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The health of the aged in India*

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Abstract

Because of declining fertility, the proportion of the aged in the Indian population has risen. Although the rise has been modest, as shown by an increase in the population over 60 years of age from 5.5 to 7.0 per cent between 1951 and 1995, by the latter date, India's experience with 65 million people of this age is unusual. The paper employs data on persons 65+ years of age drawn from the 42nd Round of the National Sample Survey, and for the analysis subdivides them into three age groups, 60-64, 65-69 and 70+. It is shown that, among population over 60 years of age, 10 per cent suffer from impaired physical mobility and 10 per cent are hospitalized at any given time, both proportions rising with increasing age. Of the population over 70 years of age, more than 50 per cent suffer from one or more chronic conditions. The very limited support provided to the old by goverment is brought out by the fact that even in Karnataka, one of the states with the most generous provision, only 15 per cent of persons over 65 years of age receive any type of pension.

India embarked on fertility and mortality control programs almost immediately after attaining independence in 1947. The First Five-Year Plan, implemented between 1951 and 1956, contained not only a health program to reduce mortality and morbidity but also a family planning program to reduce the birth rate. Thus, India has often been cited as the first country in the world to have started an official family planning program. The successive Five-Year Plans placed more and more emphasis on the fertility and mortality control programs; as a result, there have been considerable declines in both fertility and mortality. For example, the crude birth rate declined from about 40 per 1,000 population in 1941-51 to about 30 in 1990 (Government of India 1991:113). Similarly, the crude death rate has declined from a little over 27 per 1,000 population per year to a little lower than ten during the same period(Government of India 1991:113). The expectation of life at birth has increased from about 32 years in 1941-51 to about 59 years in 1986-91 (Government of India 1991:113). It has been projected that the crude birth rate will be lower than 28 and the crude death rate lower than nine in 1996-2000 (Registrar General 1988:17). The expectation of life at birth is projected to increase to about 65 years by 2001 (Government of India 1991:113).

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One of the consequences of these improvements is an increase in both the proportions and numbers of the aged, that is, those who are 60 years and above, in the total population of India. Table 1 presents data on the proportions and numbers of persons aged 60 years and

above in India from 1951 to 2001. The proportion increased only marginally from 5.5 per cent in 1951 to about 6.5 per cent in 1991 and is projected to increase to about 7.4 per cent by 2001. The proportions of the aged are, no doubt, smaller in India than in the developed and some of the developing countries. But in a country like India, with a large population, reference to the proportion of the aged conceals more than it reveals and evades the real issues rather than facing them. As can be seen from Table 1, the number of old people increased from about 20 million in 1951 to about 55 million in 1991 and is projected to increase to about 76 million by 2001. At present, India ranks third among the countries in the world in terms of the absolute number of the aged and, by the year 2000, it will rank second, next only to China.

Table 1
Numbers and proportions of persons aged 60 and above in India, 1951 to 2001

Year	Numbers (in millions)	As % of total population
1951[a]	19.61	5.50
1961[b]	24.73	5.63
1971[b]	32.67	5.96
1981[c]	43.17[d]	6.49
1991[c]	54.99[e]	6.52
2001[c]	75.93	7.43

Notes: [a] Source: Mukherjee 1976. [b] Source: Registrar General, India 1984. [c] Source: Registrar General, India 1988. [d] Excludes state of Assam [e] Adjusted to 1991 population from projected population (high variant)

In India, the old have traditionally been honoured and respected. Religious texts and writings enjoined upon the sons to provide all support for their old parents. Grown-up children, especially sons, provided not only financial and material support for their parents; they also provided psychological and emotional support. Caldwell (1982:54) wrote: 'It is a fallacy to think of the value of grown-up children being merely equivalent to an insurance policy against old age and sickness'. Like the commandment to 'Honour thy father and thy mother', there is a saying in Sanskrit: *mathru devobhava* (mother is like God), *pithru devobhava* (father is like God), *guru devobhava* (teacher is like God). Those who neglected their old parents earned social opprobrium and were ridiculed. But there is already a saying, 'mother has become poison and wife sweet'. Since Independence, India has been passing through a rapid socio-economic transformation which has brought about important changes in the social profile of the people.

The rapid urbanization has resulted in a shortage of housing in towns and cities, and consequently in exorbitant house rents which act as a severe constraint on the common residence of the aged with their sons, especially, but not exclusively, for migrant families. In fact, the extended family system is gradually breaking down, yielding place to the nuclear family system. Forces of modernization, technological changes and social mobility have changed people's lifestyles and values. These changes have adversely affected traditional respect as well as attitudes of empathy and care for the aged.

The migration of younger people from rural areas to towns and cities increases the vulnerability of the old who stay behind, particularly those living in families which do not have independent production sources like land, livestock or household industry and are dependent primarily on their labour. As a result of the acceptance of fertility control by an

increasing proportion of couples, some of the aged are likely to be given less care by their children because of increasing mobility and for other reasons.

The spread of education among women, accompanied by their employment outside the home in offices and factories, leaves no time for those women to take care of old people at home. More important, there is now a greater investment by the family in the education and upbringing of children. The high cost of living, and changing priorities, affect the intrafamily distribution of income in favour of children. In the phraseology of Caldwell (1982), the wealth flow in India is turning downward. All these socio-economic changes have adversely affected the situation of the elderly in India.

Earlier studies

Old people in India, like those in other countries, suffer from a range of problems. However, 'of all the problems associated with an aging population, health care demands top priority' (Ory and Bond 1989:1).This is particularly true of developing countries where the number of people being kept alive in misery and poor health has been increasing because of modern medical technology and the expansion of primary health programs by foreign aid, which have reduced mortality without sufficiently improving levels of health. Increasing life expectancy is certainly desirable provided levels of health are improved by effectively organizing and adequately staffing the health care delivery system (Hansluwka 1986:3).

In an analysis of the status of the aged (65+) in South Asia, Martin (1990) presented their characteristics, including their health status; investigated the changes in their family situation and status; speculated about their future; and discussed general ageing policy issues and research needs.

A study by Chanana and Talwar (1987) dealt with the growth rate of the aged population in India, the dependent population in the non-productive age groups, the old age dependency ratio, sex ratio, marital status, literacy among males and females, and working and non-working aged. The health staus of the aged was also analysed on the basis of the data collected in the 28th Round of the National Sample Survey in 1973. The analysis included measures of the prevalence of temporary illness and chronic diseases, the number of old people requiring medical assistance and the types of physical impairment from which they suffered, cross-classified by place of residence and sex. The study also threw light on the welfare programs for the aged being implemented in different states of India.

A study of ageing in the state of Kerala (Rajan 1989) described factors contributing to population ageing, changes in age composition, dependency ratios and structural changes, that is, changes in the age and sex composition of the population aged 60 years and above over a period of three decades to 1981.

The findings of another study of the population aged 60+ in the state of Kerala (Gulati and Rajan 1990) were very similar to those of Rajan (1989). After analysing the socio-economic and demographic characteristics of the aged, the study described the current welfare programs for them in Kerala, including the Kerala Agricultural Workers` Pension Scheme, 1980.

In a study of 460 persons aged 60+, of whom 130 men and 100 women were from 30 villages, and 140 men and 90 women were from two urban centres in Chittoor district of the state of Andhra Pradesh, Kumar (1991) focused his analysis on familial and socio-economic problems, including health problems.

Joseph (1991) made a comparative study of 411 persons: 207 men and 204 women over 60 living with families; 48 men and 44 women aged 60+ living in homes for the aged; and 257 people, 127 men and 130 women, aged 20-50 years in Kottayam district in Kerala. Joseph (1991) identified stereotypes of the aged, attitudes of the young towards them, their problems, including health problems, and their personality and religiosity.

A study by Nair (1989) of 745 persons aged 60+, 375 men and 370 women, from the rural areas of four districts in the state of Karnataka, investigated their socio-economic and health problems.

Although the main objectives were different, a study of demographic change in south India, employing micro approaches, enquired into support for the aged (Caldwell, Reddy and Caldwell 1988:187-195).

There are many other studies of old people in India which did not enquire into their health problems. Thus, most studies were comprehensive and when they covered health it was only as one of several problems experienced by the aged. These studies are important, but there is a need for studies devoted primarily to the health problems of this age group.

Objective

The objective of the present paper is to analyse the health status of the aged in India. This can be examined in different ways, ranging from their life expectancy at age 60 to their death rate. But here analysis is confined to four indicators of health status, data on which are readily available. These indicators are: the percentage of physically immobile persons among the aged; the percentage of aged persons having chronic disease; their disease prevalence rate (per 1000); and the proportion (per 1000) hospitalized. Differences in age, sex and rural-urban residence of the aged are analysed to see how they affect the four indicators.

Data and method

The 42nd Round of the National Sample Survey (NSS) conducted by the National Sample Survey Organisation (NSSO) in India during July 1986-June 1987 collected a wealth of data on 20 items regarding persons aged 60 years and above (NSSO 1991). Collection of data on the health status of the aged was not the only objective of the NSS; it also collected data on their socio-economic and demographic background, their past and current economic activity, living arrangements, familial integration, and participation in social and religious activities. The data pertaining to the four indicators listed above are analysed here.

The NSSO adopted a two-stage stratified sampling design. The first-stage units were villages in the rural areas and NSSO urban blocks in the urban areas; the second-stage units were households in both rural and urban areas. The sample villages were selected with a probability proportional to population size with replacement in the form of two independent interpenetrating subsamples. The sample urban blocks were selected using a simple random method without replacement in the form of two independent interpenetrating subsamples.

For the selection of sample households, the frame consisted of households in each of which there was at least one person aged 60 years or over. Three households were selected systematically with a random start from each of the first stage units. If, in a selected first stage unit, the number of households in the frame was found to be less than three, then all such households were selected for the survey.

The survey covered 49,693 households spread over a sample of 8,312 villages and 4,546 urban blocks. Of the 49,693 households, 32,237 were rural and 17,456 were urban. The methodology is described in detail elsewhere (NSSO 1991:103-105). The survey covered the whole of India except Ladakh and Kargil districts of the state of Jammu and Kashmir; and the rural areas of the state of Nagaland.

Findings

The findings have been tabulated by age, sex and rural-urban residence in a series of Tables, 2-7. The age groupings used are 60-64, 65-69 and 70+ years. I would have preferred the age

groupings for those over 70 to be 70-74, 75-79 and 80+ years, but the NSSO made only three age groupings.

Physically immobile aged

Table 2 presents data on the percentage of the population over 60 who are physically immobile, in different age groupings, among males and females, and in rural and urban areas. In the rural areas, the percentage of the physically immobile aged is 4.5 among the males and 6.8 among the females; the figures for the urban areas are 4.7 per cent and 6.7 per cent. Both among aged males and females and in the rural and urban areas, as age increases, the proportion of the physically immobile increases.

Table 2 shows that, in all age groupings and in both rural and urban areas, the proportions physically immobile are higher among old women than among old men. This is perhaps due to at least two factors: the frequent cycles of pregnancy and lactation experienced by women, and the hard work done by women over their lifetimes. In general, the finding indicates that aged women, like females in general, are accorded a lower status than the aged men.

Table 2
Percentage of the aged who are physically immobile by age, sex and residence

Sex	Age (years)	Rural	Urban
Males	60-64	2.4	2.2
	65-69	3.3	4.1
	70+	8.3	8.1
	All ages	4.5	4.7
Females	60-64	3.3	3.3
	65-69	4.9	4.7
	70+	13.5	11.7
	All ages	6.8	6.7
Persons	60-64	2.7	2.7
	65-69	4.0	4.4
	70+	10.4	9.6
	All ages	5.4	5.5

Source: NSSO 1991:S-126

Table 3 shows the percentage distribution of the physically immobile elderly by age, sex and place of residence. Somewhat contrary to expectation, the percentages of the physically immobile belonging to the age groupings 60-64 years and 65-69 years are about the same among rural old men and women, and also among urban old women; but, of the total number of the physically immobile among old men in urban areas, about 19 per cent belong to the age group 60-64 years and about 25 per cent to the age group 65-69 years. As might be expected, of all the physically immobile aged, the majority belong to the age group 70+ years. But the percentage of the physically immobile aged who are 70 or over varies by sex in both rural and urban areas. For example, of all the physically immobile old men, about 56 per cent in both rural and urban areas are aged 70+ years; and, of all the physically immobile old women, 60 per cent in rural areas and about 62 per cent in urban areas are aged 70+.

The chronically ill aged

The NSS collected information on seven chronic diseases. Only two alternative responses, 'yes' and 'no', were provided to the questions on those chronic diseases or symptoms of chronic diseases which could be easily identified by the respondents: they included cough, piles, problems of the joints and urinary problems. But the NSS did not probe further into the

reported chronic diseases or symptoms: it did not ask a further question whether the cough was due to tuberculosis, asthma, bronchitis or pleurisy. The objective of the NSS seems to have been only to indicate a need for care; from the point of view of intervention programs, this is not sufficient. Three responses, 'yes,' 'no' and 'not known', were provided to the questions on chronic diseases or symptoms which could not be easily identified by the respondents; they included abnormal blood pressure, heart disease and diabetes. It is entirely possible, therefore, that the proportions suffering from abnormal blood pressure, heart disease and diabetes could be higher than those reported, as some of the respondents who reported 'not known' might also be suffering from these chronic diseases.

Table 3
Percentage distribution of the physically immobile aged by age, sex and place of residence

Sex	Age (Years)	Rural	Urban
Males	60-64	22.7	19.1
	65-69	20.9	24.7
	70+	56.4	56.2
	All ages	100.0	100.0
Females	60-64	19.9	18.1
	65-69	19.9	19.8
	70+	60.2	62.1
	All ages	100.0	100.0
Persons	60-64	21.3	18.6
	65-69	20.4	22.3
	70+	58.3	59.2
	All ages	100.0	100.0

Source: NSSO 1991:S-176

The chronic diseases have perhaps become chronic because of the patient or the extended family neglecting to get proper treatment at the appropriate time, or because the health system is inadequate, especially through its inability to provide geriatric facilities and free medicines.

Table 4 shows the rather high percentage of the aged with chronic disease in different age groupings, among males and females, and in rural and urban areas. As might be expected, the percentage increases with age, for both men and women, both rural and urban. There are no large differences by sex or place of residence. The proportion chronically ill is about 45 per cent of aged men and women in both rural and urban areas.

Table 5 shows the percentage distribution of the rural aged with chronic disease by type of chronic disease, age and sex. There is not much difference by age among either men or women, but there are differences by sex. For example, the proportion suffering from cough is slightly higher among men (about 35 per cent) than among women (about 33 per cent). This may be due to the use of tobacco, especially smoking, by more men than women. But the proportion suffering from problems of the joints is higher among women (about 51 per cent) than among men (about 45 per cent); this proportion is higher among females than among males in all the three age groups. Of those suffering from chronic disease, the proportions suffering from urinary problems and diabetes are higher among men than among women. The differences in the proportions of males and females suffering from different types of chronic disease may be due to differences in social, behavioural and economic factors like education, religion, caste, smoking, consumption of alcohol and income.

Table 4
Percentage of the aged with chronic disease by age, sex and residence

Sex	Age (Years)	Rural	Urban
Males	60-64	38.3	36.8
	65-69	44.8	43.9
	70+	54.9	54.0
	All ages	45.1	44.3
Females	60-64	39.4	39.7
	65-69	44.5	42.8
	70+	52.6	53.6
	All ages	44.9	45.5
Persons	60-64	38.7	37.9
	65-69	44.7	43.5
	70+	54.0	53.8
	All ages	45.0	44.8

Source: NSSO 1991:S-194

Table 5
Percentage distribution of the rural elderly with chronic disease by type of chronic disease, age and sex

Sex	Age (years)	Type of chronic disease							
		Cough	Piles	Problems of joints	Blood pressure	Heart disease	Urinary problems	Diabetes	
Males	60-64	37.3	3.9	42.5	6.9	3.4	3.8	2.4	100
	65-69	34.2	3.5	47.7	5.7	3.1	3.5	2.2	100
	70+	34.9	3.9	44.1	6.4	4.4	4.7	1.7	100
	All ages	35.2	3.8	44.5	6.4	3.7	4.1	2.1	100
Females	60-64	33.2	2.6	51.3	5.9	3.1	2.4	1.5	100
	65-69	33.1	2.2	49.7	6.9	4.2	2.7	1.1	100
	70+	31.9	2.5	50.5	6.8	4.3	3.1	1.0	100
	All ages	32.7	2.5	50.6	6.5	3.9	2.7	1.2	100
Persons	60-64	35.6	3.4	46.1	6.5	3.3	3.2	2.0	100
	65-69	33.8	3.0	48.5	6.2	3.5	3.2	1.8	100
	70+	33.7	3.4	46.7	6.5	4.3	4.1	1.4	100
	All ages	34.4	3.3	47.0	6.4	3.7	3.5	1.7	100

Source: NSSO 1991:S-194

Table 6 presents the percentage distribution of the urban aged with chronic disease by type of chronic disease, age and sex. Differences in age do not make for differences in the proportions suffering from most of the chronic diseases among either men or women, but, as in the case of the rural aged, there are differences by sex. The proportions suffering from cough, piles, heart disease, urinary problems and diabetes are higher, by varying percentages, among men than among women; but the proportions suffering from problems of the joints and abnormal blood pressure are higher among women than men. The lower levels of joint and blood pressure problems reported by males may be partly due to *macho* unwillingness to admit failing physical condition, but in a micro study of the health status of the aged in a rural setting in Karnataka (Reddy 1995), it was observed that both males and females tended to overstate their chronic diseases in the hope that the investigators would arrange some treatment or financial help from the government. In fact, many of them urged the investigators to help them in getting financial assistance from government. Differences in social and

economic factors may be responsible for differences in the proportions of men and women suffering from different types of chronic disease.

Table 6
Percentage distribution of the urban aged with chronic disease by type of chronic disease, age and sex

Sex	Age (years)	Type of chronic disease							
		Cough	Piles	Problems of joints	Blood pressure	Heart disease	Urinary problems	Diabetes	
Males	60-64	24.7	4.3	34.6	18.8	7.1	4.2	6.3	100
	65-69	26.6	4.7	35.8	15.7	7.5	3.6	6.2	100
	70+	26.5	3.9	35.0	16.0	6.2	6.9	5.5	100
	All ages	26.0	4.3	35.1	16.8	6.9	5.1	5.9	100
Females	60-64	23.3	2.6	44.1	18.2	5.4	1.7	4.7	100
	65-69	20.8	2.5	43.0	20.5	6.0	2.4	4.8	100
	70+	22.7	2.6	45.0	17.5	5.5	2.9	3.8	100
	All ages	22.4	2.6	44.2	18.5	5.6	2.4	4.3	100
Persons	60-64	24.2	3.7	38.4	18.5	6.4	3.2	5.7	100
	65-69	24.3	3.8	38.7	17.7	6.9	3.1	5.6	100
	70+	25.0	3.4	39.2	16.6	5.9	5.2	4.8	100
	All ages	24.5	3.6	38.8	17.5	6.3	4.0	5.3	100

Source: NSSO 1991:S-194

A comparison of Table 5 with Table 6 is instructive. Of the aged with chronic disease, the proportion suffering from cough is over 34 per cent in rural areas and about 25 per cent in urban areas. This is true of all age groups and both sexes. This is perhaps because more people in rural areas are engaged in agricultural work and are thus exposed to dust which causes cough. Another reason may be that a greater proportion of country people than city people use tobacco. In both rural and urban areas, as expected, the proportions suffering from cough are higher among men than among women.

The proportions suffering from piles are about the same in rural and urban areas, and in different age groups, but higher among men than women.

The proportion suffering from problems of the joints is higher in rural than in urban areas. This is true of different age groups, and also of males and females. In both rural and urban areas, more women than men suffer from problems of the joints.

As can be seen from Table 5 and Table 6, the proportions of the Aged with chronic diseases who suffer from blood pressure, heart disease and diabetes are much higher in urban than in rural areas, perhaps because of differences in dietary practices and lifestyles. Perhaps, also, a greater proportion of the urban aged are likely to be diagnosed as suffering from these chronic diseases.

The chronic diseases affect both the aged and the extended family. Chronic diseases cause suffering for old people, and inconvenience and financial loss for the extended family, one of whose members must take the old person for treatment in a government or private hospital, usually far away, and must persist with treatment if the patient is not cured of the chronic disease. This may result in loss of wages for the relative who takes the patient to hospital. If the treatment is in a private hospital, the extended family has to pay the doctor's fee and purchase medicines; even when the treatment is in a government hospital, the extended family is often required to purchase medicines. Additionally, the family may have to spend money on transport to and from hospital. But the community and the state are not really affected by the chronic diseases of the aged. The community may not do anything more than show sympathy; the state expects people to avail themselves of the free services provided in

government hospitals; drugs and medicines are also provided, if available. The extended family has to take care not only of the chronic disease and disability of the aged, but also of their other necessities like food, clothing, shelter and hygiene; it may in return acquire the old person's house, other property or money, if any.

Disease prevalence rate

Table 7 presents data on the disease prevalence rate, expressed as the number of the aged suffering from each disease per 1,000 old persons, during the two weeks before the survey. This rate is quite high, 427 among men and 357 among women in rural areas; in urban areas, 423 among men and 366 among women. In both rural and urban areas, the disease prevalence rate is higher among men than among women, doubtless reflecting differences in behaviour patterns. The rate is about the same for rural men as for urban men, and for rural as for urban women. It is somewhat surprising that the disease prevalence rate is lower in the age group 65-69 years than in the age group 60-64 years, for men and women in both rural and urban areas. But, not surprisingly, the rate is highest in the age group 70+ years, for both sexes in both rural and urban areas.

Table 7
Disease prevalence rate (per 1,000) and proportion (per 1,000) hospitalized among the aged by age, sex and place of residence

Sex	Age (Years)	Rural		Urban	
		Prevalence rate	Proportion hospitalized	Prevalence rate	Proportion hospitalized
Males	60-64	464	100	443	97
	65-69	324	103	342	102
	70+	494	102	485	100
	All ages	427	101	423	99
Females	60-64	395	90	379	91
	65-69	278	92	298	95
	70+	399	97	421	94
	All ages	357	93	366	93
Persons	60-64	436	96	416	95
	65-69	306	98	324	99
	70+	456	101	458	98
	All ages	400	98	400	97

Source: NSSO 1991:S-194

Proportions hospitalized

Table 7 also presents data on the proportions in hospital, expressed as the number of the aged admitted to a hospital per 1,000 on any day during the two weeks before the survey. There are no differences by age in the proportions hospitalized,but there are differences by sex; the proportions hospitalized are 101 among males and 93 among females in rural areas. The corresponding figures for urban areas are 99 and 93. Thus, the proportions admitted to hospital are slightly lower among women than among men. This should not be surprising because it is known that females in India are accorded a lower status than males.

Discussion

The Constitution Of India recognizes the duty of the State towards the aged. Article 41 of the Constitution enjoins the State to make effective provision within the limits of its economic capacity and development for public assistance in case of unemployment, old age, sickness,

disablement and in other cases of undeserved want. Social security, social insurance, employment and unemployment are mentioned in the Concurrent List of the Seventh Schedule of the Constitution of India. Thus, the Constitution specially vests the responsibility for social security, social insurance, and public assistance in cases of unemployment, disablement, old age, etc. with state and central governments. As a result of these commitments, many state governments have been providing old age pensions, maintaining homes for the destitute aged and providing grants to voluntary organizations maintaining such homes.

The Government of Karnataka, for example, provides a pension of Rs.75 per month to about 500,000 or about 15 per cent of people 65 and over in the state; it maintains four homes for the destitute aged, and provides grants to 43 old-age homes maintained by voluntary organizations. On an average, each old-age home has about 100 residents. But, Constitutional obligation notwithstanding, there is no specific program of the Government of India which provides services for the aged.

The analysis in this paper shows that the aged in India need special health services, but, until recently, the Government of India justified its reluctance to provide special health services for them by saying:

> It is necessary to dispel the belief that old age is synonymous with ill health or disability. Thanks to modern science and technology, most people are able to lead an active and healthy life up to the age of 70 years or more (Ministry of Social Welfare, 1987:20).

The claim is disproved beyond doubt by the findings of the 42nd Round of the National Sample Survey conducted by the NSSO and analysed here. The aged were expected to use whatever health services were offered by the existing health system; however, the Government of India was aware of its inability to provide special health services for the aged.

> Health care of the elderly would best be met through the normal health infrastructure which is being progressively strengthened, particularly to reach the underprivileged sections of society. Exclusive public health services for the elderly may be difficult at the present stage of development (Ministry of Social Welfare 1987:20).

However, the Government of India has recently started a scheme of assistance to voluntary organizations which organize programs relating to the aged. The objective of the scheme is to provide physical, social, psychological and economic support for those aged 60+ years with a view to helping them to continue to be usefully active members of the community (Ministry of Social Welfare 1994:2). The programs include foster care-adoption services, mobile medical services, day care, old-age homes, and non-institutional services. The conditions stipulated for voluntary organizations to qualify for grants from the Government of India are stringent, and the number of such organizations receiving grants, except for old-age homes, appears to be very small. The program of mobile medical services for the aged deserves a detailed explanation.

Under this program, voluntary organizations are to provide services for medical consultations and treatment of old people. Since it is difficult for families to take the aged to distant hospitals, the need for assistance for geriatric disabilities is more acute among the poor. Grants will be provided to voluntary organizations which possess experience and expertise in providing mobile medical services for the aged in rural and urban slums.

The meagre financial outlay approved by the Ministry of Social Welfare for the setting up and maintenance of a mobile 'medicare' unit for the elderly is as follows: honorarium to a doctor at the rate of Rs.150 (about US $4.70) per camp up to a maximum of eight camps in a month, to examine in each camp, 15-20 old persons; monthly salaries of Rs.900 to a combined

health worker-social worker-nurse, Rs.600 to a part-time registered pharmacist, Rs.900 to the organizer, and Rs.600 to a helper; an amount of Rs.15 for medicines, including charges for pathological tests, per old person per month; Rs.500 per month for van fuel and maintenance; and contingency payments of Rs.500 per month.

For each mobile 'medicare' unit, the contribution of the Ministry of Social Welfare will be 90 per cent of the total approved cost and the voluntary organization will have to meet the remaining 10 per cent. If a unit is working in a tribal or a hilly area, the Ministry's contribution will be 95 per cent. It is hard to obtain information on the number of such units operating, but it is safe to conclude that their number is far short of requirements.

In his budget speech in Parliament on 15 March 1995, the Finance Minister of India announced a National Social Assistance Scheme (NSAS) comprising a number of programs for the weaker sections of society. One of them envisages softening the hardships of old age by providing a national minimum old age pension of Rs.75 per month to people above 65 years of age who are below the poverty line. Many state governments are already implementing the programs, including the pension program, so the NSAS can 'ride piggyback' on them. Moreover, the minimum age of 65 years announced by the Finance Minister to qualify for the pension is at variance with the minimum age of 60 years stipulated by the Ministry of Social Welfare. There is a need to reduce the qualifying age for old age pensions to 60 years and to increase the pension substantially to, say, Rs.300 per month.

The policies are likely to be implemented on a continuing basis, but a few issues need to be resolved and the financial burden shared by the state and federal governments. Both state and federal governments should agree on a minimum age of 60 years for old age pensions and free health care. While state governments adopt destitution as the criterion for the old age pension, the federal government adopts poverty as the criterion for free health care. Both should adopt one criterion for the aged, preferably poverty, for pensions and free health care. Health is generally a state responsibility, but certain components of health care are financed jointly by the state and federal governments. In the case of the aged, state governments may continue to provide pensions, while the federal government may support free health care under the program of mobile medical services.

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