



AGEING IN INDIA:

Exploring Preparedness & Response to
Care Challenges



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EXECUTIVE SUMMARY

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India is experiencing a significant demographic shift with a rapidly growing elderly population. By 2050, it is projected that the elderly population (aged 60 and above) will constitute 20.8% of the total population, up from 8.6% in 2011. This silent but significant demographic change will present unexpected challenges and opportunities. How successful we are in dealing effectively with the challenges and to take opportunities to charter a new course will depend to a large extent on preparedness. The first step to preparedness is the ability to identify the challenges and understand them with their myriad implications. Ageing is not new, but population ageing is; therefore, we have to unpack the concept of ageing and think beyond. Thanks to our concerted efforts we have successfully controlled fertility and mortality. However, we have been a bit sluggish in understanding and responding to the implications of these achievements. Population ageing today is a lived reality for all, the 10% elderly and 90% below 60 years, majority of whom are caregivers and sooner or later will become aged themselves.

The 10% population of elderly are not a homogenous group. There are gender, class, caste, region, area and other nuances that impact their life experience. Family has been glorified as the primary caregiver to any dependent member; furthermore, women have been glorified as the best caregivers. Population ageing changes this equation completely. With fertility and mortality being controlled, every family has lesser younger members to take care of older persons whose average life expectancy is increasing rapidly. These older persons do not have the opportunities for continued presence in the labour market, access to preventive and curative healthcare, social care, and inclusion in technology space. Here, it is important to add socio-economic dimensions such as education, skills, and jobs, decide the experience in old age. Gender and advanced age add to it.

Besides family, traditionally; government plays a welfarist role and provides social security, healthcare, and if required, residential care for older persons. The provisions of the Maintenance and Welfare of Parents and Senior Citizens Act, 2007 solidify the belief that in age care, the family and government have predominant roles. The family has a universal obligation, while the government has limited responsibility. It has to cover, to the extent possible, those below poverty line. There are various schemes that cater to destitute older persons in the country.

So, the major challenge here is for those older persons and families who are not 'below poverty line' and not wealthy enough to afford services available in the market i. e. the 'missing middle'. They are on their own.

NITI Aayog's position paper '[Senior Care Reforms in India: Reimagining the Senior Care Paradigm](#)', released earlier this year, drew attention to the urgent need to understand and act on the needs of this burgeoning segment of the population. So, HelpAge India decided to

delve deeper into the aspects of care and inclusion of older persons beginning with the segment of older persons that was not the focus of service delivery.

HelpAge India therefore commissioned a nationwide study to assess the care needs of older individuals, covering aspects like healthcare access, social care, elder abuse, financial capacity, and digital technology access. The study involved a cross-sectional survey across ten states and twenty cities, including both Tier I and Tier II cities, ensuring a representative sample of more than 5000 elderly individuals and 1300 caregivers. Households belonging to the Socio-Economic Classification – SEC “B” and SEC “C” were selected for the survey.

Key Findings

1. Only around 15% of elderly persons reported currently working, with 24% elderly male and only 7% elderly female reporting work participation. The work participation for elderly varied marginally with their place of residence, Tier I cities (17%) and Tier II cities (14%). Work participation didn't vary at all across socio-economic categories. Work participation dropped significantly with the literacy rate and majority of these elderly were working in informal and unorganised sectors.
2. A small proportion of the elderly (29%) reported having access to social security schemes i.e. old-age pension / contributory pension / provident fund. Access to pension didn't vary much across Tier I and Tier II cities. However, 35% elderly from SEC B categories reported having pension in comparison to 20% elderly from SEC C.
3. One in every three elderly respondents reported they didn't have any income in the past one year. Around 31% elderly respondents in the age group of 60-69 years, 36% in the age group of 71-79 years and 37% in the age group of 80 years and above reported 'No income' in the past one year. The proportion of respondents reporting no income didn't vary across the Tier I and Tier II cities. However, there was significant variation among SEC categories and 38% respondents from SEC C categories reported this in comparison to 29% of the respondents from SEC B.
4. Close to two third (65%) of respondents reported that they are financially not secure with their current income and access to savings and investment. Only around 29% of elderly persons reported that they receive financial support from their family members. Only one in every four elderly male respondents and one in every three elderly female respondents receive financial support from their family members.
5. Little less than half of all respondents (48%) were diagnosed with hypertension or high blood pressure and a similar proportion of respondents (43%) also suffered from diabetes. More than one third of all respondents (35%) were suffering from arthritis / osteoporosis or other bone / joint diseases and a few respondents (19%) have also reported issues of high cholesterol. No variation in prevalence of chronic diseases was reported across the place of residence (Tier I and Tier II cities) and socio-economic categories.
6. The study also reported high prevalence of multiple morbidities, as 54% of all elderly persons were suffering from two or more Non-Communicable Diseases (NCDs). 26%

of all elderly were diagnosed with only one NCD and 20% of these respondents were not diagnosed with any NCD. Majority of the respondents in the age group of 80 years and above were suffering from two or more than two NCDs.

7. Most of the elderly persons (79%) have visited government hospitals / clinics / PHCs in last one year and half of the elderly respondents have visited private hospitals/ clinics. Access to healthcare facilities didn't vary much with the gender of the respondents.
8. Awareness of Geriatric Healthcare facilities was low at just 15%. Among the aware elderly only about half (54%) had visited these facilities – mainly for preventive checkups (57%) and free medicines (62%).
9. Average medical expenses (including doctor's fees, medicines, tests and travel costs) for the last outpatient visit to a healthcare facility for an elderly person was reported as Rs. 1973. Average expenditure was Rs. 2027 for male and Rs. 1913 for female respondents. Average expenditure in Tier I cities was Rs. 2110 and in Tier II cities it was Rs. 1849. Respondents from SEC B reported much higher expenses (Rs. 2246) in comparison to respondents from SEC C (Rs. 1528).
10. Only 31% elderly persons reported access to health insurance. 33% elderly male and 29% elderly female were covered. Access to health insurance varied with socio-economic categories, 35% elderly persons from SEC B covered under health insurance and only 25% of elderly persons for SEC C reported the same.
11. More than half of elderly persons (52%) reported facing at least one challenge related to activities of daily living (ADL / IADL). 54% elderly female reported facing at least one difficulty related to ADL, which is marginally higher than the male respondents. Majority of the respondents in the age group of 70–79 years (63%) and 80 years and above (71%) reported facing difficulties related to ADL. As expected, a higher percentage of those requiring assistance for daily activities were suffering from chronic diseases such as Hypertension, Diabetes, Arthritis and Neurological problems.
12. In accordance with Indian culture, majority of the respondents who have faced challenges related to ADL also received support / assistance from their family members. 83% of all elderly persons who have faced difficulties related to ADL, reported receiving support and the family members e.g. spouse and children were the primary caregivers. Elderly across both Tier I and Tier II cities and SEC categories reported similarly with a majority of them receiving support from their family members.
13. Around 29% of the caregivers reported physical challenges in providing care to the elderly person - 36% female caregivers and 24% of male caregivers reported this. 32% of all caregivers also reported facing financial challenges in providing care to the elderly persons.
14. Very few elderly respondents (7%) reported membership of any social organization, 8% male respondents and 5% female respondents reported the same. Membership varied with the place of residence and socio-economic categories.

15. Elder Abuse - 7% elderly respondents faced this issue, and 5% respondents declined to respond to this question. No variation in reported pattern of elder abuse was found across gender and age group of the respondents. However, respondents from SEC C (11%) reported experiencing higher elder abuse in comparison to respondents from SEC B (4%).
16. Awareness of Maintenance and Welfare of Parents and Senior Citizen Act, 2007, was quite low at 9%. 11% elderly male and 6% elderly female were aware about this Act. Awareness of the Act was further down at 6% for elderly in the age group of 80 years and above and 5% for elderly in SEC C categories.
17. 39% had access to a smartphone, among digital devices, while 59% had access to no digital device. Smartphone access was higher for males (47%) and the youngest age group of 60-69 years (43%). Just around 12% used digital medium for paying utility bills or for internet banking and 8% used it for any health-related uses.

Addressing the challenges of ageing in India requires a multi-faceted approach that encompasses healthcare, financial security, social support, and protective measures. A collaborative effort involving government, non-governmental organisations, communities, and families is essential to create an environment where the elderly can live with dignity, security, and well-being. As India prepares for an ageing population, it is crucial to adopt innovative solutions and scalable models of care to meet the diverse needs of its elderly citizens.

1. INTRODUCTION

1.1 Background of the Study

The world's population is ageing, with nearly every country experiencing an increase in both the number and proportion of older individuals. With appropriate policies in place, an ageing population can yield significant benefits. The accumulated assets, wisdom, and skills of older individuals can enrich communities and contribute positively to various sectors. Recognising this potential, the United Nations has designated the years 2020-2030 as the Decade of Healthy Ageing, emphasising the need for a holistic societal approach to elder care.

This demographic shift is particularly significant in India, where the population above 60 years is expected to double from 10.5% in 2022 to 20.8% by 2050. The population of 80 years and above will grow at a much faster rate with a predominance of widowed and highly dependent very old women¹.

This rapid ageing process necessitates a comprehensive approach to ensure the well-being of the elderly. Addressing the needs of the elderly population requires greater attention to chronic illness, higher medical expenses, and the vulnerabilities associated with frailty, sickness, isolation abuse and how to enable and empower them. Preparing for this demographic shift and having the right policies and programmes in place is an immediate priority for the government and other relevant stakeholders. By adopting innovative solutions and scalable models of care, India can ensure that its elderly population lives with dignity, security, and well-being.

This rapid ageing process necessitates a comprehensive approach to ensure the well-being of the elderly.

In February 2024, the NITI Aayog has released a position paper titled 'Senior Care Reforms in India: Reimagining the Senior Care Paradigm', which calls for action on what needs to be done to bring a greater focus on senior care. The objective of this paper is to encourage collaboration among individuals, families, communities, civil society and the private sector and pave the way for quality outcomes in senior care.

HelpAge India is a leading charity in India working for disadvantaged elderly for more than four decades. Its mission is "to work for the cause and care of disadvantaged older persons and to improve their quality of life." HelpAge envisions a society where elderly have the right to an active, healthy and dignified life.



¹ <https://india.unfpa.org/en/news/india-ageing-report-2023-unveils-critical-insights-elderly-care-india1>

² <https://www.narendramodi.in/prime-minister-narendra-modi-pioneers-a-robust-eldercare-ecosystem-579460>

Taking inspiration from the NITI Aayog's position paper, HelpAge India commissioned a pan-India study to assess the care needs of older persons.

1.2 Study Objectives

The specific objectives of the study are as follows:

Access to Healthcare:

- Evaluate access to preventive healthcare and awareness about Non-Communicable Diseases (NCDs) such as hypertension and diabetes.
- Assess the availability of geriatric services
- Assess the treatment costs, and contributions by family
- Investigate the reach of teleconsultations services
- Understand the access to health insurance

Access to Social Care:

- Examine the role of family members in addressing the general and special needs of older persons.
- Evaluate the access to paid care facilities in terms of knowledge, appropriateness, and affordability.
- Understand the role of community-based organisation like Senior Citizens' Associations (SCAs) and Resident Welfare Associations (RWAs).
- Explore the extent of participation by older persons in civic processes to articulate demands for an age-friendly society.

Perception around inadequacy in Health and Social Care Services:

- Evaluate feelings of inadequacy in terms of healthcare and social care services,

Experience of Elder Abuse and Awareness around Legal Provision

- Assess the prevalence of elder abuse, experience of the elderly and their responses.
- Awareness about Maintenance and Welfare of Parents and Senior Citizens Act, 2007.

Capacity of the Elderly to Meet Their Needs:

- Assess the financial and physical capacity of older persons to meet their own needs, access to savings instruments, financial literacy.
- Assess the opportunities for re-skilling and employment, willingness to work, seeking employment, and willingness for voluntary services.
- Identify access to government schemes / NGO programmes.

Access to Digital Technology

- Assess the access to digital devices and digital technology.
- Assess the role of family, government, private companies, and non-profit organisations in providing digital devices, and digital literacy training to seniors.

1.3 Technical approach and methodology

Keeping in view the objectives and the information requirements a cross-sectional quantitative household survey was conducted across 10 States and 20 Cities (one Tier I and one Tier II city in each State) in India. States were selected ensuring adequate regional representation.

A total of 5169 elder individuals and 1333 caregivers were surveyed using a structured questionnaire. The caregiver was defined as a family member in the age group of 18–49 years, who provides care including general, social and emotional care to the elderly individual (respondent) most of the time. After the main interview with the elderly was completed, if a caregiver was present meeting the above-mentioned criteria, he/she was also interviewed. Households belonging to the Socio-Economic Classification – SEC “B” and SEC “C” were selected for the survey³.

To ensure adequate representation of both the genders and older age groups, the entire sample was equally distributed among males and females and an effort was made to cover at least a 5% sample size in the age group of 80 years and above and 20-25% in the age group of 70–79 years.

The structured questionnaire was designed after a thorough literature review and face-to-face interviews were conducted by trained enumerators using CAPI (Computer Aided Personal Interviewing) tools and devices. A quality assurance mechanism was followed to ensure data quality with regular spot/ back checks and documentation of non-response, refusals and incomplete interviews.

1.4 Sampling design

A multi-stage stratified Probability Proportional to Size (PPS) sampling design was adopted for the study to ensure separate state level estimates for each state. In total 10 states were selected with established and functioning National Programme for Health Care of the Elderly (NPHCE) and geriatric care health facilities, old age homes, helplines, and above average literacy rates. One Tier I city and One Tier II city were selected in each State and 12–13 municipal wards were selected in each city. A total of 20 households with elderly individuals were selected in each ward following a modified cluster sampling approach.

³ See Appendix for Socio-Economic Classification (SEC) table

1.5 Sample Coverage

The states and cities covered are shown below.

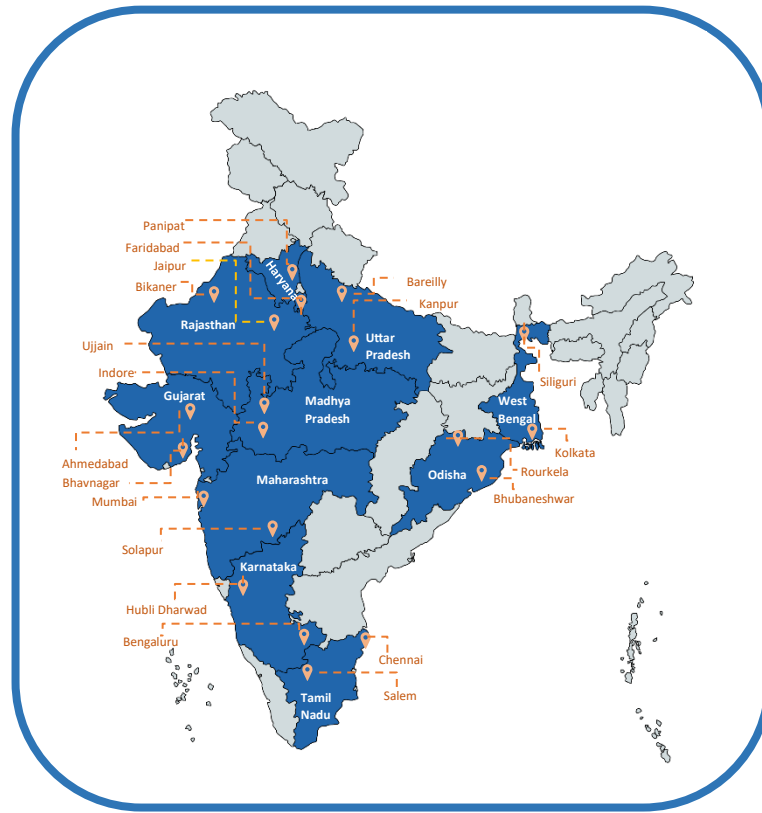


Figure 1: Covered States and Cities

Zones	States	Tier 1 cities	Tier 2 cities
North	Rajasthan	Jaipur	Bikaner
	Haryana	Faridabad	Panipat
Central	Uttar Pradesh	Kanpur	Bareilly
	Madhya Pradesh	Indore	Ujjain
East	West Bengal	Kolkata	Siliguri
	Odisha	Bhubaneswar	Rourkela
West	Gujarat	Ahmedabad	Bhavnagar
	Maharashtra	Greater Mumbai	Solapur
South	Tamil Nadu	Chennai	Salem
	Karnataka	Bengaluru	Hubli-Dharwad

Table 1: Cities covered

The Tier 1 cities were those cities that had a population of 10 lakhs or more according to the 2011 population census, while the Tier 2 cities were those that had a population of 5-10 lakhs.

The age, gender and SEC-wise breakup of the sample is given in the table below.

Profile	Tier I Cities	Tier II Cities	All India %
<i>Male</i>	49.8%	49.8%	49.8%
<i>Female</i>	50.2%	50.1%	50.2%
<i>60-69 years</i>	65.7%	67.2%	66.4%
<i>70-79 years</i>	26.3%	26.8%	26.5%
<i>80 years and above</i>	8.1%	6.1%	7.1%
<i>SEC B</i>	57.8%	59.8%	58.8%
<i>SEC C</i>	42.2%	40.2%	41.2%
Total Elderly covered	2566	2603	5169
Total Care givers covered	684	649	1333

Table 2: Profile of Respondents covered

2. DEMOGRAPHIC & SOCIO-ECONOMIC PROFILE OF THE RESPONDENTS

This chapter presents the demographic and socio-economic profile of the survey respondents.

2.1 Age group

The study reported 66% of all respondents in the age group of 60 to 79 years, 27% of the respondents were found in the age group of 70–79 years and 7% of all respondents belonged to 80 years and above. Coverage of respondents across these three age brackets remained similar across both the socio-economic groups (SEC B and SEC C) and Tier I and Tier II cities. All other states have achieved the targeted threshold of 5% coverage of super senior citizens (80 years and above).

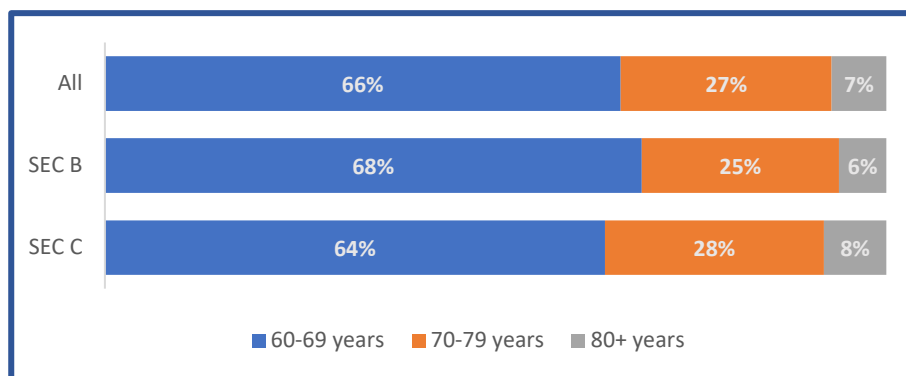


Figure 2: Age group of elders surveyed across SEC

2.2 Education profile

Literacy rate for the elderly persons was reported as 67%, with a gender gap - 78% of male elderly respondents were literate while only 55% of female respondents reported the same. The literacy rate dropped with the age of the respondent, from SEC B to SEC C and from Tier I to Tier II cities. Literacy rate was reported as 70% for Tier I cities and 64% for Tier II cities and for SEC B and C, literacy rates were 73% and 57% respectively.

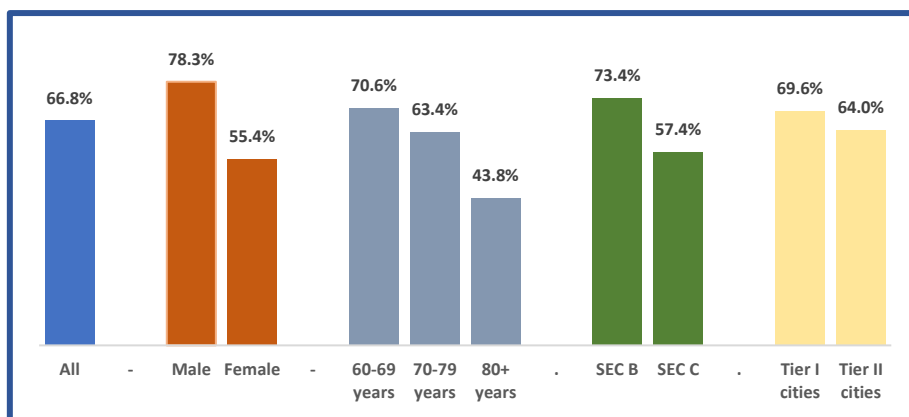


Figure 3: Literacy Rates

Average number of years of education for literate elders, was reported as 7.3 years for all respondents, 7.6 years for male and 6.8 years for female. For the respondents above 80 years of age, average number of years of schooling was 6.8 years. Tier I and Tier II cities reported 7.5 years and 7.0 years of schooling respectively. Average years of schooling improved with economic conditions of the household and SEC B (7.6 years) reported better education profile in comparison to SEC C (6.7 years). Among the study states, Odisha reported highest number of years of education among elderly population (9.1 years) and Madhya Pradesh reported lowest (5.5 years).

Only one in three literate male elderly persons and one in four literate female elderly persons have completed education up to secondary school.

2.3 Marital status

70% of all elderly persons are married while 27% are widowed and the remaining 3% are either divorced / separated or have a live-in relationship or have never married. A higher incidence of widowhood among females (36%) and among those above 80 years of age (57%) supports the key demographic characteristic in India of higher life expectancy among females.

2.4 Status of migration

21% of the elderly population had migrated to the city they were living in now, i.e., it was not their place of birth and they had come there sometime during their adult life. However, this migration was not recent as the average years spent in that city was around 33 years. Migration was found as more common for the respondents from Tier I cities (23%) in comparison to Tier II cities (18%), with Tier II cities migrants having migrated on an average 35 years ago as compared to the Tier I cities migrants (31 years). In Haryana, more than half and in Uttar Pradesh about one-third of the elderly population surveyed had migrated, while in Rajasthan it was below 10%.

Migration was mainly from the rural areas of the same state (50%). Over 80% of the respondents in Madhya Pradesh, Rajasthan, Tamil Nadu and Uttar Pradesh reported migrating

from rural areas of the same state. 19% reported migrating from the rural areas of another state and this was most prevalent in Maharashtra (82%) and to some extent prevalent in Haryana (24%), West Bengal (36%) and in Tier I cities (27%).

Majority of the elderly persons reported the reasons for migration as, getting a job in the city (30%) or due to marriage (40%). A notable portion of the respondents (13%) reported that they have migrated to live with their children, who are working in the city. The elderly who had migrated to the city to live with their working children, were older than the average respondents, with 44% being over 70 years of age. 37% of them had no income of their own as compared to 33% of all respondents. 91% had some chronic disease as compared to 80% of all respondents having such diseases. A lower percentage of them (16%) had access to health insurance and a higher percentage (10%) had reported abuse as compared to all elderly surveyed. This showed that this section of elderly, though small in number, were quite vulnerable economically and emotionally.

Reasons for migration did not vary across the Tier I and Tier II cities and across SEC categories of respondents.

There is a distinct difference in the pattern of migration and the reasons for migration across the gender of the respondents. While only 11% males reported migration, 29% female reported the same. Most of the females (53%) migrated within the state, from a rural area to the city, while about 30% males migrated across states, from a village to a city. The reasons for migration also varied across gender with 62% males migrating for reasons of livelihood and 53% females migrating due to their marriage.

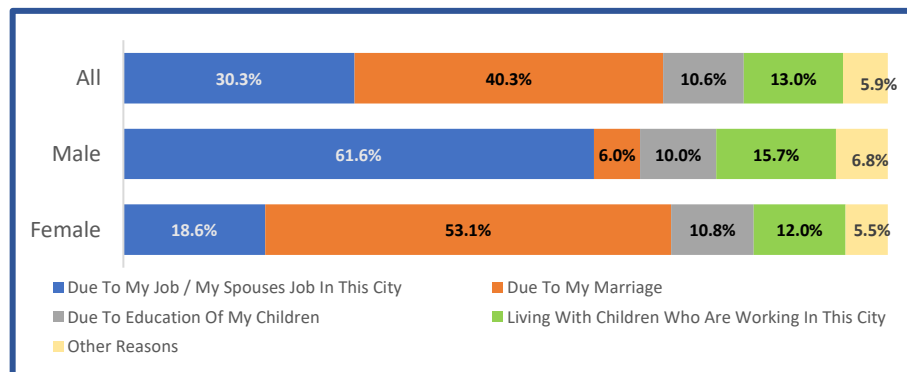


Figure 4: Reasons for Migration

2.5 Current living arrangements

Living arrangements for the elderly has been a matter of concern in the country in recent years as a greater number of elderly persons have started living alone. The study revealed that 5% are currently living alone and 7% are living with only their partner. Most (62%) of the elderly are living with their family consisting of their spouse and children. Around 26% elderly are living with their children without their spouse and this was more prevalent for elderly female (34%) and elderly above 80 years of age group (57%).

Living arrangements for elderly across Tier I and Tier II cities and across SEC B and SEC C respondents were found to be similar. Among the study states Tamil Nadu reported highest number of elderly staying alone (20%) and Madhya Pradesh and Maharashtra reported least with less than 1% elderly persons reporting staying alone in these states.

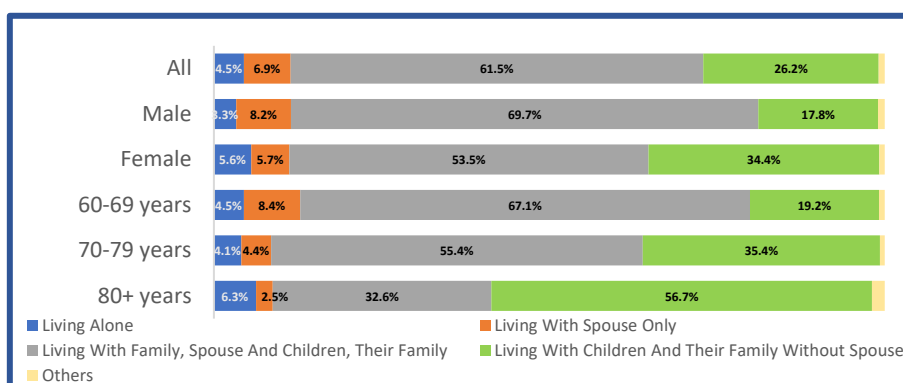


Figure 5: Current Living Arrangements

2.6 Working status

Only around 15% of elderly persons reported currently working. While 24% elderly male reported work participation, only 7% elderly female reported the same. Those who were currently working had a higher literacy rate of 85% (all respondents – 67%), but were working in lower paying jobs as they were mainly (69%) earning less than Rs. 1 lakh per annum from all sources, as compared to all respondents (only 65% were earning less than Rs. 1 lakh per annum from all sources).

Work participation reduced significantly with the age of the respondents and only 7% respondents in the age group of 70-79 years and 1% respondents in the age group of 80 years and above reported as working currently. This suggests that a large proportion of elderly persons are completely dependent on their families or other social security means for taking care of their needs.

The work participation for elderly varied marginally with their place of residence - Tier I cities (17%) and Tier II cities (14%). Work participation didn't vary at all across socio economic categories.

2.7 Willingness to work

The study reported (7%) elderly reported that they are interested in getting a job, consisting of 10% elderly males and only 4% elderly females.

Around **12%** of all respondents reported that they are willing to take up voluntary work.

Half of these respondents who have reported that they were looking for a job also adopted informal ways of job seeking e.g. requesting family members / friends for a suitable job

Around **21%** of these respondents were extremely confident about getting a job in the next six months.

Elderly who were not looking for a job were asked about the reasons and more than half of the elderly respondents felt that they were too old for a job. More than one third of the respondents reported that their family members, especially their children, are not willing to let them work and a similar proportion of respondents also felt that they don't have required skillsets for a job or health issues prevent them in getting engaged in economic activities. More than one third of elderly female reported that they were homemakers and never worked all through their life and hence it is difficult for them to work now.

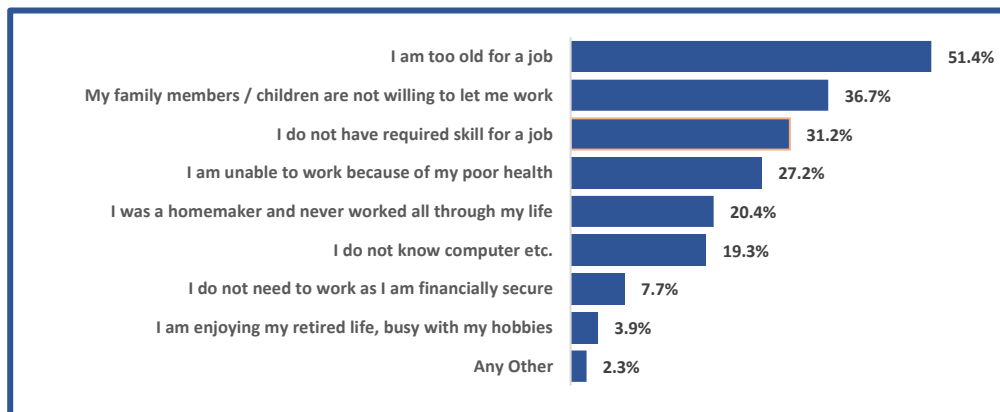


Figure 6: Reasons for not working (all respondents)

The study also enquired about social services/ voluntary work without any payment

Elder employment is a requisite for healthy and active ageing and is promoted by the World Health Organization. There is a need to work on changing the mindset of the community and also design appropriate skilling programmes and platforms to facilitate engagement of elderly in economic activities.

2.8 Income details

2.8.1 Sources of Income

The survey revealed access to different sources of income for the elderly population. One in every three elderly respondents reported they didn't have any income in the past one year – more among females (38%) than males (27%).

Around 31% elderly respondents in the age group of 60–69 years, 36% in the age group of 71–79 years and 37% in the age group of 80 years and above reported 'No income' in the past one year. The proportion of respondents reporting no income, didn't vary across the Tier I and Tier II cities, but there is a significant variation among SEC categories - 38% respondents from SEC C reported this in comparison to 29% of the respondents from SEC B.

Further deep dive into the respondents having no source of income revealed the economic insecurity and vulnerability of a sizable portion of elderly population who were illiterate.

Around **40% elderly who are illiterate also reported not having access to any income sources** in comparison to 29% respondents who are literate.

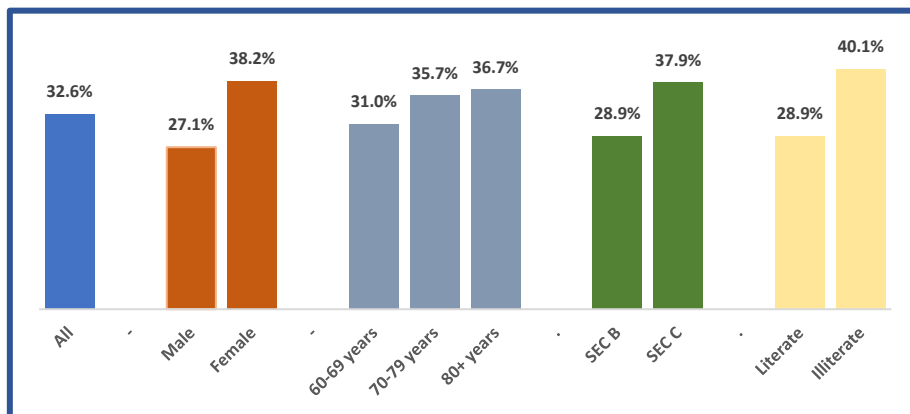


Figure 7: Respondents who had no income in the past one year

Around 29% of the elderly reported having access to social security schemes i.e. old-age pension / contributory pension / provident fund. Almost all these respondents, who reported access to pension, were availing the benefit of different state sponsored pension schemes or NPS (National Pension Scheme) and a small proportion of these respondents also reported access to Employee Provident Fund (EPF) or Public Provident Fund (PPF). Access to pension didn't vary much across Tier I and Tier II cities.

2.8.2 Average Annual Income

It was found that one in three elderly respondents or their spouses have an annual income of less than Rs. 50,000. A similar proportion also reported income in the range of Rs. 50,000–Rs. 1,00,000 in a year and

35% elderly from SEC B categories reported having pension in comparison to **20% elderly from SEC C.**

in the range of Rs. 1,00,000–Rs. 3,00,000. The range of income didn't differ with the age group of the respondents which is in line with low work participation and less dependence on salary and wages. Overall, majority of elderly (65%) reported annual income of less than Rs. 1,00,000 - Tier II cities (69%) and SEC C Categories (69%) have marginally larger proportion of respondents in this income range in comparison to Tier I cities (61%) and SEC B categories (63%).

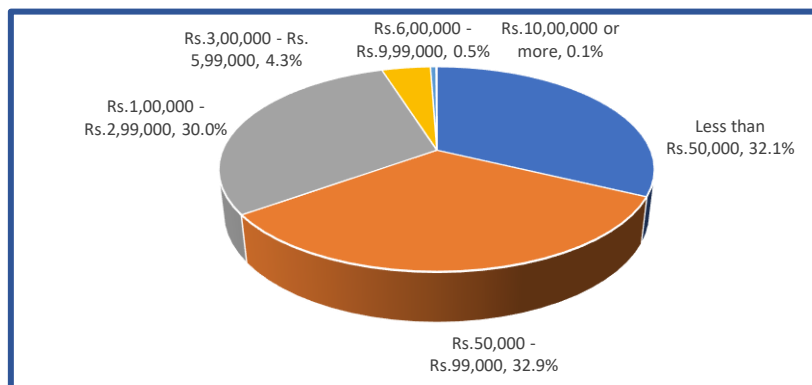


Figure 8: Average Annual Income for all respondents

2.9 Savings and Investment

Majority of the elderly persons (74%) reported having savings accounts in their name or their partner’s name either in the Bank or Post Office. About one-third of them (35%) reported having investments in the form of gold and around 15% of them reported having term deposits.

A notable proportion of elderly respondents (14%) also didn’t have access to any savings / investment.

The pattern of savings and investment didn’t vary much across Tier I and Tier II cities and SEC categories.

2.10 Financial insecurity and support received

Close to two third (65%) of respondents reported that they are financially not secure with their current income and access to savings and investment. Females were significantly more financially insecure as compared to males. Across the study states, almost all elderly persons in Madhya Pradesh (90%) revealed their financial insecurity in comparison to few elderly respondents in Tamil Nadu (38%).

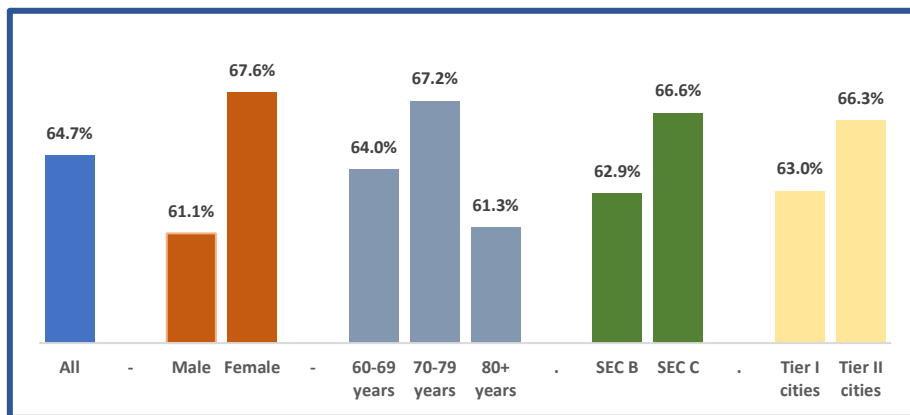


Figure 9: Respondents who reported income insufficient to live on

Only around 29% of elderly person reported that they receive financial support.

Only one in every four elderly male respondents and one in every three elderly female respondents receive financial support.

A marginally higher proportion of elderly respondents received financial support from their family members in Tier I cities as compared to Tier II cities, while there was no significant variation across SEC categories.

Only 36% of the elderly, who have reported that they don't have any income over the past one year, received financial support.

Around 20% of all elderly respondents don't have access to income and don't receive any financial support.

The profile of the respondents reporting no income and no financial support is given below showing that there was a higher proportion of females among them as compared to all respondents interviewed.

Profile parameters	All Respondents	Respondents having no income and no financial support
Male	50%	44%
Female	50%	56%
60-69 years	66%	63%
70-79 years	26%	29%
80+ years	8%	8%
Currently married	70%	72%
Widowed	27%	26%
Others	3%	2%

Table 3: Profile of Respondents having no income and no financial support

Around 59% of those who have received financial support, have received such support regularly.

Others have received this occasionally and based on their requirements.

Further enquiring on the proportion of expenses covered by such financial support, around 45% of those who receive financial support reported that more than half of their living expenses are covered by the financial support received from their family. By and large almost all these respondents (86% of those who have received financial support) reported that their children provided them this support.

2.11 Financial Literacy

Only 23% elderly, who have savings / investment reported that they are extremely confident of handling their savings and investment on their own. Others were somewhat confident or not at all confident. This suggests that there is a need for appropriate financial literacy training for the elderly persons.

Almost all the respondents (85%) with savings and investment reported that either their children or their spouses help them in handling their savings / investment.

2.12 Profile of the Caregivers

The study covered 1333 caregivers, 58% of the caregivers were male and 42% of the caregivers were female. Majority (44%) of the caregivers were in the age group of 30–39 years. Caregivers were almost equally distributed across Tier I and Tier II cities. Almost 70% caregivers belonged to SEC B category households and 30% caregivers were from SEC C category households.

Profiling Parameters		Respondents
Gender of the caregivers	Male	58%
	Female	42%
Age of the caregivers	18-29 years	25%
	30-39 years	44%
	40-49 years	31%
Age group of the elderly respondents	60-69 years	62%
	70-79 years	27%
	80+ years	10%
Types of cities	Tier 1 cities	51%
	Tier 2 cities	49%
SEC Categories	SEC B	70%
	SEC C	30%
Total Number of Caregivers		1333

Table 4: Profile of the Caregivers and the respondents they cared for

2.13 Summary

Low level of education, lack of participation in economic activities, limited access to pension, due to informal nature of work and a sizable proportion of the elderly not having access to any income sources and not receiving any financial support from their family are some of the key challenges faced by elderly person across the study geography. These aspects need policy makers' attention and intervention.

3. ACCESS TO HEALTHCARE AND SOCIAL CARE

Health is a crucial aspect in the lives of the elderly, and understanding the various facets enabling and impacting their health is essential. According to geriatric experts, health and well-being are determined not only by our genes and personal characteristics but also by the physical and social environments. This chapter reflects on the current health status, prevalence of chronic diseases, challenges faced in performing activities of daily living, access to healthcare facilities and health insurance, treatment costs and contributions by family members.

3.1 Perception of general health (Self-reported)

Majority of the elderly persons (68%) have perceived their general health condition as good or very good. 10% felt that they have poor or very poor health. Self-reporting of poor / very poor health was marginally higher for the female respondents (11%) in comparison to male respondents (9%). Perception of general health varied significantly with age of the respondents. For the respondents in the age group of 80 years and above little less than one fourth of the respondents reported poor or very poor health. This highlights that elderly who are living longer, are increasingly facing challenges of poor health.

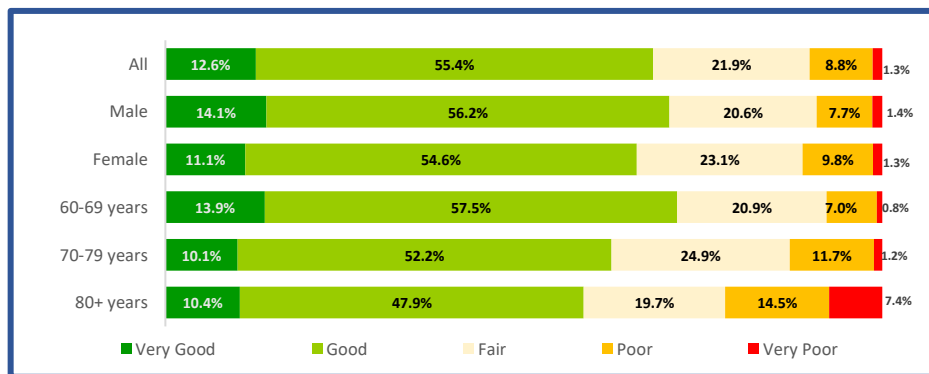


Figure 10: Respondents’ Perception of their general health condition

3.2 Prevalence of chronic disease

Little less than half of all respondents (48%) were diagnosed with hypertension or high blood pressure and a similar proportion of respondents (43%) also suffered from diabetes. More than one-third of all respondents (35%) were suffering from arthritis / osteoporosis or other bone / joint diseases and a few respondents (19%) have also reported issues of high cholesterol. Prevalence of chronic diseases was similar for elderly male and elderly female. However, prevalence increased significantly with the age of the respondents. The study revealed that 62% elderly persons in the age group of 80 years and above were diagnosed with high blood pressure and 54% were

Elderly in the age group of 70-79 years and 80 years and above reported higher incidence of all chronic diseases.

diagnosed with high blood pressure and 54% were

also diagnosed with diabetes. No variation in prevalence of chronic diseases was reported across the place of residence (Tier I and Tier II cities) and socio-economic categories.

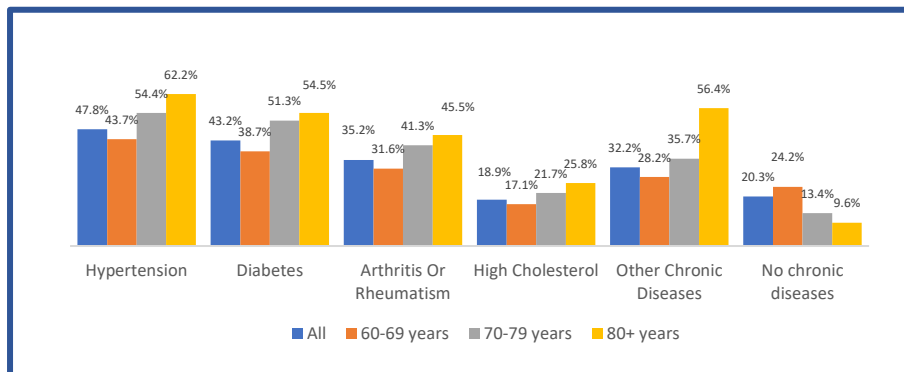


Figure 11: Prevalence of Chronic Diseases

The study also reported high prevalence of multiple morbidities, as 54% of all elderly persons were suffering from two or more Non-Communicable Diseases (NCDs). 26% of all elderly were diagnosed with only one NCD and 20% were not diagnosed with any NCD. Majority of the respondents in the age group of 80 years and above were suffering from two or more than two NCDs.

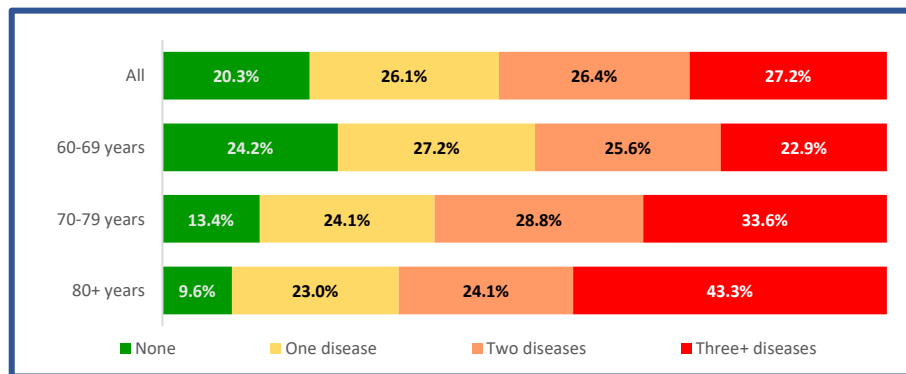


Figure 12: Presence of Multiple Morbidities

3.3 Access to healthcare facilities

Most of the elderly persons (79%) have visited government hospitals / clinics / PHCs in last one year while half of the elderly respondents have visited private hospitals / clinics. Access to healthcare facilities didn't vary much with the gender of the respondents, though a small difference was found across the three age groups. A marginally higher proportion of elderly in the age group of 60 – 69 years have visited a private hospital / clinic, in contrast to most of the elderly in the age group of 80 years and above having visited government hospitals / clinics. Almost half (47%) of these super senior citizens who visited mainly government hospitals / clinics have no personal income and the remaining (43%) have annual incomes of less than Rs. 1 lakh. So monetary constraints did not allow them to visit any private healthcare facilities. Higher proportion of elderly from SEC B have visited private healthcare facilities in comparison to elderly from SEC C.

A notable proportion of respondents (11%) have visited geriatric healthcare centres / clinics for elderly persons.

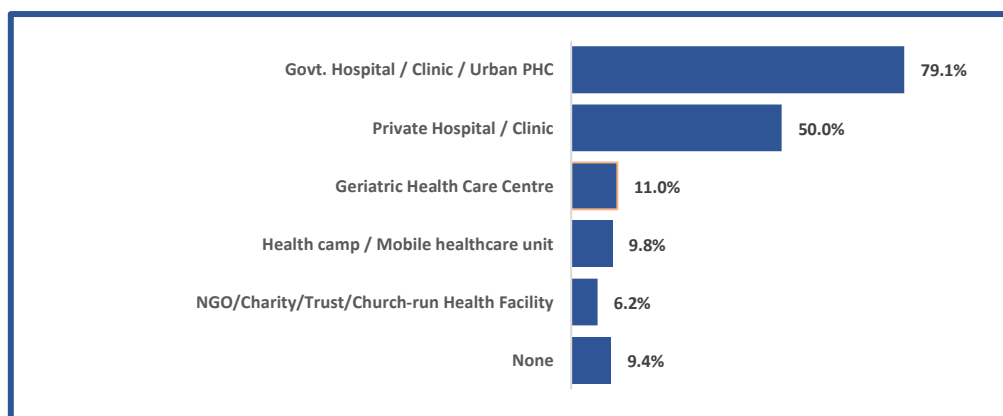


Figure 13: Healthcare facilities availed of in the past one year across all respondents

Over 9% of elderly persons have not visited any healthcare facilities in the past one year. Across the study states, 37% respondents in Odisha reported not visiting health care facilities in the last one year and 24% respondents in West Bengal reported the same. Three primary reasons for not visiting healthcare facilities were as follows:

- The elderly respondents were not sick in the past one year.
- Their illness was not serious enough to warrant a visit to a healthcare facility.

Around 6% of respondents have not visited any facilities despite them being diagnosed with NCDs.

c) They were taking medicines at home.

The elderly who were taking medicines at home and had not visited any healthcare facility in the past one year were mainly suffering from hypertension (39%) and arthritis (36%).

This suggests that there is a lack of awareness about the importance of preventive health check-ups for elderly and an emerging need for community level awareness sessions for improving health-seeking behaviour of elderly persons.

3.4 Medical expenses during last hospital visit

Majority of the respondents reported visits to outpatient departments (OPDs) and expenses included doctor's fees, medicines, tests and travel related expenses. Average expenditure for the last visit to a healthcare facility for an elderly person was reported as Rs. 1,973. Average expenditure was Rs. 2,027 for male and Rs. 1,913 for female respondents. Average expenditure in Tier I cities was Rs. 2,110 and in Tier II cities it was Rs. 1,849. Respondents from SEC B reported much higher expenses (Rs. 2,246) in comparison to respondents from SEC C (Rs. 1,528). Elderly who visited only government hospitals / clinics spent less (Rs. 1,635) during their last visit than those that visited only private hospitals / clinics (Rs. 2,080).

Majority of the elderly respondents (76%) reported that their children have paid their expenses during the last hospital visit.

3.5 Support available for visiting healthcare facilities

One third of respondents, who have visited healthcare facilities in the past one year, reported that no one accompanied them during their last visit to healthcare facilities. The proportion was slightly lower for females and elderly in the age group of 80 years and above as compared to males and 60-79 years respondents.

By and large almost all elderly (90%) who were accompanied during the last visit to healthcare facilities reported that their spouse or children accompanied them.

Marginally higher percentage of elderly from SEC C (34%) were not accompanied during their last visit to healthcare facilities.

Support for the elderly by the family in visiting healthcare facilities, particularly by accompanying them, is a crucial component in enhancing their health-seeking behaviour and ensuring they receive the necessary medical attention.

3.6 Challenges related to Activities/ Instrumental Activities of Daily Living (ADL/ IADL)

Activities of Daily Living (ADLs) are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.

Instrumental Activities of Daily Living (IADLs) are activities related to independent living. They include preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone.

More than half of elderly persons (52%) reported facing at least one challenge related to ADL/ IADL. Most of these respondents reported facing challenges in shopping for groceries (34%) and taking medications (32%). Around 54% elderly female reported facing some difficulty related to ADL/ IADL, which is marginally higher than the male respondents. Most of the respondents in the age group of 70–79 years (63%) and 80 years and above (71%) reported facing difficulties related to ADL/ IADL. In line with the high prevalence of NCDs, Haryana and Karnataka reported more challenges related to ADL/ IADL. Majority of the elderly respondents in Haryana (64%), Karnataka (77%), Madhya Pradesh (59%), Maharashtra (56%), Tamil Nadu (59%) and Uttar Pradesh (69%) reported at least one challenge related to ADL/ IADL.

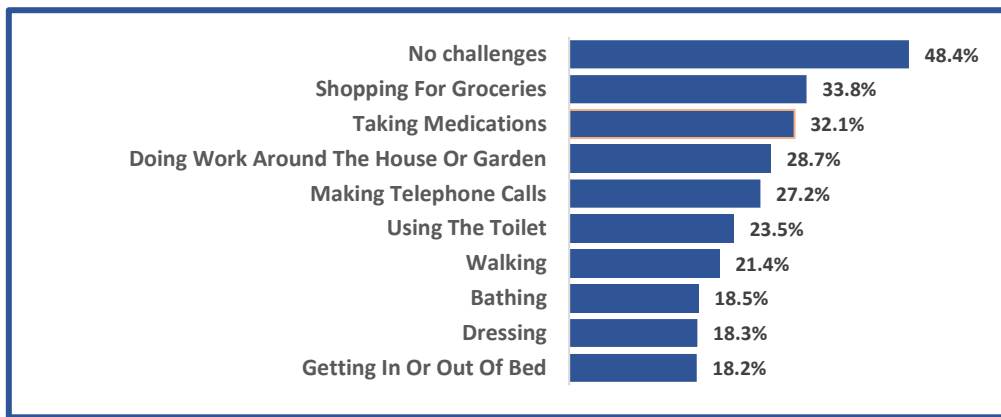


Figure 14: Presence of challenges related to ADL/ IADL among all respondents

As expected, a higher percentage of those challenges related to ADL/ IADL, were suffering from chronic diseases such as Hypertension, Diabetes, Arthritis and Neurological problems.

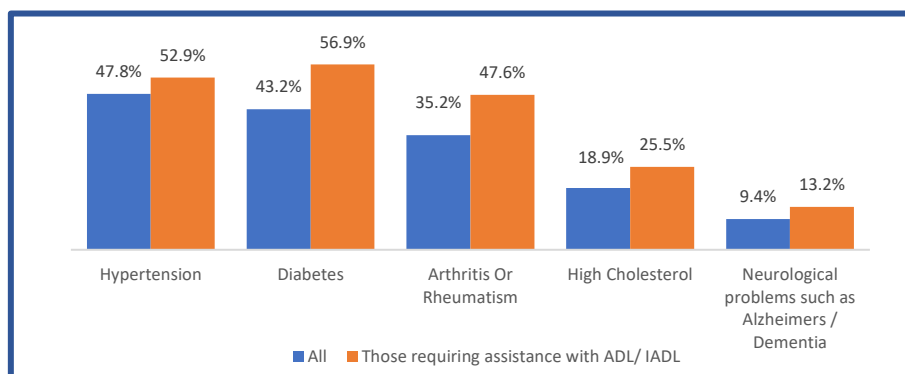


Figure 15: Prevalence of chronic diseases among those requiring assistance with ADL/ IADL

3.7 Support received for challenges related to ADL/ IADL

Majority of the respondents who have faced challenges related to ADL/ IADL, have also received support / assistance from their family members. 83% of all elderly persons who have faced difficulties related to ADL/ IADL, reported receiving support from family members; of whom the spouse and children were the primary caregivers. Elderly across both Tier I and Tier II cities and SEC categories reported similarly, with majority of them receiving support from their family members.

17% of elderly respondents reported not receiving any assistance despite facing challenges related to ADL/ IADL. Majority of these elderly, either didn't have any family member to assist them or their family members were busy with their work and couldn't assist the elderly person. Analysis of the living arrangements and annual income of these respondents revealed that 24% of these respondents were either staying alone or staying with only their spouse (overall only 12% were living alone or with only spouse) and 85% of the respondents reported their annual income as less than Rs. 1 lakh, i.e. less than Rs. 10, 000 per month. So affording a paid domestic help was difficult for most of them.

In India, the family has always been the primary source of social support for the elderly, traditionally. They are expected to provide care when their elderly family members' physical and mental capacities decline with age. However, elderly today find themselves in a difficult situation due to the disintegration of traditional joint family structures. As joint families become less common and urbanization changes living arrangements, the elderly face increased isolation and reduced support networks.

3.8 Type of care received for bedridden patients

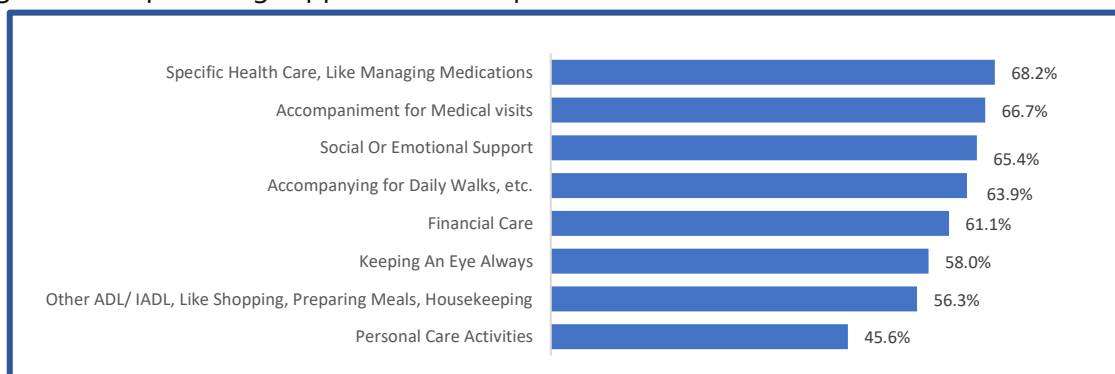
Little less than onethird of all elderly reported that they were bedridden for a month or more because of a health problem in the past one year. Again, the family played the role of primary caregivers when these elderly persons were bedridden and almost all respondents reported that their spouses or children took care of them in this situation. Proportion of bedridden patients in last one year and the practices of receiving support from the family members remained similar across Tier I and Tier II cities and SEC categories.

More than half of the elderly persons in the age group of **80 years and above** reported being bedridden for a month or more in the past year.

3.9 Types of care provided – Caregiver's perception

The study interviewed a total of 1333 caregivers in the age group of 18-49 years, who were the family members for the elderly respondents and were providing care to the elderly most of the time. The responses given by the caregivers regarding the types of care provided were in line with the responses given by the elderly. More than two-thirds of all caregivers reported that they supported the elderly in managing medications (68%) and accompanying the person to healthcare facilities (67%). A similar proportion of caregivers reported providing emotional support (65%), support in outdoor activities (64%) and financial support (61%). Female

caregivers were providing support related to personal care activities and other ADL/ IADL more



than their male counterparts.

Figure 16: Types of care provided to the elderly – the Caregivers’ perception

An increase in the age of the elderly resulted in a considerable increase in the percentage of caregivers providing each type of care. Around 79% caregivers in Tier II reported accompanying the elderly person for medical check-ups, while 55% caregivers in Tier I cities reported the same. Also, the fact that a higher percentage of elderly were staying with their spouse and children in Tier II cities (66%) as compared to Tier I cities (57%) is reflected in the pattern of caregiving. The types of care provided didn’t vary at all with socio-economic categories.

An interesting point to note is that **caregivers in smaller towns (Tier II cities) reported providing more support across all categories in comparison to Tier I cities.**

Type of care	All	Male Caregiver	Female Caregiver	60-69 years	70-79 years	80+ years	Tier I Cities	Tier II Cities
Specific Health Care, Like Managing Medications	68.2%	64.4%	73.4%	63.3%	75.2%	79.1%	63.6%	73.0%
Accompaniment for Medical visits	66.7%	68.1%	64.6%	61.1%	75.8%	76.3%	55.3%	78.7%
Social Or Emotional Support	65.4%	61.0%	71.4%	60.8%	73.6%	71.9%	60.4%	70.7%
Accompanying for Daily Walks, etc.	63.9%	63.0%	65.1%	59.0%	71.1%	74.8%	57.0%	71.2%
Financial Care	61.1%	64.4%	56.5%	56.8%	68.3%	68.3%	51.2%	71.6%
Keeping An Eye Always	58.0%	56.3%	60.3%	52.8%	63.9%	73.4%	53.2%	63.0%
Daily Life Activities, Like Shopping, Preparing Meals, Housekeeping	56.3%	44.4%	72.7%	52.7%	62.8%	60.4%	51.8%	61.0%
Personal Care Activities	45.6%	37.7%	56.5%	39.4%	52.6%	64.7%	38.6%	53.0%

Table 5: Different Types of Care provided by Caregivers across their gender, age of elderly and Tier of city

3.10 Access to health insurance

The study revealed that health-related vulnerabilities were very high for the elderly persons. The prevalence of chronic diseases increased with age along with increased cost of treatment. Hence the importance of health insurance cannot be overstated.

Only 31% of all elderly persons reported access to health insurance. 33% elderly males and 29% elderly females were covered. Access to health insurance varied with socio-economic categories, 35% elderly persons from SEC B were covered under health insurance and only 25% of elderly persons from SEC C reported the same.

The respondents who had health insurance were mainly living with their children and spouse (65%) or with their children without their spouse (22%). They were mainly literate with an above average literacy rate of 72%. Two-thirds of those who had an income, earned less than Rs. 1 lakh per annum. 26% also had no source of income, indicating that they had mainly access to schemes financed by the government.

More than two-thirds of the respondents (68%) who were covered under health Insurance, reported coverage under Ayushman Bharat Programme (ABP) – Pradhan Mantri Jan Arogya Yojana (PMJAY). It is the largest health insurance scheme in the world which is fully financed by the government of India. One-third of the respondents (36%) reported coverage under state sponsored health insurance schemes.

The reasons for not having health insurance were mainly focused on lack of awareness (32%), affordability (24%) and lack of need for it (12%).

A very small proportion of respondents (3%) reported purchase of commercial health insurance.

Notably, 16% had applied for health insurance, but it was denied to them.

3.10.1 Amount of Health Insurance

Majority of the elderly persons (55%) were not aware about the amount of insurance coverage or the sum insured in terms of rupees. 27% elderly reported that the amount of coverage is more than one lakh rupees and remaining 18% elderly reported the coverage as less than one lakh rupees. It is evident that most of the elderly respondents were covered under Govt. sponsored health insurance and the coverage for these insurance schemes was limited to medical care during hospitalisation and all medical expenses for outpatient visits and regular medical expenses are borne by the family.

3.11 Experience of insurance utilization / claim

Only 21% elderly persons, who have access to health insurance reported utilising it in the last one year. The percentage of respondents reported utilising health insurance didn't vary much with the gender and age group of the respondents. Tier I cities (26%) reported slightly higher percentage of insurance utilisation in comparison to Tier II cities (18%). Among the schemes

against which the insurance was utilised, 72% were insured under the PM-JAY scheme, 20% under Central Government Health Scheme (CGHS) and 14% under state health insurance schemes. Only 2% of those making claims were insured under private health insurance schemes.

The three key challenges faced while claiming insurance were as follows:

- a) Long waiting time for processing insurance claim (45%),
- b) Deduction in claim amount during settlement (43%) and
- c) Rejection of claim (40%).

25% of the respondents reported that the cashless facility was not available for them and they had to claim reimbursement after paying the amount at the hospital. The elderly who were making this claim were mainly insured under PM-JAY (76%), CGHS (19%) and state insurance schemes (13%). 4% were insured with private health insurance providers.

3.12 Desired Improvements of healthcare facilities

In the past one-year, different types of healthcare facilities visited by the respondents are listed below:

- a) Government Hospital / Clinic / Urban Primary Health Centre (PHC)
- b) Geriatric Health Care Centre / Clinic – a dedicated facility for elderly persons
- c) Private Hospital / Clinic
- d) NGO/Charity/Trust/Church-run Health Facility
- e) Health camp / Mobile healthcare unit

All elderly persons were asked regarding their suggestions for improving the healthcare facilities. More than two-thirds of all respondents felt that quality healthcare facilities should be available near their house.

A similar proportion of respondents also opined that the waiting time for the elderly in the health facility should be reduced. More than half of all elderly felt that

medicines should be available free of cost and treatment costs should be reduced. A little less than half of all respondents felt that doctors should be more sympathetic to elderly persons. Improvements of healthcare facilities required across gender and age groups were found to be similar.

Improvements desired included –

- Quality Healthcare Facilities nearby
- Healthcare providers more sympathetic towards the elderly
- Reduction in waiting time
- Less expensive treatment for the elderly
- Free medicines
- Comprehensive health insurance coverage

Significantly higher proportion of respondents in Tier II cities (78%) reported that quality healthcare facilities are required nearby in comparison to Tier I cities (55%). This reflects that non-availability of appropriate healthcare services for elderly in smaller cities is a challenge and needs attention of the authorities.

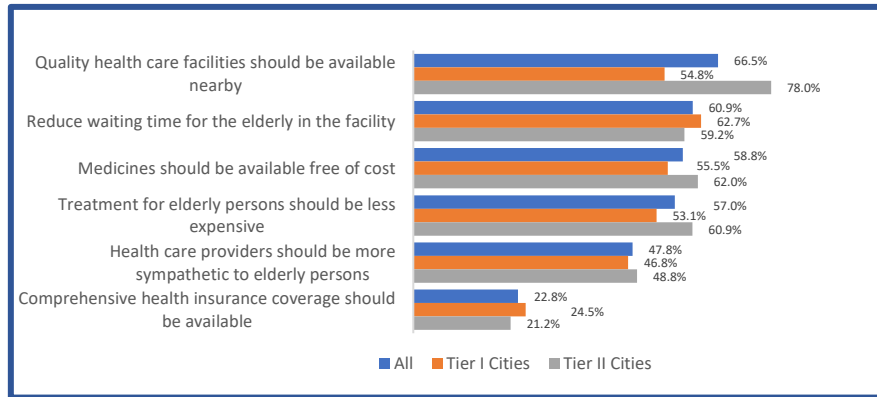


Figure 17: Suggestions for improvement of healthcare facilities

3.13 Awareness and access to geriatric healthcare centre

A small proportion (15%) of all respondents were aware about geriatric healthcare facilities. Elderly female (13%) reported less awareness in comparison to elderly male (16%). Elderly respondents in Tier I cities (17%) reported better awareness in comparison to elderly respondents in Tier II cities (12%).

Elderly who have visited these geriatric healthcare facilities were further asked about the type of services availed at the geriatric centre.

By and large almost all the respondents (86%) who have visited these facilities also described the services there as very good or good.

Majority of the respondents reported that they have visited these geriatric facilities for free medicine (61%) and preventive checkups (57%).

3.14 Experience of availing tele-consultation services

A negligible proportion (1.5%) of all respondents have availed teleconsultation services in the last one year. A similar trend was reported across both Tier I and Tier II cities and SEC categories.

Almost all (88%), who had availed of tele-consultation services, had access to smartphones as compared to only 39% of all respondents who had access to smartphones. Only 12% of

these tele-consulting elders had no access to a digital device, indicating that someone else facilitated this for them.

3.15 Summary

Elderly respondents across the study locations were experiencing high prevalence of multiple morbidity, limited access to healthcare facilities, as majority of the respondents have accessed government facilities, low health insurance coverage and high out-of-pocket expenses for healthcare. The study revealed that it is imperative to enhance availability and accessibility of healthcare services for elderly persons. Government-funded health insurance schemes need to be expanded and efforts should be made to ensure that these schemes specifically cover the healthcare needs of elderly individuals, including OPD visits and medicines.

4. ACCESS TO FAMILY AND SOCIAL NETWORKS

The previous chapters revealed the economic and health related vulnerabilities of elderly persons in Tier I and Tier II cities in India. It was found that the family is the key informal support system for elderly population. However, this also creates enormous caregiving responsibilities for the family members. Access to family and social network is crucial for physical, mental and social wellbeing of the elderly persons. This chapter presents involvement of elderly persons in household activities, decision-making related to self-care, access to paid care facilities and perception of the family members around paid care facilities, role of social organisations, Resident Welfare Associations (RWAs) and Senior Citizens' Associations (SCAs).

4.1 Involvement in household activities

Majority of the elderly persons reported involvement in taking care of grandchildren (61%) and providing advice or counselling their family members (58%). More than one third of elderly respondents were involved in regular household chores, cooking and shopping for the household. Involvement of elderly female in cooking (58%) was much higher in comparison to elderly male (11%). However, involvement in household activities reduced significantly with the age of the respondents and only 26% respondents in the age group of 70–79 years and 16% respondents in the age group of 80 years and above reported involvement in cooking.

Involvement in household activities was found to be similar across both Tier I and Tier II cities and across socio-economic categories.

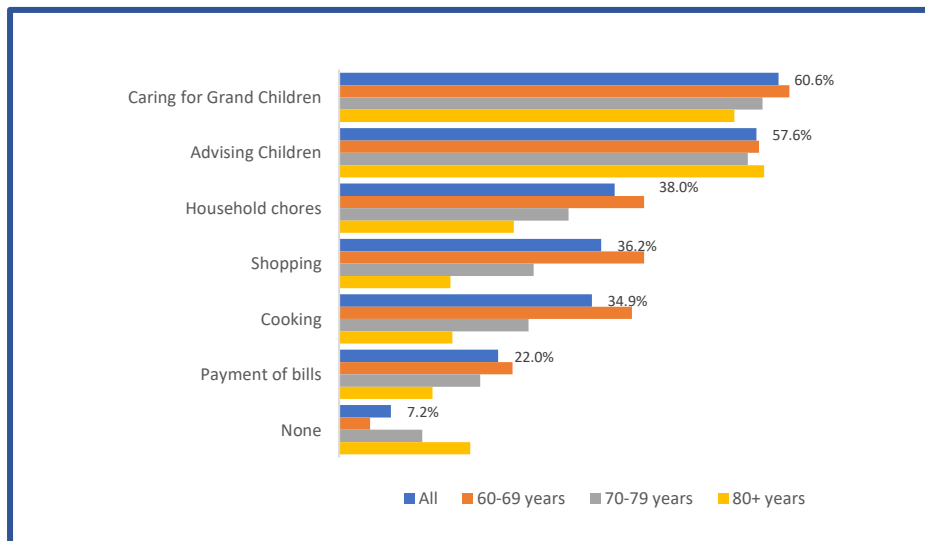


Figure 18: Involvement of the elderly in household activities

4.2 Decision making related to self-care

More than half of the elderly persons (56%) reported that they were the key decision makers for the food they eat and close to two-thirds of them (65%) also reported that they primarily decided their own clothing. However, only one in every three elderly decided the type of healthcare facilities they will visit and one in four decided regarding investment of their own money. These decisions were mainly influenced by the family members.

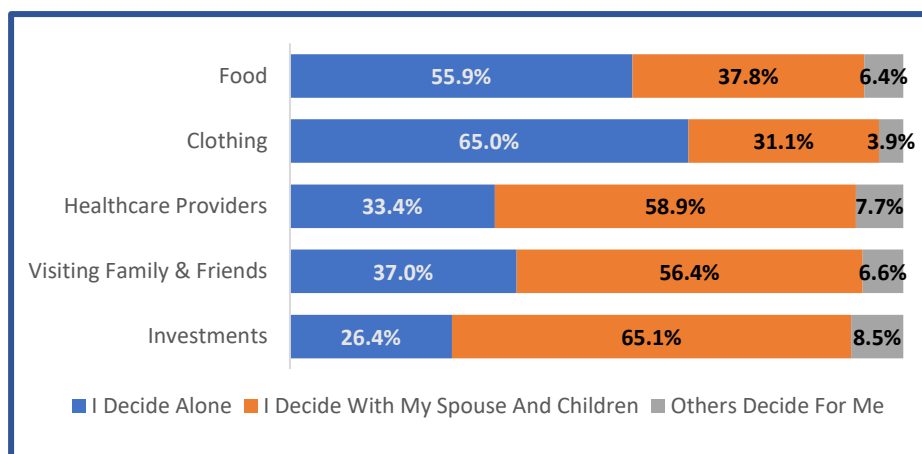


Figure 19: Decision-making of all elderly persons regarding self-care

Decision-making by self goes down considerably as the age of the elderly increases, with most 80+ elders deciding in consultation with other family members or letting others take the decision. Self-decision was also lower for females as compared to males especially with respect to medical facilities and investments.

Respondents in Tier II cities reported somewhat more autonomy related to self-care in comparison to respondents in Tier I cities. The respondents from SEC C reported marginally lower self-decision making in comparison to respondents from SEC B.

4.3 Membership of social organisation

Very few (7%) elderly persons reported that they were members of any social organisation - around 8% males and 5% females. A negligible proportion of elderly in the age group of 80 years and above reported such membership. Membership in social organisation improved marginally for Tier I and SEC B categories.

4.4 Perceived benefit and Activities related to social organisations

Majority of the respondents (77%) who are members of social organisations felt that the main benefit is connecting with others in the same age group and with similar interest. Others (63%) also felt that such networking keeps them physically and mentally active. This perception did not vary at all with Tier I and Tier II cities and socio-economic categories.

In line with the perceived benefit of being associated with any social organisation, only 3% respondents have ever raised issues concerning older persons with the local leaders in the last one year.

4.5 Membership and activities related to RWA / SCA

A negligible proportion of respondents (3%) reported membership of Resident Welfare Associations / Senior Citizens' Associations. These were mainly safety and security issues faced by the elderly as well as issues related to caregiving by the family members.

44% respondents who were members of RWAs / SCAs reported **raising issues/ concerns with RWAs**. The **responses by the associations** were reported as **positive** by **over half the elderly** who had raised these issues.

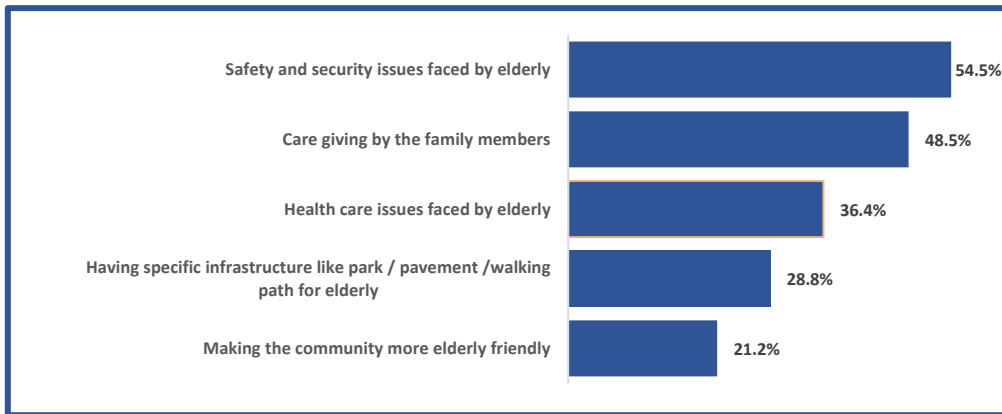


Figure 20: Issues raised by elderly members of associations

4.6 Challenges of Caregivers

The study revealed that the family members play an indispensable role in supporting the elderly, often taking on a substantial physical, and financial stress. The demands placed on caregivers are significant, with a majority (68%) of caregivers reporting that they provide support to the elderly person every day. On an average a caregiver has spent around 20 hours in the past week i.e. close to three hours every day.

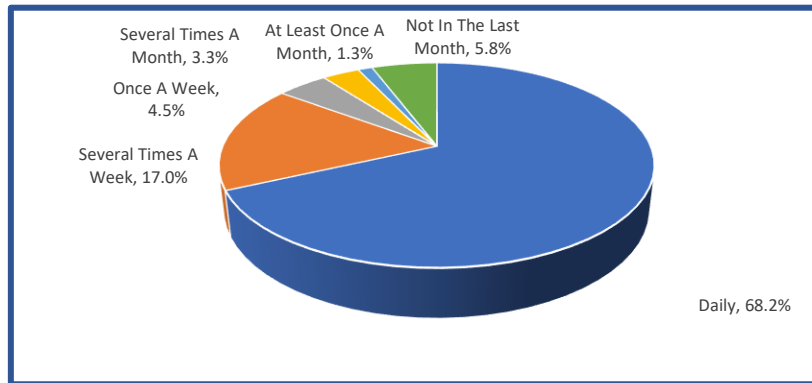


Figure 21: Frequency of providing care to the elderly by all caregivers

This daily commitment underscores the intense level of care required, which leads to considerable challenges as reported by the caregivers. Around 29% of the caregivers reported physical challenges in providing care to the elderly person - 36% female caregivers and 24% of male caregivers reported this. Caregivers in the younger age group reported more physical challenges in comparison to caregivers in the older age group. This could be due to the fact that their busy work schedules made it physically challenging to provide continuous care. Physical challenges increase with the age of the elderly persons as he/ she increasingly becomes more dependent and faces challenges with ADL/ IADL.

Considerably **higher percentage of caregivers in Tier II cities reported physical challenges related to caregiving as compared to Tier I cities.**

36% caregivers, who are providing support to elderly, aged 80 years and above, reported physical challenges.

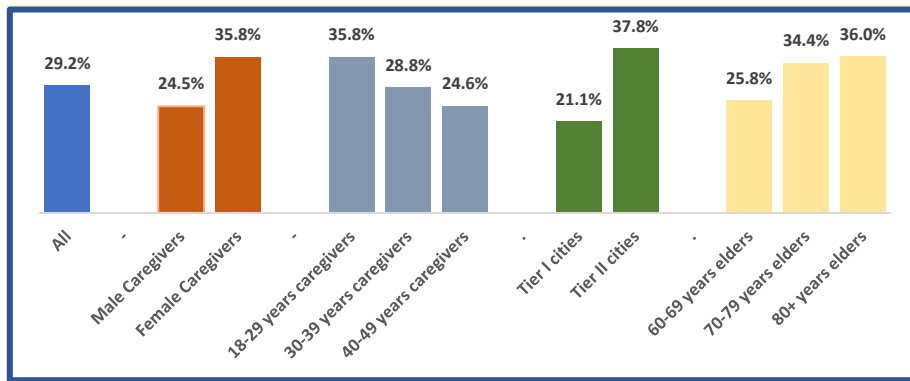


Figure 22: Percentage Caregivers reporting physical challenges while providing care for the elderly

Little less than one third of all caregivers also reported facing financial challenges in providing care to the elderly persons. Caregivers in the younger age group reported more financial challenges in comparison to older age group.

Financial burden of providing elderly care remained similar across socio economic categories. 39% caregivers in the age group of 18–29 years and 29% caregivers in

Caregivers in Tier II cities reported experiencing more financial challenges in comparison to caregivers in Tier I cities (Tier I cities – 25% and Tier II cities - 38%).

41% caregivers, who are providing support to elderly aged 80 years and above reported financial challenges.

the age group of above 30 years reported financial challenges. Interestingly, financial challenges increased with the age group of elderly persons due to increased medical expenses.

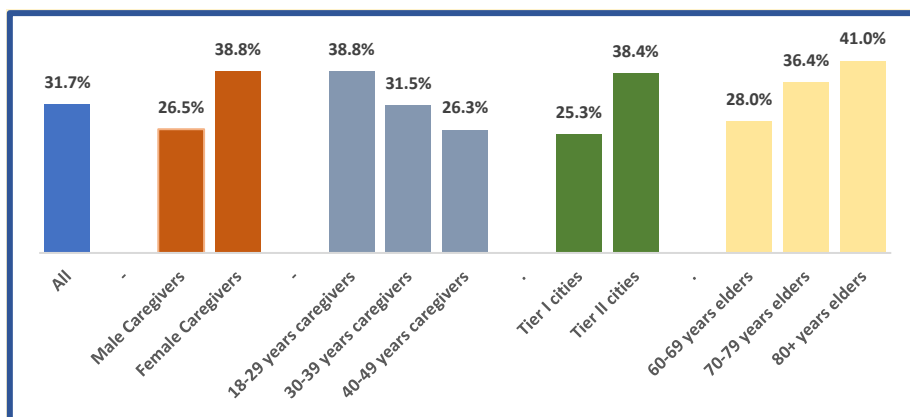


Figure 23: Percentage Caregivers reporting financial challenges while providing care for the elderly

4.7 Availing services of paid domestic helpers

A proportion of caregivers (4%) reported availing services of paid domestic helpers for the elderly. There was a small variation on the reported availability of paid domestic helpers. While less than 1% elderly respondents reported that they have received services of a paid helper, a higher proportion of family members (primary caregivers) reported that they have availed such services. This indicates a difference in perception between the elderly and their caregiving family member.

City Tier wise and SEC wise breakup not provided due to very small base.

4.8 Willing to avail the services of paid domestic helpers

The study also enquired about the willingness to avail the services of paid helper in future if needed. 12% caregivers from SEC B and 7% caregivers from SEC C reported the same.

Close to **10% caregivers overall** reported that they are willing to avail services of paid helpers.

Regarding the **payment to the paid domestic helper**, caregivers who have reported willingness to avail the service also expressed that **on an average** they will be able to spend **Rs. 3398 per month for this service**.

4.9 Awareness about any age care services available in the neighborhood

The awareness didn't vary across tiers of cities and across socio-economic categories. These age care services are essential for supporting the elderly and their caregivers, ensuring that older adults can live with dignity and in comfort. However, a lot of work needs to be done to increase the awareness on the availability of such services.

Only **10% of all caregivers** were aware about the **availability of paid age care services** e.g. old age homes, day care centres, palliative care, etc. **near their home**.

4.10 Summary

It was observed elderly persons were taking care of their grandchildren. Limited membership in social organisations for the elderly requires immediate attention. The study also highlighted that providing resources and support for the caregivers is essential considering the physical and financial burdens faced by them. Improving awareness around appropriate age care services needs to also be another essential policy-making decision.

5. EXPERIENCE OF ELDER ABUSE

Elder abuse in India is a significant and growing concern, with elderly persons more likely to suffer ill-treatment due to declining financial status and functional capabilities. Family caregivers are often the primary abusers, leaving the elderly feeling helpless and reluctant to report such incidents. This chapter presents the experience of elder abuse, awareness of legal provisions, perception of safety and security at home and experience of facing crime in the past one year.

5.1 Experience of elder abuse

7% elderly reported facing abuse like disrespect or beating, slapping or verbal abuse, isolation, humiliation, etc. in the last year. 5% elderly also refused to answer this question. No variation in reported pattern of elder abuse was found across gender and age group of the respondents.

In very few cases the perception of abuse was related to minor disagreements with family members or not getting food on time or not getting quality food, etc.

Respondents from **SEC C (11%)** reported **experiencing higher prevalence of elder abuse** in comparison to respondents from **SEC B (4%)**.



Figure 24: Percentage elderly reported facing abuse

Further analysis revealed that a higher percentage of elderly who have faced abuse in the past one year were illiterate as compared to all surveyed elderly persons. 76% of the elderly respondents reporting abuse were “currently married” as compared to 70% of the general surveyed elderly. Elder abuse increased with decrease in income of the respondents and majority of the respondents (73%) who have faced abuse reported an annual income of less than Rs. 1 lakh. Very often, elderly who have faced abuse were suffering from NCDs. By and large, almost all elderly (94%) who have faced abuse, reported at least one chronic disease.

This suggests that poor literacy, low income along with lack of access to income sources and prevalence of NCDs – the factors which increased dependency of the elderly on the family members – were also the key determinants for elder abuse.

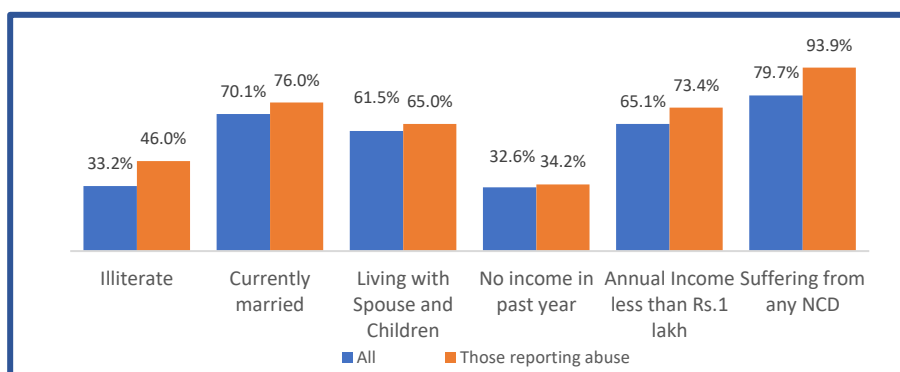


Figure 25: Profile of elderly reported facing abuse

A large proportion of respondents reported that their sons (42%) and daughters-in-law (28%) were the primary abusers. Abuse by sons was higher among male elderly (44.8%) as compared with females and abuse by daughters-in-law was higher among female elderly (35.2%) as compared to male elderly. Regarding the types of action taken to resist elder abuse, most of the elderly who have experienced abuse revealed that they have scolded / requested the abusers, others have either reported to their friends or other trusted members in the family or they didn't do anything. A small portion of these respondents reported that they have lodged a police complaint regarding the abuse.

5.2 Awareness of MWPSA Act

The Maintenance and Welfare of Parents and Senior Citizens Act, 2007 (MWPSA Act, 2007) plays a crucial role in maintaining the well-being and dignity of senior citizens in India. This law guarantees financial security, healthcare access, and property protection for the elderly, holding children and relatives accountable for their care in order to prevent neglect, abandonment, and abuse. The Indian Constitution highlights the need for state intervention to safeguard the elderly. This requires the state, within its economic means, to ensure the right to work, education, and public assistance in cases of unemployment, old age, sickness, disability, and other instances of need.

Only 8% elderly persons reported being aware about MWPSA Act - 11% elderly male and 6% elderly female. Awareness about the act reduced with the age of the respondents. Tier I cities reported marginally better awareness in comparison to Tier II cities and similar gap in awareness was also found between socio-economic categories where respondents from SEC B were more aware in comparison to respondents from SEC C.

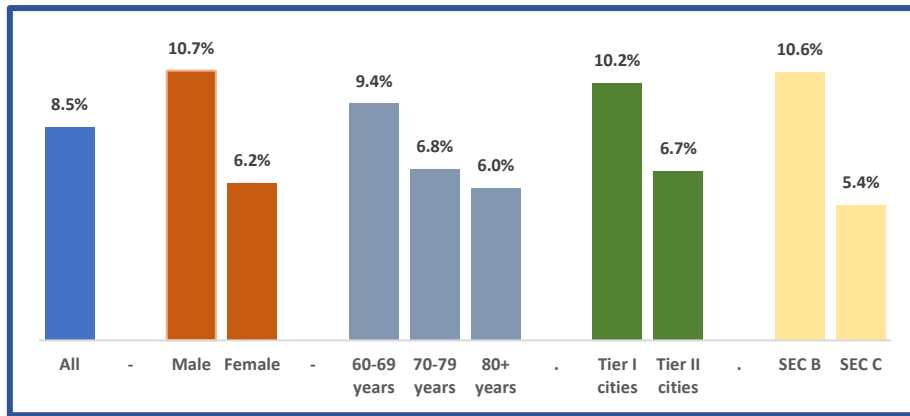


Figure 26: Awareness among the elderly of the Maintenance and Welfare of Parents and Senior Citizens Act

Further analysis of the profile of the respondents who were aware about the MWPSA Act highlights that almost all these respondents were literate, and a higher percentage of these respondents were currently working. Also, a notably higher proportion of these respondents reported having access to health insurance. However, interestingly, a marginally higher proportion of these respondents have also reported experiencing elder abuse.

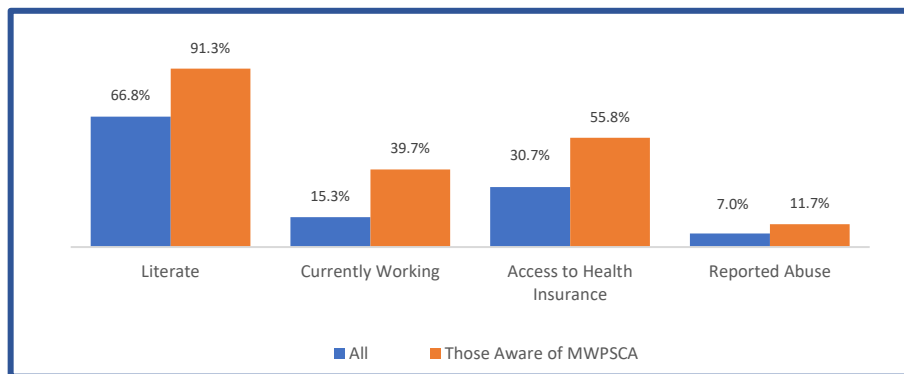


Figure 27: Profile of elderly aware of the Maintenance and Welfare of Parents and Senior Citizens Act, 2007

Further enquiry on awareness of specific provisions of the Act revealed that most of the respondents (54%) who were aware of the MWPSA Act were aware about the maintenance provision for parents / senior citizens. All other provisions of the Act like a conditional will or responsibility of the government for providing healthcare facilities and old age homes were known to only a few (less than 20%) respondents.

5.3 Perception of safety, security at home, in neighbourhoods

By and large almost all respondents reported that they felt safe from crime and violence even when they were alone at home. 96% of all respondents reported feeling 'completely safe' or

'safe' when they were alone at home. Perception of safety didn't vary at all with gender, age group, place of residence or socio-economic categories. Elderly respondents in Tamil Nadu reported more safety concerns at home in comparison to all other states. 20% elderly in Tamil Nadu reported feeling 'not very safe' or 'not safe at all'.

Perception of safety on the road in the neighbourhood during evening or night didn't vary much and an overwhelming proportion of respondents also reported feeling safe (92%). This perception did vary with the age group of the respondents with only 85% elderly in the age group of 80 years and above reporting feeling safe on the road during the evening / night. Among all study states, Tamil Nadu reported maximum proportion of respondents reporting not feeling safe also on the road at evening / night.

5.4 Experience of facing crime in the past one year

A negligible proportion (3%) of respondents reported facing any crime in the last one year. The pattern of this reporting didn't vary at all across gender, age group, Tier I / Tier II cities and socio-economic categories. Among the study states Karnataka (13%) and Tamil Nadu (14%) reported higher prevalence of crime against elderly.

Less than one-third of all elderly who have experienced crime in the past one year have reported the crime to the police. Others have either discussed this with their family members and friends or they didn't do anything.

5.5 Summary

The issue of literacy, no access to income, and chronic diseases were leading to higher dependency on family members and higher elder abuse. Close family members such as sons and daughters-in-law were often identified as the primary abusers. Addressing the economic vulnerabilities and health needs of the elderly is crucial. Policies should focus on improving access to income sources, healthcare, and health insurance for the elderly, particularly for those who are illiterate and economically disadvantaged.

Very few elderly persons were aware of the MWPSA Act, with higher awareness among less elderly, literate, male respondents and those in Tier I cities. Interestingly, a notable proportion of those aware of the Act also reported experiencing elder abuse. There is a need for increased awareness campaigns about the MWPSA Act and its specific provisions, especially targeting older women, and lower socio-economic groups. This should involve partnerships with community organisations and a multi-media outreach.

6. ACCESS TO DIGITAL TECHNOLOGY

Access to digital technology for the elderly in India holds immense potential for social inclusion, empowerment and improved quality of life. The Internet and new technologies offer a unique opportunity to enhance the well-being, and mental and physical health of senior citizens. This section deals with access to digital devices, pattern of usage of digital devices, availability of support while using digital devices, experience of facing online fraud and access to training related to digital technology

6.1 Access to digital devices

Only 41% of the respondents reported having access to any digital device. The gender digital divide was prominent as 48% male elderly reported access to any digital device while only 33% female elderly respondents reported the same. Access to digital devices dropped significantly with the age of the respondents, with 44% elderly in the age group of 60–69 years, 36% in the age group of 70-79 years and 26% in the age group of 80 years and above reporting that they have access to any digital device. Tier I cities (43%) reported slightly better access in comparison to Tier II cities (39%) and access didn't vary with the socio-economic categories of the respondents.

Among literate respondents, more than half the elders had access to a digital device, while only 15% of the illiterate elders had a similar access.

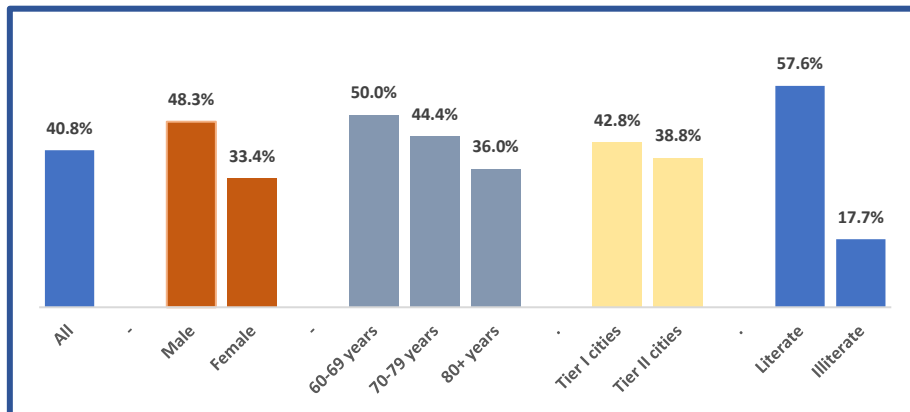


Figure 28: Elder Access to Digital Devices

The study highlights that smartphone are the most common digital devices, with almost all elders (96%) with access to a digital device, reporting having access to a smartphone. A negligible percentage of respondents reported access to tablets, laptops and computers.

6.2 Pattern of usage of digital services

Amongst those using of digital devices, it was found that it was mainly for entertainment and social media with 34% of all elderly surveyed using them for entertainment and social media regularly, very often or sometimes. 17% did information search, 13% internet banking / digital payments, 12% payment of utility bills / booking tickets and a very small percentage (8%) used health apps.

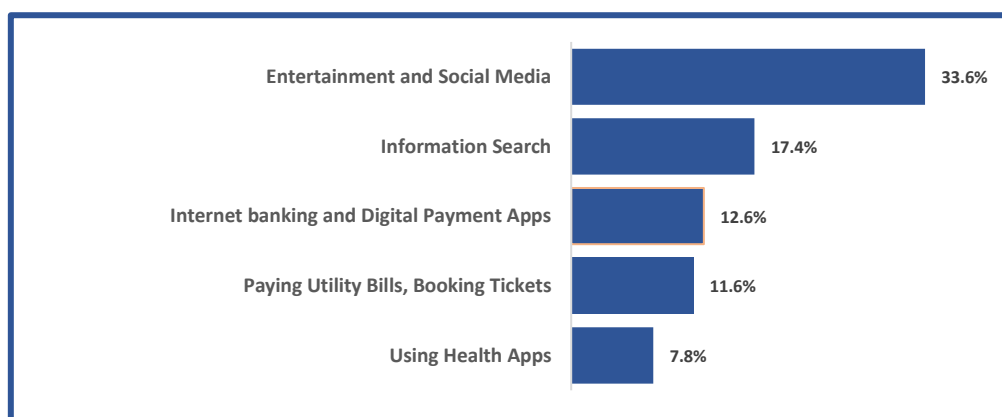


Figure 29: Elder use of Digital Services amongst those using

There was a gender divide even in the usage of services with a higher percentage of males using digital services as compared to females. Usage of digital services also dropped as the age of the elderly increased and from Tier I to Tier II cities.

Functional use of digital devices is limited, more used for entertainment purposes.

6.2.1 Caregivers' perception on digital technology to support older persons

The study validated the findings and recommendation of Niti Aayog's 'Senior Care Reforms In India' report that research is needed to assess how technology can be used to improve senior care services, including the use of wearable devices, telehealth, and other digital tools and that awareness around this area is extremely limited.

By and large almost all the caregivers (91%) also reported that they **were not aware about any digital technology to support or to improve the lives of elderly.**

6.3 Availability of support while using digital services

One in every five elderly using digital devices, reported that they can use digital devices comfortably, while the remaining four either can't use the digital devices at all or need continuous support. More support is needed by elderly female, older senior citizens and those in Tier II cities and belonging to SEC C.

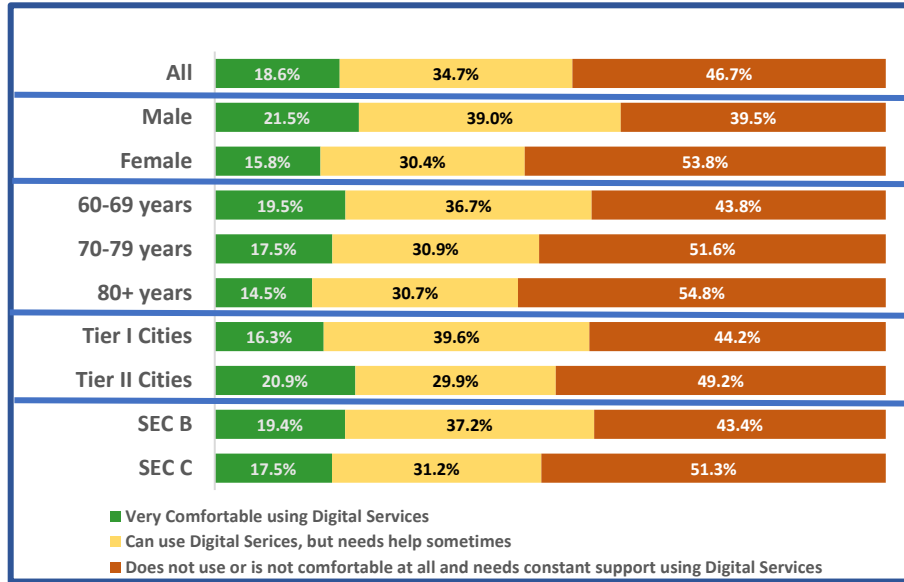


Figure 30: Support needed by elderly while using digital services

More than half of the elderly persons (53%) reported that their children helped them while using digital devices and in case of any technical issues, a small proportion (8%) of respondents also received help from their grandchildren.

6.4 Availability of training programme for using digital devices

Less than 1% of the surveyed elderly reported attending any digital skills training programme conducted by local training institutes, community clubs or as part of a government initiative. Around 6% of all elderly interviewed were willing to take formal training on digital technology.

6.5 Experience of facing online fraud / scam etc.

8% reported experiencing online fraud.

More fraud was reported by males and those in Tier I cities and those belonging to SEC C.

More than half of

96% those who complained were satisfied with their experience of the cyber security cell.

the respondents (59%) who have experienced online fraud also said that they had complained to the cyber security cell.

6.6 Summary

The study revealed that access of older persons to digital technology is extremely limited. Even those who had access to devices were mainly using it for social media and entertainment, very few were using it for accessing utility services or for health care. The gender divide is also an important area that needs special attention.

Conclusion

The study findings indicate that the elderly face significant challenges in terms of their economic participation, social inclusion, and overall well-being. Their vulnerability is exacerbated due to low literacy rates and incomes. Majority of seniors are not engaged in remunerative economic activities and lack a regular source of income. This, coupled with limited access to pensions, savings, and investments, forces them to rely on their family members for financial support and basic necessities.

Only a small number of elderly individuals reported receiving financial assistance from their family members, with older women being particularly disadvantaged in this regard. It is worth noting that there is a law called the Maintenance and Welfare of Parents and Senior Citizens Act 2007, which grants older individuals who are unable to support themselves, the legal right to claim a maintenance allowance from their children. However, the study found that there is very low awareness about this law and its utilization is minimal.

The study underscored the widespread prevalence of chronic diseases among the elderly in India, revealing that nearly half of all respondents were diagnosed with hypertension or high blood pressure and diabetes. Furthermore, the study found a high prevalence of multiple morbidities, with a large proportion of elderly persons suffering from two or more Non-Communicable Diseases (NCDs). These diseases are incurable and can only be managed by regular treatment that includes periodic visits to medical experts, tests and medication. A majority of elderly persons visited government healthcare facilities in the past year, while about half visited private hospitals or clinics. Geriatric healthcare centres were accessed by very few respondents.

Family support, particularly from children, was crucial in managing the medical expenses. Despite this support, a third of the elderly had no accompaniment during their healthcare visits, highlighting a gap in physical assistance.

Access to health insurance was limited, with only a small proportion of elderly respondents covered, primarily under government schemes like Ayushman Bharat Programme (ABP) and state-sponsored initiatives. Challenges in claiming insurance included long processing times, claim deductions, and claim rejections. The lack of awareness and affordability were major barriers to broader insurance coverage. Improving healthcare facilities emerged as a crucial need, with respondents emphasising the importance of accessible, high-quality healthcare near their homes, reduced waiting times, free medicines, and sympathetic treatment from healthcare providers. Awareness of geriatric healthcare centres was low, but those who accessed these services rated them positively.

The findings indicated that more than half of the elderly population in the study faced at least one challenge related to activities of daily living (IADL / ADL). The prevalence of ADL-related difficulties increased significantly with age. Majority of elderly individuals facing ADL challenges received support from family members, primarily spouses and children. However, few elderly did not receive any assistance, often due to lack of available family support or financial constraints.

A limited proportion of caregivers used paid domestic helpers. A small proportion of caregivers expressed willingness to use paid helpers in the future. Very few caregivers were aware of age

care services such as old age homes, day care centres, and palliative care facilities in their neighbourhoods. Though the family was the mainstay of support, the caregivers in their responses mentioned about physical and financial stress in caregiving to the older members affecting them.

A majority of elderly individuals were engaged in taking care of their grandchildren and providing advice or counselling to family members. Participation in household activities declined with age, especially in cooking. More than half of the elderly decided on their food, and chose their clothing. Autonomy in self-care decisions decreased with age and was lower among women. Very few elderly individuals were members of social organisations, with slightly higher membership among men. Membership in RWAs/SCAs was also negligible, but those involved often raise issues related to safety and caregiving.

A small proportion of elderly individuals reported experiencing elder abuse. Factors such as illiteracy, lack of income, and chronic diseases contributed to increased dependency on family members, which in turn heightened the risk of abuse. Sons and daughters-in-law were frequently identified as the main abusers. Awareness of the Maintenance and Welfare of Parents and Senior Citizens (MWPSA) Act, 2007, was low among the elderly, with higher awareness among younger, literate and male respondents.

Access to digital technology among the elderly in India remained significantly low, presenting a critical area for improvement and this access further declined with age. Smartphones were the most common digital device, with negligible access to tablets, laptops, and computers.

Usage of digital services was also minimal, with only a few respondents using devices for entertainment and negligible usage for utility services or accessing health apps. Support while using digital services mainly came from family members, with children being the primary source of assistance. However, only one in five elderly reported being able to use digital devices comfortably, highlighting the need for further support and training programmes. Unfortunately, a negligible proportion of respondents reported attending any digital skill training programmes, although a small proportion of respondents have expressed willingness to do so.

The study revealed many challenges that older persons in the 'missing middle' category face and also the available responses to it. It showed a lack of preparedness even to income and health security. The older persons and their families tried to manage with their own limited resources and access to public facilities and schemes wherever possible. Systematic and systemic responses should be co-created that are not only appropriate, but, also sustainable. Therefore, partnership of all stakeholders is important to develop an age care system that will be able to cater to the needs of majority of the elderly in the near future and will serve as the foundation for the next couple of decades.

APPENDIX

Socio Economic Classification

No. of Durables Owned	Chief Earner: Education						
	Illiterate	Literate but no formal schooling/ School-Upto4 years	School-5 to 9 years	SSC/ HSC	Some College (including Diploma) but not Graduate	Graduate/ Post Graduate: General	Graduate/ Post Graduate: Professional
None	E3	E2	E2	E2	E2	E1	D2
1	E2	E1	E1	E1	D2	D2	D2
2	E1	E1	D2	D2	D1	D1	D1
3	D2	D2	D1	D1	C2	C2	C2
4	D1	C2	C2	C1	C1	B2	B2
5	C2	C1	C1	B2	B1	B1	B1
6	C1	B2	B2	B1	A3	A3	A3
7	C1	B1	B1	A3	A3	A2	A2
8	B1	A3	A3	A3	A2	A2	A2
9+	B1	A3	A3	A2	A2	A1	A1

Items owned / have access at home
Electricity Connection
Ceiling Fan
LPG Stove
Two Wheeler
Frost Free Refrigerator
LCD/ LED Colour TV
Fully Automatic Washing Machine
Personal Computer / Laptop/Tablet
Smart Phone
Sedan car/ Hatch back car
Air Conditioner