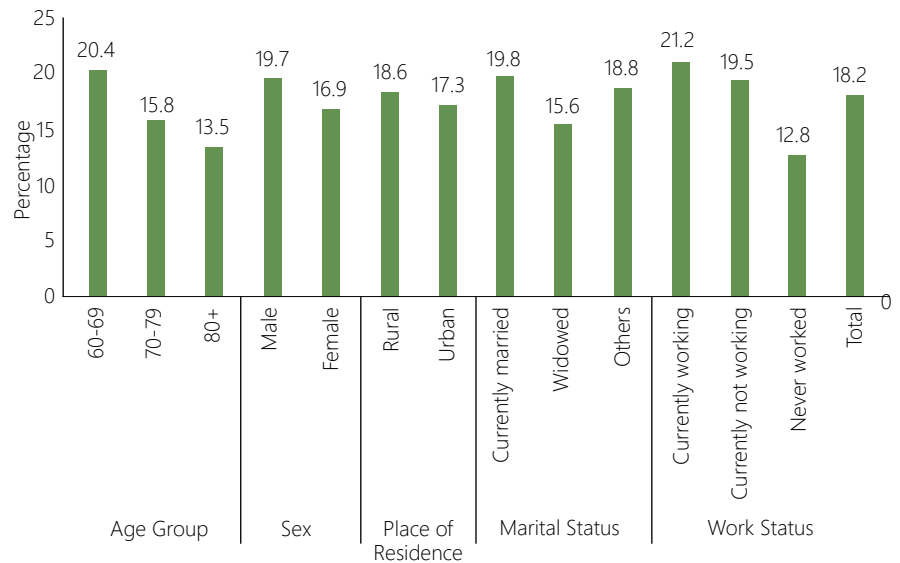
The survey also collected information on the coverage of various health insurance schemes such as Central Government Health Scheme (CGHS), Employees State Insurance Scheme (ESIS), Rashtriya Swasthya Bima Yojana (RBSY), other central and state government health insurance schemes, community/cooperative health insurance schemes, medical reimbursement from an employer, health insurance through employer and privately purchased commercial health insurance schemes. The coverage of the health insurance schemes is highest in the age group of 60–69 years (20.4 percent) (Figure 6.9). Elderly men (19.7 percent) had a greater share of coverage than elderly women (16.9 percent). Not much variance

The top ten reasons for accessing out-patient care were fever/pyrexia of unknown cause, chronic pain in joints/arthritis, high blood pressure, generalized pain, diabetes or related complications, breathing problems, problems with eyes, heart-related issues, gastroenteritis, and injuries or accidents.

was observed between urban and rural areas regarding coverage of health insurance schemes. Moreover, a higher proportion of the elderly who were 'currently married', 'currently working' and/or faced limitations in conducting activities of daily living had health insurance coverage.

The elderly residing in the rural areas had lesser awareness about the health insurance schemes than their urban counterparts.

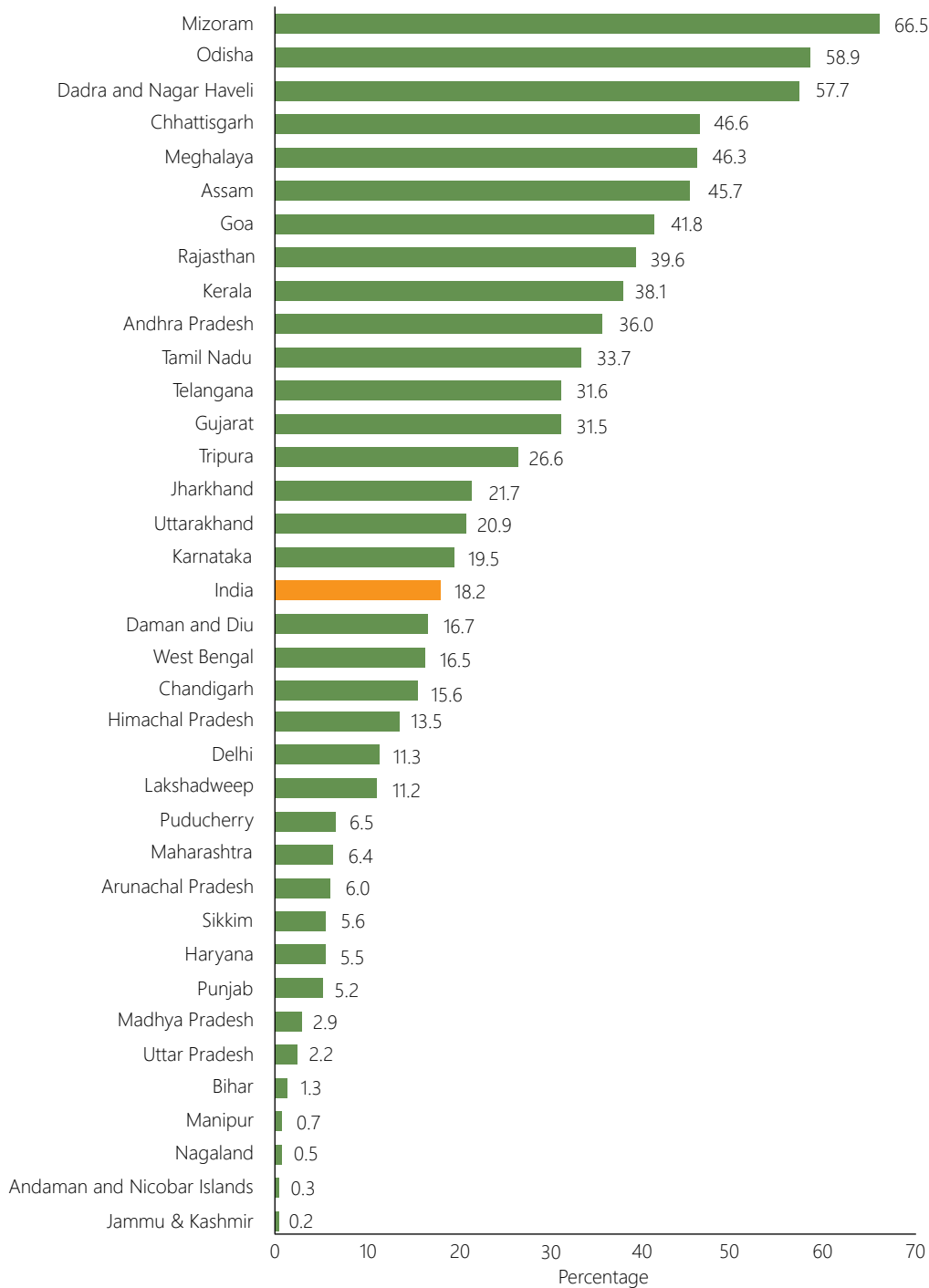
Figure 6.9: Coverage of health insurance schemes across background characteristics among the elderly



Source: Computed from individual level data, the *Longitudinal Ageing Study in India, Wave-1* (same as Figure 6.1).

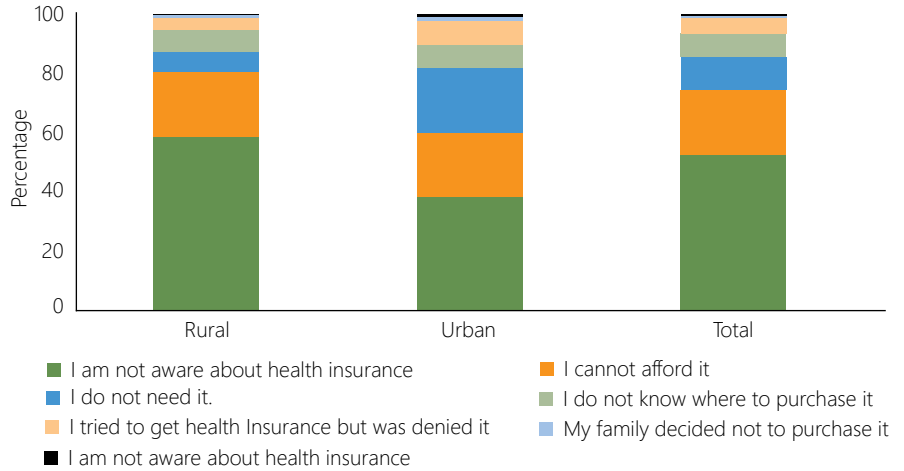
States that had higher coverage of health insurance schemes include Mizoram, Odisha, Chhattisgarh, Meghalaya, Assam, Goa and Rajasthan. States with very low coverage included Uttar Pradesh, Madhya Pradesh, Punjab and Haryana (Figure 6.10). It was found that around 60.5 percent of the elderly availed state government health insurance schemes. Rashtriya Swasthya Bima Yojana had the second highest coverage among the elderly population. Low awareness (52.9 percent) and non-affordability (21.6 percent) were the primary reasons cited by the elderly for not availing of any health insurance (Figure 6.11). The elderly residing in the rural areas had lesser awareness about the health insurance schemes than their urban counterparts.

Figure 6.10: Coverage of health insurance schemes among the elderly across states and Union Territories



Source: Computed from individual level data, *Longitudinal Ageing Study in India, Wave-1* (same as Figure 6.1).

Figure 6.11: Reasons for not being covered under any health insurance scheme among the elderly



Source: Computed from individual level data, *Longitudinal Ageing Study in India, Wave-1* (same as Figure 6.1).

6.8 Conclusion

This chapter analyzes the three primary factors that determine the utilization of various social security schemes specially meant for the needy elderly. They are (a) knowledge/awareness, (b) reach/access and (c) actual use of the schemes. Smaller proportion of the elderly using these schemes indicates that either knowledge/awareness is low and/or reach/access is poor. Findings reported in this chapter using the LASI survey data align closely with the findings using BKPAI⁴ data. At one level, awareness itself is low and at another level there is a gap between awareness and use, implying that even among those who know about the schemes, actual utilization is low. This raises certain questions for future policies to respond to: Why is there a gap and what needs to be done? Is this gap due to supply system factors or demand system factors? And what actions are required to increase awareness among target beneficiaries (indigent elderly)?

This chapter helps to understand the reasons for the gap between knowledge and use. Multiple administrative requirements that

⁴ BKPAI = Building Knowledge Base on Population Aging in India.

include excessive documentation and mandatory physical presence in the offices do not make the schemes elder-friendly. Older persons often do not understand the nuances of the scheme and the staff, too, fails to communicate effectively. They often miss out on availing the scheme benefits owing to incorrect status (for instance, being declared 'not eligible') and/or incomplete or wrong documentation. Often, older persons who are eligible and keen to avail the benefits do not do so because of cumbersome and complex processes. Even with low premiums many of the elderly cannot afford health insurance.

All these findings have significant programme implications and point towards the need to increase level of awareness, extent of reach and ease of access for the elderly to start benefitting from the social security schemes.

7

COVID-19 Pandemic and the Elderly

7.1 The Pandemic and Government Response

The coronavirus disease (COVID-19) was first reported from Wuhan, China in December 2019. Coronaviruses are a family of viruses that cause respiratory tract infections that can range from common cold to life-threatening illnesses related to co-morbidities. In January 2020, WHO declared the coronavirus outbreak as a public health emergency of international concern. In March, WHO announced that the outbreak could be characterized as a pandemic. By the end of April 2020, 63 percent of global mortality from COVID-19 was from Europe. It issued several global advisories, some of which sound very familiar at present but in 2020, came with challenges of effective and inclusive communication to the masses; manufacturing and supply of protective equipment, medicines, vaccines; and purchasing capacity of the same. Some of the safety guidelines that came into force included:

- (a) frequent washing of hands with soap or using sanitizer;
- (b) maintaining social distance between two persons;
- (c) wearing masks; and
- (d) avoid touching eyes and mouth.

In India, the first COVID-19 case was reported from Kerala at the end of January 2020. Within a few months, Kerala reported 7,798 cases and 100 deaths. For India as a whole, the first pandemic wave (Wave-1) began in March 2020 and lasted till nearly November 2020 before tapering off, while Wave-2 began in March 2021 and peaked in May 2021 before sloping off gradually June

through August of 2021.¹ Daily cases during Wave-1 peaked in mid-September 2020 to nearly 100,000 before dropping below 15,000 by January 2021.² A general lockdown was announced on 24 March 2020, which lasted till 31 May 2020. Thereafter, a slow 'unlocking' process started with gradual lifting of restrictions as the number of daily reported cases went down.

A second and a more severe pandemic wave started in March 2021 with a faster spreading virus variant that saw hundreds of people being hospitalized, and hospitals across the country faced severe shortages of beds, oxygen cylinders, medicines and other medical supplies. By late April 2021, India was reporting the highest number of daily new cases (hovering around 400,000) globally.³ The crisis started waning only over June–August 2021 and by March 2022, India's daily COVID-19 case numbers had fallen to 22,500 cases a day.

Senior citizens above the age of 60 years, especially those with medical conditions, were particularly susceptible to infections during the COVID-19 pandemic. The Ministry of Social Justice and Empowerment (MSJE), which is the nodal ministry for the older persons, collaborated with Ministry of Health and Family Welfare and Department of Geriatric Medicine, All India Institute of Medical Sciences, Delhi and issued an advisory on 13 April 2020 to be followed by all the senior citizens and their caregivers. The advisory included dos and don'ts for senior citizens that included specific guidelines for senior citizens who are mobile, those suffering from mental health issues, and caregivers of dependent senior citizens. Prior to this, MSJE had also issued instructions on 17 March 2020 for senior citizens living in old age homes and advised all implementing partners to

Some of the important government efforts undertaken to combat the pandemic included a massive vaccination drive, public education regarding COVID-19-appropriate behaviour, setting up of COVID-19 testing and quarantine facilities, and implementing travel restrictions.

¹ Zirpe KG, Dixit S, Kulkarni AP, Pandit RA, Ranganathan P, Prasad S, et al. The Second- vs First-wave COVID-19: More of the Same or a Lot Worse? A Comparison of Mortality between the Two Waves in Patients Admitted to Intensive Care Units in Nine Hospitals in Western Maharashtra. *Indian J Crit Care Med* 2021; 25(12):1343–1348.

² <https://www.mohfw.gov.in/>.

³ Ibid.

Executing the vaccine rollout programme across the country was an administrative and a logistical challenge given geographical spread, population size, limited shelf life of the vaccines, need for cold chain to transport vaccines, and dealing with vaccine hesitancy, misinformation and distrust among people.

take necessary measures to monitor the spread of infection, such as recording temperatures of all inmates regularly; checking respiratory health; maintaining proper hygiene and physical distance; ensuring supply of hand sanitizers, soaps and running water; and discouraging entry of visitors.

Some of the important government efforts undertaken to combat the pandemic included a massive vaccination drive, public education regarding COVID-19-appropriate behaviour, setting up of COVID-19 testing and quarantine facilities, and implementing travel restrictions. Private sector collaboration with necessary quality control measures was a key strategy. The Arogya Setu application and CoWIN platform helped in scheduling vaccinations, sending alerts and tracking vaccination progress, as well as enabling vaccination certificate downloads. The government also introduced Air Suvidha, an online form that had to be mandatorily filled to track vaccination and RTPCR testing status when coming from another country.

7.2 India's Vaccination Programme

India began its vaccination programme on 16 January 2021 with two vaccines—Covishield and Covaxin. More than 2.2 billion vaccine doses have been administered across the country and as of 31 July 2022, 88.9 percent of the adult population in India has received two doses.⁴

Executing the vaccine rollout programme across the country was an administrative and a logistical challenge given geographical spread, population size, limited shelf life of the vaccines, need for cold chain to transport vaccines, and dealing with vaccine hesitancy, misinformation and distrust among people. Capacity development of healthcare workers and availability of personal protective equipment (PPE) also presented a challenge. However, measures such as price cap on vaccines administered in private hospitals; free vaccination in government facilities; prioritizing vaccination of healthcare and other

⁴ <https://www.cowin.gov.in/>.

frontline workers, senior citizens, and those with co-morbidities; and a phased manner of stepping up vaccination among the rest of the population helped make India's vaccination drive a success story. Management of such a large vaccination programme also earned international recognition for India.

7.3 COVID-19 and the Elderly

The pandemic impacted thousands of families and perhaps affected older persons in a more significant manner than other age segments of the population. Senior citizens were not only a high-risk group owing to their age and health co-morbidities but were also economically vulnerable as they faced the risk of losing a younger earning member of the family and/or losing their independent and limited earning opportunities due to lockdowns and related COVID-19 norms. The lengthy lockdowns affected their access to healthcare and ongoing medical treatments along with non-availability of medicines. There was a manifold increase in general fear and anxiety owing to inability to meet friends and relatives, lack of outdoor physical activity and forced loneliness. Destitution and neglect affected the elderly more than others as many elderly households were pushed below the poverty line during the pandemic. Thus, both lives and livelihoods were impacted and hence, the government had to take measures that would maintain a fine balance between the two.

Older persons faced higher vulnerability during the pandemic owing to high rates of infection, co-morbidities, hospitalization and death. Poverty, lack of social security in old age, poor public health facilities, illiteracy and digital ignorance created additional challenges. Service delivery to those living independently or in institutions such as old age homes was also proving to be difficult, and here, efforts of nongovernmental organization (NGOs) and community-based organizations (CBOs) were invaluable.

At the onset of the pandemic, the government responded by setting up helplines, announcing food rations and emergency packages, and advance payments of social security. At the primary healthcare

Older persons faced higher vulnerability during the pandemic owing to high rates of infection, co-morbidities, hospitalization and death.

While governments are able to plan and implement such programmes, NGOs and CBOs are able to supplement and complement government efforts by reaching the grassroots level, especially in remote areas.

level, ASHA⁵ workers were engaged to build awareness among communities as well as to perform initial health screening such as checking for fever, cough and other symptoms. Several voluntary agencies stepped in to fill some of the gaps by adding COVID-19-related care to their already existing community services, with support from NITI Aayog in some operational aspects. Many state governments set up inter-agency groups/committees for district-level coordination of supplies and routed the supplies through district administrations.

However, despite these efforts, ground-level realities indicate that, in general, disaster relief work till recently did not often include older persons as a separate group. Organizations working for the cause of older persons highlighted these concerns based on their experience during the post-disaster relief and rehabilitation work. The inability of older persons to access healthcare, the inequitable distribution of emergency supplies and ageism amongst relief workers continued to be a challenge. This often leaves a long-term impact on the poor, particularly on vulnerable groups like young children, women and the elderly.

The government recognized the vulnerability of senior citizens and framed policies focusing on the elderly and implemented them. For instance, during the first wave of the pandemic, pensioners received three months' pension in advance along with ₹1,000 as ex gratia payment, and older persons were given priority for vaccinations.

While governments are able to plan and implement such programmes, NGOs and CBOs are able to supplement and complement government efforts by reaching the grassroots level, especially in remote areas. This chapter is an effort to document the efforts of NGOs and CBOs that exclusively focus on the welfare of the elderly, integrating the latter's needs with social security, healthcare, etc., and enabling them to lead a dignified life.

⁵ ASHA = Accredited Social Health Activist.

It also emphasizes the need for the government and private sectors to help strengthen such voluntary efforts through funding and capacity building in planning, monitoring and evaluating progress, enhancing their overall effectiveness in providing post-pandemic relief to the elderly. The chapter explores processes and practices that will help identify and respond to the needs and vulnerabilities of the elderly during and after a pandemic.

7.4 Role of HelpAge India

Exclusive care of older persons by HelpAge India and other NGOs/CBOs was initiated in eight states (Delhi/NCR, Chhattisgarh, Uttar Pradesh [UP], Madhya Pradesh [MP], Bihar, Odisha, Telangana and West Bengal) in April 2020, with support from many donors, including the United Nations Population Fund.

Established in 1978, HelpAge India is dedicated to respond to the emerging challenges of the ageing population. Its focus has been on issues regarding care, relative poverty in old age, access to healthcare, affordability of health services, socially productive roles, emotional isolation and many more. It also provides active support for disaster relief and rehabilitation during natural calamities. As part of its pandemic response, HelpAge India's decentralized procurement procedure helped to reduce response time, and it partnered with mobile health units (MHUs) and local partners (NGOs/CBOs and senior citizens associations) to ensure last mile distribution and delivery of services. Elder self-help groups (ESHGs) were formed in partnership with other voluntary organizations and members of the community.

HelpAge India's pandemic response focused on the following areas:

- (a) *Food and nutrition:* Amid the challenges presented by lockdowns and other COVID-19 protocols, HelpAge India, in collaboration with its corporate partners, was able to distribute 150,000 meals to old age homes, day care centres and urban destitute elderly that included 70,000 meals in Delhi/NCR and 24,000 in Telangana.⁶ The cooked meals and hygiene kits were initially

⁶ MIS data of HelpAge India.

During the first wave, HelpAge India's helpline staff worked alongside volunteers (including student volunteers) to call the members of senior citizens' associations to spread awareness about the guidelines issued by the government.

distributed in urban slums, semi-rural areas and old age homes. The ESHGs in Bihar, UP and MP helped by providing dry rations.

- (b) *Communication regarding COVID-19 protocols:* Community volunteers and MHU staff helped in disseminating the governments' messages regarding standard protocols and guidelines pertaining to the COVID-19 pandemic. These were translated in local languages and put up as posters and banners for older persons in the community. The community volunteers additionally communicated these messages to older persons individually over phone. The correct ways to use masks and wash hands were also demonstrated by MHU staff members. The ESHGs also played an important role in reinforcing the importance of following these safety protocols.
- (c) *Helpline/Elderline:* During the first wave, HelpAge India's helpline staff worked alongside volunteers (including student volunteers) to call the members of senior citizens' associations to spread awareness about the guidelines issued by the government. During the second wave, they provided guidance on legal aspects, counselling and moral support, as well as facilitated direct interventions in the field and connected with other services. In Delhi, the HelpAge India Helpline assisted 60 percent of older persons secure hospital beds and followed up with them for treatment. The HelpAge India team coordinated with local police and medical units to arrange for blood plasma and oxygen for elderly patients and also assisted the local administration in cremations. Apart from facilitating vaccine registrations and coordinating with Uber for free services for vaccination, the helpline team also coordinated for free rations, social pensions, medical health facilities and employment opportunities as well as engaged in calls for active listening.
- (d) *Old age homes:* Old age homes were assisted with grants for construction or enhancement of facilities and procurement of fixed assets—these included renovation of toilets and cupboards, and repair of terraces and balconies, water tanks, and solar water harvesting facilities. During the first wave, 20 old age homes in

Chhattisgarh, West Bengal, MP, Odisha and Telangana were given support for food ration and upgrading infrastructure, while 49 homes were given grants for the same in UP, Gujarat, Delhi/NCR, Rajasthan, Punjab, Tamil Nadu, Telangana and Maharashtra during the second wave. During first wave, HelpAge India also provided survival kits to 120 old age homes across the country, with support from various donors including United Nations Population Fund.

- (e) *Healthcare*: The MHUs are designed as primary healthcare units to provide various services to the community that include primary healthcare, referrals, special screening camps, optometric services and distribution of disability aids. During the lockdowns, the MHUs initiated public health awareness campaigns to sensitize the elderly about the pandemic.
- (f) *Vaccination drive*: HelpAge India teams actively participated in the government's vaccination drive by conducting outreach programmes in order to get the maximum number of older persons vaccinated. The HelpAge India central team also provided its staff and volunteers with communication material to deal with vaccine hesitancy and provide information about post-vaccination symptoms, how to manage the symptoms and precautions.
- (g) *Livelihoods*: To augment the decreased income of the ESHGs during the pandemic, a corporate-supported programme was started that provided ₹5,000–₹5,500 as a direct benefit transfer (DBT) to the ESHG members, which they could use for income-earning activities like poultry farming, mushroom cultivation, etc., along with a DBT of ₹266 per member for buying rice. Village-level federations and ESHGs were also given funds to set up enterprises such as seed-bed preparation, masala grinding and incense stick preparation. Each ESHG member was given four trees (mango, guava, lemon and coconut) to nurture and they could use the fruits from these trees for generating future income. Around 400 ESHGs were covered under these initiatives.

Some of the major challenges faced during implementation included identification and fulfilling of digital needs with the demand far exceeding supply and provision/continuation of services during lockdown periods.

- (h) *Digital and social inclusion*: Since many senior citizens were feeling digitally excluded, HelpAge India teams in some areas organized online digital literacy programmes after teaching them to use the Zoom platform. This initiative was supported by volunteers from NASSCOM⁷ and Google, along with the active involvement of the local senior citizens' associations which encouraged its members to learn and use the various digital applications.

Some of the major challenges faced during implementation included identification and fulfilling of digital needs with the demand far exceeding supply and provision/continuation of services during lockdown periods. However, with support from corporate donors as well as the state governments and district-level organizations, many of these challenges were overcome. For instance, in some places, the local police helped in maintaining order during the distribution of essential supplies. In UP, the district administration coordinated supply of essential items to the people. Community volunteers played a crucial role in connecting with older persons in the community, articulating their urgent requirements and explaining to them the rules of the new normal.

7.5 Good Practices in COVID-19 by Partner Voluntary Organizations

The NGOs/CBOs are good facilitators and act as a bridge between the people and the government. During the pandemic, coordination among NGOs maximized reach, reduced response time and helped deliver the various services to the elderly more efficiently. The most significant contribution of these voluntary organizations was the sense of security they could offer to the senior citizens; the latter could rely on these organizations when, sometimes, even the family could not be of assistance.

Some of the state-based NGOs/CBOs that partnered with HelpAge India during the pandemic are discussed in Table 7.1.

⁷ NASSCOM = National Association of Software and Services Companies.

TABLE 7.1: COVID-response and support by voluntary organization to help older persons

<i>Organization details</i>	<i>Core area of work</i>	<i>Work undertaken during the pandemic</i>	<i>Support received</i>
Koshish Charitable Trust, Bihar (1997)	Works for the rights and needs of children, women and all older persons.	<ul style="list-style-type: none"> • Provided financial help and training to the elderly to start livelihood activities such as mushroom cultivation and making health and hygiene products (such as hand wash products and household disinfectants), and helped in marketing these products. • Volunteers did a needs assessment of the older people in the districts and sent a list of demands for action to the government. As a response, many doctors of Patna Medical College along with medical students came forward to provide healthcare and medical assistance to the community. • Food packets were also distributed based on need. 	Support from HelpAge India, Action Aid, Oxfam and Disaster Management Authority to run various initiatives and also recruit student volunteers to assist the NGO.
Rehab Foundation, Chhattisgarh (2012)	Focuses on persons with disabilities (PwDs), children, women and older people.	<ul style="list-style-type: none"> • Implemented proper COVID-19 protocols in old age homes and engaged women who were victims of domestic violence to help older persons in these homes. • Continually assessed the needs of the elderly and fine-tuned their care according to their requirements. 	HelpAge India and Jindal Foundation generously supported the organization in upgrading its facilities and procuring rations for the old age homes.
Chetanalaya, Delhi (1970)	Fosters community development through its work for children, youth, women, PwDs and older people.	<ul style="list-style-type: none"> • Distributed food, hygiene kits, medicines and oxy meters and also set up community kitchens. • Helped unemployed persons who had labour cards receive DBT to the tune of ₹5,000 and enabled ration card holders avail government rations. • Dispelled fears about COVID-19 through information dissemination. • Facilitated the vaccination drive with the help of youth volunteers, appointing one volunteer for every 10 older persons. 	The organization received financial support from Deutscher Caritasverband e. V. (German Caritas Association) and the Delhi government.

<i>Organization details</i>	<i>Core area of work</i>	<i>Work undertaken during the pandemic</i>	<i>Support received</i>
		<ul style="list-style-type: none"> Volunteers also helped older people in procuring rations, medicines, getting online consultations for healthcare and teaching them use of mobile applications to receive pensions. 	
Public Health Empowerment and Research Organization, Delhi (2005)	Focuses on mental health with two operations, in Delhi and Samastipur, Bihar.	<ul style="list-style-type: none"> Promoted COVID-19-appropriate behaviour and awareness about vaccines among the community. Set up a separate healthcare unit for the care of and support to the elderly. Volunteers were trained to give injections, dispense medicines for basic health needs and deal with emergencies, along with providing care and emotional support. Conducted a needs assessment exercise through direct community contact and visits to old age homes along with government representatives. 	
Anand Service Society, Madhya Pradesh (1990)		<ul style="list-style-type: none"> Provided services and support to PwDs with free food rations and hygiene kits, and facilitated hospital admissions for COVID-19 treatment. 	Anand Society received support for its activities from HelpAge India and Rotary International for distribution of rations to elderly PwDs.
		<ul style="list-style-type: none"> Launched a helpline for the community members and also created a YouTube channel for health workers and other volunteers on how to communicate with deaf and mute patients. Shared tutorials on how to use Google Location to facilitate delivery of food and other services for PwDs, especially the elderly. 	

<i>Organization details</i>	<i>Core area of work</i>	<i>Work undertaken during the pandemic</i>	<i>Support received</i>
Centre for Advocacy and Research, Odisha (1980)	Started its operation in eight districts in the state.	<ul style="list-style-type: none"> • Launched initiatives to raise awareness on preventive protocols, helping the elderly follow these measures, and facilitated vaccine registration. • Volunteers set up help desks to monitor supply of food and medicines, and offer counselling and guidance to senior citizens for availing pensions and government benefits by helping them register for Aadhar card, etc. • Implemented a special drive in the slums for free distribution of ration kits and survival kits, benefitting almost 3,000 older persons. • Identified the need for home visits and setting up help desks in slums to help the elderly in matters of pensions, rations, water supply, sanitation and other grievances. • Maintained a proper dashboard recording timelines, beneficiary history, etc. to increase efficacy of the drive. • Worked with the National Rural Health Mission and provided guidance on COVID-19-appropriate behaviour. It regularly monitored quarantined people, ensuring they received food and medicines. • Worked in close collaboration with Bhubaneswar Municipal Corporation, providing teleconsultation to older people and organizing special counselling sessions to address mental health issues. 	The NGO was supported by HelpAge India and local municipalities to expedite the process of disbursing pensions and providing ration cards as part of the Pradhan Mantri Garib Kalyan Yojana.
Telangana Senior Citizens Service Trust, Telangana (2008)	Works closely with HelpAge India in elder care activities.	<ul style="list-style-type: none"> • Actively involved with distribution of food to unemployed slum-dwellers. • Focused on facilitating door-to-door surveys by health workers in order to identify specific needs of the elderly in the community. 	The organization was supported by HelpAge India in its initiatives.

Organization details	Core area of work	Work undertaken during the pandemic	Support received
		<ul style="list-style-type: none"> • Provided healthcare support to the elderly by helping in hospital admissions, distributing medicines, setting a physiotherapy centre with free services for those below the poverty line, and facilitating vaccination for senior citizens. • Provided legal guidance especially in terms of protection under Maintenance and Welfare of Parents and Senior Citizens' Act. 	
Manav Sewa Kendra (MSK), Uttar Pradesh (1987)	Operates in the districts of Chandoli, Mizrapur and Varanasi in UP and works with children, women and older persons.	<ul style="list-style-type: none"> • Supplied dry rations and medicines and connected the elderly with primary health centres and community health centres to meet their healthcare needs. • Established a small hospital within the community delivering basic healthcare and medicines and making referrals to government hospitals for acute cases. • Made arrangements for quarantining infected older people and created awareness within the community regarding COVID-19 guidelines. • Set up communication linkages between counsellors and the village elderly. 	<p>Several donors supported by supplying food packets consisting of <i>atta</i>, rice, pulses, oils and spices to the destitute elderly poor. Some such donors are listed below:</p> <ul style="list-style-type: none"> • Child Fund supported for 100 families • Jan Vikas Samiti supported 60 families • IMPACT supported 300 families • Milaan Foundation supported 500 families • Kiran Society provided twice for 500 older persons. <p>The organization received support from the government for its healthcare initiatives.</p>

<i>Organization details</i>	<i>Core area of work</i>	<i>Work undertaken during the pandemic</i>	<i>Support received</i>
Sundarban Social Development Centre, West Bengal (1986)	Does charitable relief work for disaster-affected communities, especially in the Sundarbans.	<ul style="list-style-type: none"> Helped in raising awareness about COVID-19 and facilitated supply of food rations and medicines to the poorest elderly with support from HelpAge India; organized orientation programme for senior citizen volunteers who distributed food and hygiene kits in their communities. Undertook community sensitization programmes on prevention of COVID-19 infections in six gram panchayats and supported the government's vaccination drive. Supported farmers by providing them with organic fertilizers and helped them set up poultry farming. ASHA workers helped in the needs assessment of the vulnerable population in coordination with local panchayats. Provided healthcare support in terms of oxy meters and oxygen concentrators to those in need. Along with HelpAge India, Sight Savers International and KFV Australia also provided assistance for community outreach programmes for psycho-social motivation, cataract procedures and food distribution to the elderly. 	Sundarban SSDC received support from the block development officers too. SSDC receives support for various other healthcare programmes from HelpAge India too.

7.6 Experience of Older Persons

Older persons interviewed for the report were satisfied with the services, frequency and duration of help extended by the NGOs and CBOs. The poor elderly, especially in the villages in economically backward states who were more severely affected by the lockdowns and reverse migration, acknowledged the importance of receiving food rations and hygiene kits from the NGOs/CBOs. They regarded the NGOs/CBOs as a dependable and authentic source of information for anything related to the pandemic or government

Almost all senior citizens complained that nobody except the NGOs/CBOs operating in the area came to assist them in such trying times and added that organizations like HelpAge India should expand their services.

announcements. The healthcare interventions by the NGOs/CBOs were also highly appreciated as the only service available at their doorsteps. Though the elderly continued to receive support from the state in terms of food rations and social pension without facing much difficulty, most of them stated that this was not sufficient to meet the challenges of the rising cost of living in the face of an economic downturn and hence, sought more in terms of livelihood support.

Almost all complained about the lack of accessible public healthcare facilities for older persons including special services for geriatric healthcare. This, according to them, should be a priority area of intervention. Almost all senior citizens complained that nobody except the NGOs/CBOs operating in the area came to assist them in such trying times and added that organizations like HelpAge India should expand their services.

The vaccination drive, however, presented a better picture. The prioritization of senior citizens for vaccination coupled with multiple outreach campaigns by NGOs/CBOs and village panchayats for awareness generation led to a large number of older persons getting vaccinated, including all the respondents of this survey.

7.7 Way Forward

Inadequate social security in old age increased the dependence of older persons on charity or welfare schemes. The lockdown periods were particularly difficult for them with no access to any kind of livelihood opportunities, depending on the government and NGOs to receive their daily meals and/or free rations. This showed that more dependable and economically viable social security and welfare schemes were needed to sustain the poor elderly and the unemployed in times of crisis.

Secondly, interruption in the primary healthcare system especially affected the elderly with non-communicable diseases. Lack of income also meant that most of them could not bear the cost of

treatment and medication. The pandemic highlighted the need for better mental health and counselling services along with curative care. It is, therefore, essential to develop a robust healthcare system that can meet the demands of the population in times of crises and disasters and is especially focused on the elderly and other vulnerable sections of the population. This should include full-time helplines for the senior citizens to provide information regarding services, schemes, etc., as well as counselling. Focusing on the needs of the elderly while framing welfare schemes is one way to ensure that they get what is due without facing too many problems.

A reliable network of trained volunteers, with higher participation from the younger population, is needed, especially during national disasters and emergencies. Voluntary efforts by corporates also need to expand to meet the demands of national emergencies such as the pandemic. While senior citizens' associations and elderly volunteers provided the much needed support to their peers in the community, more active participation of older persons should be encouraged in times of national emergencies. With increasing longevity, it is necessary to get support from more able and younger seniors to play a positive contributory role in community development and disaster response.

8

Way Forward

India's National Policy on Older Persons (NPOP) 1999 and efforts to enhance the quality of life of senior citizens predate the Madrid International Plan of Action on Ageing (MIPAA) 2002. The national policy document undertakes (i) an in-depth analysis of ageing in India and (ii) a diagnosis of factors increasing vulnerability in later years (especially for women) to arrive at (iii) policy responses needed to alleviate problems in old age and actions needed at national, state, district and lower levels and defines (iv) roles of various ministries towards the implementation of the national policy. India's early declaration of such a national policy has been a model to emulate, not only for MIPAA but also other developing countries.

The *India Ageing Report 2017* extensively covered status of Indian elderly, outlined several early response and policy interventions towards their betterment and made recommendations to ease implementation bottlenecks.¹ It emphasized the need for enhancing policy and programme relevance through regular user feedback. This was supplemented by six-monthly programme audits to examine how services and benefits are actually reaching beneficiaries, to identify bottlenecks and initiate corrective actions. Advocacy at policy level as well of involvement of civil society institutions at implementation level were also highlighted in that report. In continuing pursuit of the national ageing policy objectives, India Ageing Report 2023 focuses more closely on institutional arrangements for implementation of the programmes.

The implementation philosophy of the NPOP makes it clear that the government alone cannot realize the policy vision without supplementary and complementary implementation action by civil society, community-based

¹ UNFPA, *Caring for Our Elders: Early Responses, India Ageing Report 2017*, (United Nations Population Fund, 2017).

organizations (CBOs), the media and the private sector. To follow through on the ageing policy therefore, funds were allocated and the necessary institutional support system articulated for mobilizing wider participation in the implementation process. For example, the National Institute of Social Defence (NISD) was given a key role in coordinating between different stakeholders, to develop their capacity and support policy-oriented research, dissemination and implementation of the programme for the wellbeing of older persons.

The pandemic years significantly disrupted the functioning of such institutions in the fulfilment of their regular mandate and implementation of the programmes because attention and resources had to be diverted to COVID response. This highlighted the need for further strengthening of Panchayati Raj Institutions (PRIs) and CBOs particularly in meeting such emergency situations.

In the sections that follow, we examine the roles of the government, the community, the private sector, and PRIs in creating a robust institutional wireframe for not only achieving the objectives of the National Policy on Older Persons but also tackling large scale crises such as the one precipitated by the pandemic.

8.1 Response of the Government

Financial and technical support: For any pan-India development initiative (including elder care), we look towards the government for clear and cogent policy-based technical, financial and administrative support backed by effective technology-led communication strategy. The successful COVID-19 vaccination story in India (Chapter 7) is testament to the successful fulfilment of this role by the government. It is hoped that the Government of India will continue to provide key institutional support along similar lines in all other contexts too.

Enhancing collaboration among stakeholders: As demonstrated by the pandemic experience and vaccination management, while the government takes the lead in any initiative, coordination and collaboration across service providers in public and private hospitals,

municipal health institutions and civil society institutions remains central to maximizing efficiency of resource use while minimizing wastage and costs in achieving defined goals. Therefore, the government needs to focus on systematic coordination, convergence and collaboration across key stakeholders to avoid duplication of effort, operations at cross-purposes and bureaucratic hold-ups. This is unlikely to happen unless government orchestrates this process to synergize total effects to exceed the sum of individual agency effort.

Departments within the government need to converge their efforts to ensure that their respective programmes are elderly friendly and delivered in a holistic fashion. For example, programmes of the Ministry of Health and Family Welfare should prioritize the training of service providers and supervisors on geriatric care. Other ministries should focus on empowering the elderly with knowledge and awareness and increase efforts to address the needs of elderly women in particular.

Knowledge management: As demonstrated by the pandemic management and vaccination drive experience in India, any large-scale initiative or programme invariably generates a wealth of knowledge and data through on-ground action which may be especially relevant for senior citizens who form a large vulnerable group. Such data needs to be systematically recorded, arranged, retrieved and analysed so that it may suitably inform future policy and programme support of the government. Government institutions such as NISD with support from private sector should fund a coordinated research programme for this purpose. Good practices should be identified, documented and disseminated for which experienced institutions should be utilized.

The government, private sector and relevant institutions can work together to encourage research and knowledge building on the implications of prevailing and emerging social, political, economic, technological, market and business, financial, health and institutional processes and safety nets on ageing including services and products for the elderly. A Research Advisory Committee consisting of

programme managers, academics and private participants may be set up for identifying and funding research priorities and subsequently incorporating findings to improve programme implementation and effectiveness and expand the research base. Research on quality of care from the user's perspective with the user's participation would be essential to increase the reach and utilization of public services specially meant for elderly.

Contractual arrangement with non-governmental organizations (NGOs) in elder care: The management of elder care programmes under PRIs could be assigned to select local NGOs operating within an adequate result-oriented accountability system developed for the purpose. Lessons could be drawn from the experiences of state governments which have successfully handed over the management and operations of some primary health centres to select NGOs/CBOs and witnessed good outcomes.

Capacity development of government functionaries at district and panchayat level: The India Ageing Report 2017 has already highlighted the need for developing capacities of mid-level managers, PRIs, health professionals and service providers for better coordinated implementation of both central and state sponsored schemes. District Development Officers in close collaboration with PRIs must develop better convergence of development initiatives in villages aimed at improving lives and living standards of elderly taking a comprehensive view rather than individual projects. The National Institute of Social Defence can facilitate the capacity development of the district level officials by offering regular courses. There is a greater role for Regional Resource and Training Centres (RRTCs) (recommended by the NPOP) in re-structuring both short duration and long-term courses for training of existing staff as well as education of families on active ageing.

Training of trainers and personnel in geriatric care: National Programme for Health Care of the Elderly is a key government initiative that envisages both infrastructure and human resource development for comprehensive elderly health care. A review of this programme

indicates the need for training of trainers through well-designed and delivered geriatric training courses. A cadre of caregivers for home-based care for disabled older persons needs to be developed.

Engaging with grassroots organizations: We have already mentioned that the collaboration of government agencies with voluntary organizations (VOs) as well as private players is necessary to fulfil their mandate in elder welfare. More effort will be needed to link officials responsible for implementation of senior citizen initiatives with experiences and learnings of VOs in the field. In particular, they should mandatorily spend 3–4 weeks of attachment with selected VOs. Upon return, their report must include lessons learned to enhance relevance of government schemes and suggestions for more effectiveness implementation. These reports must be diagnostic and analytical in nature (not just an administrative requirement). Based on a collection of such internal reports, the government may seek from the UNFPA, technical and financial assistance on improving the effectiveness of schemes meant for senior citizens.

Similarly, CBOs can be a bridge between the government and the older population in eliciting beneficiary feedback on schemes and projects, their access and impact. Many practically useful suggestions emerge from the grassroots and beneficiary feedback and recommendations must be a part of routine and regular interface of senior managers at central and state levels. In the absence of such an arrangement, many good ideas get ignored. When government initiatives and schemes are not informed by beneficiary feedback, they may not be able to provide the targeted assistance that they intend to while maximizing outreach, particularly among vulnerable population groups. The intended beneficiaries and target population will not be able to avail of them as envisaged and impediments and obstacles they face will unaddressed, simply because the voices of the people were not heard.

8.2 Response from CBOs

Although the number of CBOs has increased over time, rural areas populated by a large proportion and absolute numbers of elderly with little or no income security remain under-served. The NPOP (long before the MIPAA) recognized the significance of making consistent and stable financial allocations towards establishing rural CBOs, supported and monitored by PRIs to serve the needs of the rural elderly (especially from disadvantaged groups).

In practice though, this raises many questions—where can additional funds come from? How can CBO capacity be enhanced? How can elders change from being passive recipients to more active participants in elder care? Is there an existing organization that can be involved in creating and helping CBOs in unorganized sectors facing high income insecurity?

Apart from government sources, there is significant scope for mobilizing corporate social responsibility (CSR) funds for this purpose as elder care falls well within the activities recognized under the CSR mandate. Funds are needed for the development of related infrastructure such as the construction of meeting rooms or halls, training equipment and digital infrastructure and platforms for connecting the elderly to government schemes and portals that can improve their quality of life. Research institutions could develop project proposals on issues related to the elderly to avail of CSR funds. However, given the nature of such initiatives, achievements are difficult to measure in the short term against expected results or targets. Therefore, for CBOs to attract CSR funds may need some government support, assurances or guarantees. The mandate of RRTCs to stimulate and support the growth of CBOs could be strengthened through the use of CSR funds.

As mentioned earlier, CBOs can enable regular interface between project beneficiaries and managers at central and state levels so that inputs from the community can enrich project design, implementation and create opportunities for mid-course correction for better outcomes and improved outreach.

8.3 Deeper Collaboration with Private Sector

This report elaborated on two examples of private sector participation in service provisioning for the elderly—National Stock Exchange (NSE) Foundation and Tata Trusts.

Tata Trusts collaborated with the Ministry of Social Justice, Government of India to scale up the National Elder Help Line across all the states in India. Similarly, many partners have come together to take forward the 'Digital Health' intervention in select aspirational districts so that a model can be piloted for wider adoption by the government. The *India Ageing Report 2017* made a reference to the Sansad Adarsh Gram Yojana (SAGY) to enhance convergence of schemes and services from different sources with attention to elder care. This report details out how two significant efforts from private sector can offer implementable models of such care.

The NSE case study on the other hand focused on social inclusion, financial inclusion and health access for the elderly, creating models of public–private collaboration on addressing elder issues while aligning with NITI Aayog's programme of aspirational districts.

A distinct reality highlighted through the NSE case study is of the elderly caring for the elderly as the next generation migrates in search of livelihoods. A group of young-old persons must be formally identified for providing care and support for older elderly. Local governments in collaboration with private organizations should arrange for orientation of such groups and facilitate their work.

8.4 Strengthening PRIs, the Essential Community-Level Agency

Active PRI involvement is essential for community transformation aimed at building a supportive environment for senior citizens. The PRI representing a decentralized governance system essential for local development is robust in some states but not in others. The elderly in rural areas, often faced with extremely adverse economic, social and health situations and insecurities, would benefit immensely

from PRI support at village, tehsils and district levels provided they are strong and have financial, digital, and administrative capacity to deliver on their mandate. Experience sharing across states on PRI development may help states with weaker institutions to catch up and bridge the gap. The *India Aging Report of 2017* extensively covered the innovative interventions related to the elderly by PRIs such as Kudumbashree, Asraya and Palliative Care in Kerala, which can be replicated in other states as well.

8.5 Intergenerational Solidarity and Promoting Good Practices

Indian culture stands on the concept of filial piety, where caring for the elderly is considered a duty of the younger generation. Socio-economic development and the disintegration of joint family system have led to breaking of family ties. In recent years, India witnesses substantial increase in the number of elderly living alone or exclusively living with spouse.

Intergenerational solidarity and the relationship between generations need to be nurtured for ensuring the wellbeing of the elderly. Contrary to popular belief, the elderly are not only recipients of care and support from their families and communities (and hence burdensome). In reality they contribute substantially to their families, often taking care of the grandchildren, offering financial support and performing household chores while also enriching the younger generation with their experience and wisdom. Though nuclear families are on the rise, multi-generational families are considered better for the elderly as they cultivate the sense of mutual care.

Many CBOs, working to protect the rights of the vulnerable elderly in family and social settings, have raised concern that the contribution of the elderly in nurturing and mentoring the young generation is poorly appreciated. Moreover, there has been an increase in elder abuse and an exacerbation of their economic and health vulnerabilities in the recent past. The retrieval of the traditional value system and the strong bonding between generations is the need of

the hour. Therefore, the programmes that enhance intergenerational solidarity have to be conceptualized and promoted.

8.6 Special Focus on Older Persons in Disaster Preparedness Plans

The COVID-19 pandemic proved to be a major challenge for the general population but especially for older persons in seeking health care and ensuring social connectedness; it aggravated cases of elder abuse and discrimination. Unlike the other disasters, the pandemic revealed the importance of a segmented approach to the provision of elder care. It was implemented successfully in India across select services like vaccination and COVID-19 related care. Disasters like floods, droughts, cyclones, landslides, earthquake and tsunami also have a disproportionately adverse impact on the lives of the elderly. However, evidence of said impact is seldom gathered in a way that is systematic enough for devising effective ways to address them. The specific concerns of older persons during and after disasters are overlooked in the design and implementation of most relief and rehabilitation processes.

During the pandemic, the vulnerability of older people increased, with those afflicted by non-communicable diseases finding it extraordinarily difficult to access routine healthcare services and medication. Lack of digital literacy and inability to modern devices such as the smart phone effectively further contributed to their vulnerability. Forced loneliness due to lockdown and isolation aggravated mental health issues, which were left unattended. These issues have drawn the attention of stakeholders who unanimously acknowledge the need for concerted action towards addressing specific issues that elderly face during disasters.

During the pandemic, helplines proved to be useful in linking the elderly to relevant services and addressing other needs. It may therefore be concluded that a better equipped network of helplines geared towards active listening, information provisioning and coordination across service providers, volunteers and older persons

will be hugely beneficial. The sensitivity of the VOs to the cause of older persons, their continuous engagement with them and speed of response make them most useful agencies in the context of elder care.

8.7 Strengthening Data System on Population Ageing

There has been lack of credible information on the various issues related to elderly in India, though is improving over time. Existing data from the Census, LASI, SAGE and BKPAI provide larger insight on the macro situation of older persons in the country. These information sources need to be substantiated with micro level studies detailing the underlying reasons behind data characteristics and trends. It is important that such studies be encouraged not only for an effective understanding of the elderly in different contexts but also to document the best practices being followed in various parts of the country.

More data can be generated by other mechanisms, including management information systems (MIS) of ongoing programmes like National Programme for Health Care of the Elderly, programmes on non-communicable diseases, etc. The availability of such data and its meaningful analysis at regular intervals will help in monitoring and evaluation of these programmes more effectively and also appraisal of the scenario at the grass roots. This can provide a deeper insight into existing initiatives on geriatric care and the effectiveness of social welfare programmes in reaching older persons. Further, partnerships with large data systems and its collection agencies such as National Sample Survey by Ministry of Statistics and Programme Implementation; National Family Health Survey by Ministry of Health and Family Welfare; and Census of India by the Office of the Registrar General and Census Commissioner should be established to include questions on relevant and emerging issues related to older persons in their upcoming data collection exercises.

India Ageing Report 2023

Caring for Our Elders: Institutional Responses

The impending rise in the 60+ population in India in the coming decades will have significant implications for the health sector, the economy, and the society. Building on its earlier edition in 2017, the *India Ageing Report 2023* re-examines the conditions of older persons in the country, based on the most recent data and attempts to map institutional responses to stepping up the quality of elder care in the country. It focuses on the responses from the government, community-based organizations and associations of older persons, efforts by the corporate houses under the corporate social responsibility mandate, and measures taken for the care for older persons during the COVID-19 pandemic.

In canvassing the utilization of elder care services in India, making suggestions for strengthening schemes and programmes and suggesting the way forward, the report will be immensely useful for scholars, policy and programme managers and stakeholders in elder care, which includes all of us.



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