

ISSUES IN GERIATRIC CARE IN INDIA

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Abstract

As the second most populous country in the world (next only to China), population of India is 1.21 billion (2011). In the age group of 60 years and above, the population has increased by about 55% in the last 15 years. Contrary to this, the working population (15-59 years) has grown by 42.34% in the last 15 years. The old age dependency ratio, which measures the number of elderly people as a portion of those of working age, stands at 0.132 (01 March 2012), which is expected to be over 0.20 (by 2050). With the increase in life expectancy and decline in death rate, there is an increased demand for care-givers to provide care to the elderly. According to prediction by demographers, globally, in about another 25 years, the population aged 65 years and above will be double the population under age of 5 years. So, we would need more geriatricians than pediatricians in the next few years. In the Indian context, the situation is acquiring a critical status, as the healthcare system is still not geared for geriatric care as a separate specialization. Eventually, the number of geriatricians in public and private sector is minimal and grossly inadequate to ensure a reasonable level of healthcare to the ageing nation. This article is an attempt to enlist and analyse the salient features of Geriatric care system in the Indian context, the problem associated with it and probable solutions to these issues.

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Geriatric care in India

The total fertility rate in India declined to 2.6 (2011) from 3.5 (1994). The life expectancy at birth in India as per the 2011 census is 65 years of age. In 1991, it was 58.6 years for males and 59 years for females. There was a major demographic change because of declining fertility rates and increasing life expectancy. With both the under 15 and the 60+ population increasing more rapidly than the 15-60 population, the population pyramid has assumed a 'pear shape'. The adverse effect of such a transition is on the working population of the country.

A paper published for the WHO titled 'Ageing in India', states that "The UN defines a country as 'ageing' where the proportion of people over 60 reaches 7 per cent. By 2000 India will have exceeded that proportion (7.7%) and is expected to reach 12.6% in 2025." By that definition alone, India qualifies as an 'Ageing' country. An aging population puts an increased burden on the resources of a country. With more mouths to feed and less hands to earn, the productivity of a country goes down. "Nearly 60-75% of all elderly are economically dependent on others, usually their children. Even those with pensions find their economic status lowered after retirement". With such a large old aged dependent population, India faces a unique problem.

Near about 830 million people currently live in rural areas against 31.99% in urban areas (census 2011). Although the percentage population staying in rural areas has gone down from 2001 (72.19%) to 2011 (68.84%), the significant majority still resides in rural India. The prominent majority of them are elders. This rural-urban disparity is a significant socio-demographic factor. This factor becomes more important in the scenario where majority of geriatric care is offered in tertiary hospitals in urban India, and the rural elders face a sort of negligence. Not only hospital care, but elder nursing homes, recreation facilities and old age centres are mostly present in urban areas. With this sort of disparity in the rural-urban population and health care delivery system in India, geriatrics and elderly care continues being a challenging task.

Gerontology in India is still in an early stage. Gerontology incorporates an arrangement of conditions particularly connected with age maturity. The rate of such conditions, for example, falls, subjective weakness, vision disability, listening to debilitation, wooziness and fragility is expanding. The normal Indian specialist does not get presented to the obliged instruction to

oversee such conditions. Except a modest bunch of foundations, gerontology and geriatric fellowships are barely advertised. Geriatric medication is not empowered as a practice. As a consequence of this, aside from a couple of private healing facilities, geriatric patients are taken care of in the inward solution branch of most government possessed open clinics. Interns, without being exceptionally qualified to survey and treat geriatric conditions go to such patients. Thus, the normal geriatric restorative condition goes under/untreated and the aggregate weight in the number of inhabitants in such conditions is constantly disparaged. With expanding life compasses, elderly folks in India are usually confronting conditions which were viewed as uncommon two eras back.

Just sporadic information has been gathered on different wellbeing conditions on the elderly in India. The most well-known geriatric condition connected with maturity in India is disability related to listening and vision disability. In any case, the profundity and scope of information with respect to predominance of such issue in the shifted Indian populace are a long way from acceptable. Also, information on other normal conditions, for example, Dementia and Alzheimer's ailment are rare. There is an impending need to set up a database of such conditions to start intercession techniques and to alter needs for arranging health awareness administrations in regard to the elderly.

Healthcare programmes in the country in the last few decades have focused intensively on obvious issues, as family planning (and population stabilization), reproductive and child health (RCH) or maternal and child health (MCH), and disease control. But, equally important sector, i.e. Geriatric care has skipped the attention of policy makers. There is an urgent need to highlight this sector alongside different policies, as the elder population has shown continuous increase in effect of clinical, social, economic and behavioral problems.

Apart from geriatric conditions seen specifically in these populations, the average elder in India suffers from dual set of conditions: communicable/ infectious and non-communicable conditions. Physiological changes with age as well as a decrease in immunity lead to an increase in communicable diseases. A large number of infectious cases seen in the public hospitals in India are in the geriatric age group. Risk for cardiovascular disease is also known to increase with age.

Diabetes, hypertension and heart disease are fairly common conditions seen in India. With increasing life spans, more and more elders find themselves to be suffering from these chronic debilitating disorders. An aging Indian population ailing from chronic illness puts an incredible amount of burden on the already stretched health care system. In 2005, India lost an estimated 9 billion dollars to heart disease, stroke and diabetes. It is also expected to lose between 23 billion dollars to 53 billion dollars annually, in foregone national income over 10 years between 2005 and 2015 due to deaths from these conditions.

Elderly are also prone to mental disorders, primarily, as senile changes are more prominent. It may lead to conditions like dementia, delirium or may take more severe form as Alzheimer's. Rapid urbanization and migration to urban areas has led to increased preference for nuclear families. Somehow this trend also leads to psychological issues in elderly population, arising because of a sense of social insecurity, economic dependence and vulnerability. As the life expectancy and average life span for Indian women is more than males, it also leads to a different set of social issues, as widows are socially stigmatized and economically dependent on their care-givers. There are incidents of elder abuse and domestic violence reported frequently, which highlight the plight of elderly females, more specifically in rural and semi-urban arena. The condition is aggravated by lack of access and availability of adequate healthcare facilities and social security. Most of the social security incentives are available for those elderly who have worked in public or organized sectors, and a huge proportion of employees in unorganized sector, are devoid of retirement benefits/social security in later years of life.

Government Initiatives:

Governments at various level have initiated their share of efforts to take care of these issues. Few of these steps are:

NPOP:*The National Policy on Older Persons established in 1999 visualizes Government support to elderly to ensure financial and food security, health care, shelter, equitable share in development, protection against abuse and exploitation, and availability of services to improve the quality of their lives. It also covers issues like social security, intergenerational bonding, family as the primary caretaker, role of Non-Governmental Organizations, training of*

manpower, research and training. (Ministry of Social Justice & Empowerment, Government of India)

NSAP: Objectives: *The National Social Assistance Programme (NSAP) which came into effect from 15th August, 1995 represents a significant step towards the fulfillment of the Directive Principles in Article 41 of the Constitution. The programme introduced a National Policy for Social Assistance for the poor and aims at ensuring minimum national standard for social assistance in addition to the benefits that states are currently providing or might provide in future. NSAP at present, comprises of Indira Gandhi National Old Age Pension Scheme (IGNOAPS), Indira Gandhi National Widow Pension Scheme (IGNWPS), Indira Gandhi National Disability Pension Scheme (IGNDPS), National Family Benefit Scheme (NFBS) and Annapurna. (<http://nsap.nic.in/>)*

NOAPS: *Indira Gandhi National Old Age Pension Scheme (IGNOAPS) or National Old Age Pension Scheme (NOAPS) is a social sector scheme and forms part of the National Social Assistance Programme (NSAP) which came into effect from 15th August, 1995. This scheme provides social assistance for the old age persons. (Government of India)*

But there have been accusations of irregular payment, long procedures, beneficiary identification problem and insufficient allocation of budget in these schemes and implementation is also not uniform. All these leads to loss of reputation and trust for Government sponsored programmes.

Improving quality of life of older adults

Indian public healthcare delivery system needs to devise strategies, keeping in consideration, the following:

- Training of medical and para-medical professionals in geriatrics. This should be the primary goal, as most of the geriatric care centres are available in tertiary care hospitals. So, having trained care providers at primary and secondary level may be more accessible to the population.
- Training of health workers and volunteers in geriatric care to enable them to identify the cases to be referred to healthcare institute.

- Availability of adequate transport facility at primary or secondary level of healthcare centres to refer the elderly patient to a higher centre as and when needed. It will also reduce their dependency on someone to avail healthcare.
- Government and non-government organizations should be encouraged to organize frequent screening camps for common ailments like cataract, dental problems and awareness camps for lifestyle conditions like cardiovascular disease, diabetes, can be significant.
- Provision for rehabilitation of elderly, which includes counselling, physiotherapy, psychological rehabilitation and most significantly, employment opportunities, as financial dependency is also one main reason for exploitation of elders.
- Promotion of professional trainings in Geriatrics, specifically at tertiary level. This would include medicos from different specialties, who are also formally trained in geriatrics and gerontology. The trainings should also include focus on sensitization to the psychological issues of elderly. It should also address the incidents of 'ageism' in healthcare.
- Research in this field needs more attention and encouragement. Indian Council of Medical Research is also keen to get research done in the area of eldercare.

Significance of Accreditation/standards in promoting geriatric care:

The Joint Commission (the agency regulating JCI Hospital accreditation standards at the United States) and Quality Council of India (the Indian agency regulating NABH Hospital accreditation standards) in their respective standards, have given special consideration to the patients with special needs, which also includes elderly patients. It includes restructuring infrastructure and procedures in such a way, so as to minimize discomfort to all type of patients. But the main cause of concern is that, these standards are not mandatory for all healthcare organizations, so, only the hospitals applying for these accreditation standards can be regulated under these parameters.

From the available literature, it can be visualized that geriatrics or elderly care is an area, preferable neglected in most healthcare settings. Though, it is significantly mentioned in the healthcare policies, but implementation phase witness great deal of ignorance or neglect.

Conclusion:

This is a period of paradigm shift in terms of demographic changes and modified lifestyle, which has led to an ambiguous situation. Now the older adults find it very difficult to keep pace with the changing times. This, coupled with perceived indifferent attitude of medical professionals towards the healthcare issues of elderly, has made the matter worse. The focus of this article has remained on the healthcare issues of elderly in India and few recommendations to improve the situation. But, to achieve the goal of Quality of life to all citizens, especially for those in the later stage of life, a combined effort is the need of the hour.

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