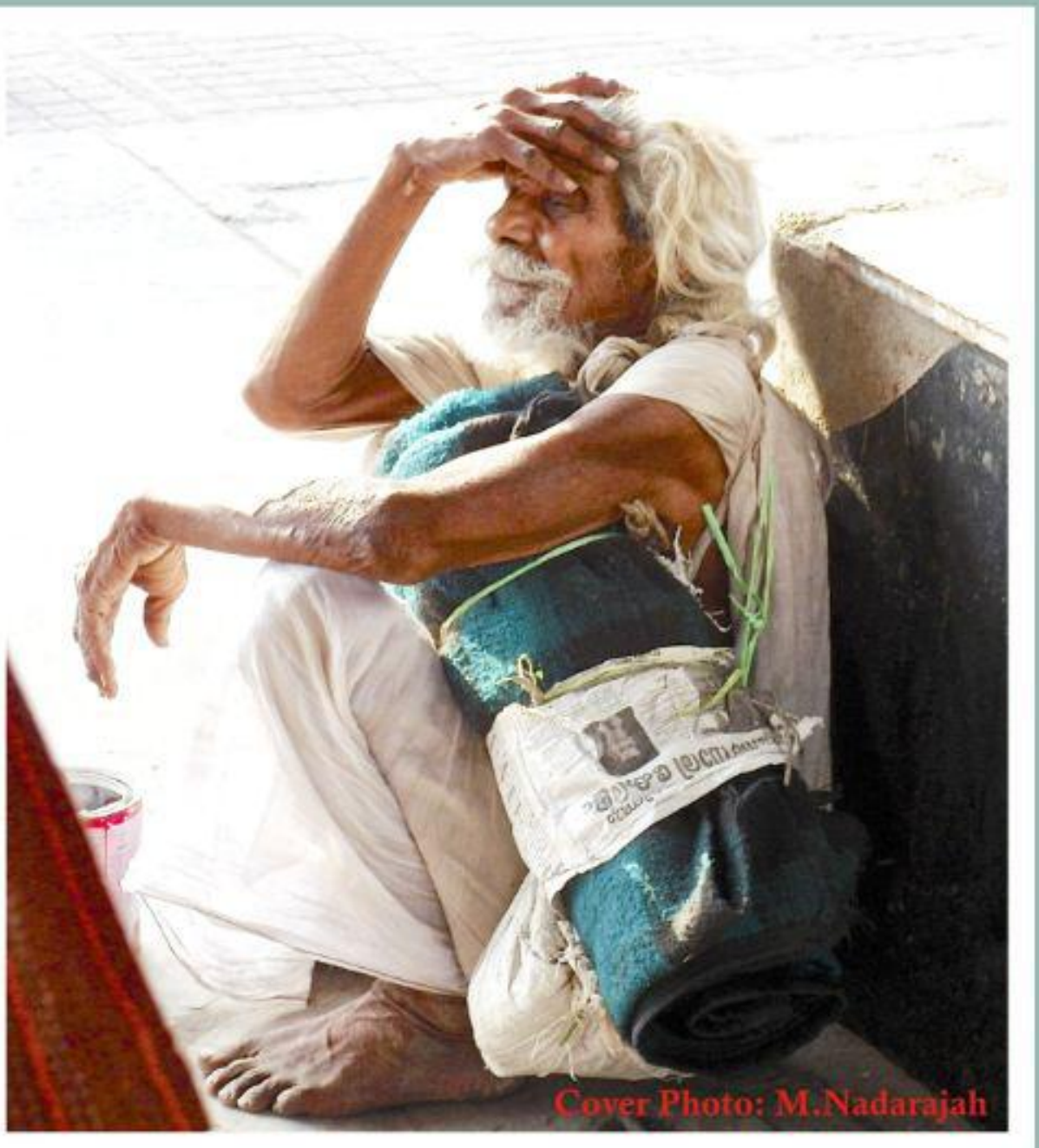
Old Age in an Indifferent Society



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T K Nair

NIRUTHA Publications

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T.K. Nair (Ed)

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By T.K. Nair (Ed)

Publisher : Ramesha M.H. for Niruta Publications, # 244, 3rd Main, Poornachandra Road, MPM Layout, Mallathahalli, Bangalore-560056, Ph : 080-23212309, Mob : 9980066890
Email: ramesha.mh@gmail.com, nirutapublications@gmail.com
www.niratanka.org

Printed at: Niruta Print Solutions, # 244, 3rd Main, Poornachandra Road, MPM Layout, Mallathahalli, Bangalore-560056, Ph: 080-23212309, Mob: 9980066890
Email: ramesha.mh@gmail.com, nirutapublications@gmail.com
www.niratanaka.org

First Edition : 2013
ISBN : 978-81-923326-3-5
Pages : 146
First Impression : 1000 copies
Paper : NS Maplitho 70 GSM
Price : 200/-
Size : 1/8th Demy
Cover Page Design : Premnath M
Cover Photo : M.Nadarajah
Typeset : Shivakumar

Dedicated to
Millions of Elderly Men and Women
Who Toil Day and Night for
Survival

Contents

Preface

Ageing is an inevitable, natural phenomenon. From nearly hundred million in 2011-2012, the estimated sixty-plus population of India will be around three hundred and twenty million in 2050. This phenomenal increase poses many challenges and provides many opportunities depending on the perception and preparedness of the central and state governments. This edited book, a collection of articles, aims at addressing some issues.

The first article discusses the concept of old age. One of the earliest studies was by Marulasiddaiah. Old people of Makunti, published after a long gap, was based on a village study conducted by him more than fifty years ago. His findings are relevant even today. A significant feature is with regard to the partition of the family property. Often the parents, along with the land, house, utensils, ornaments, grains, money, and other trivial things, are also divided. Visweswara Rao's article on the rural elderly analyses the situation of the older people in Indian villages. He also reviews the relevant policies and programmes.

Devi Prasad, as the title of his article suggests, narrates the struggles of the elderly victims of abuse and neglect in the Indian families. The stories of elder abuse reveal two main angles according to Devi Prasad. One is that the patterns of elder abuse reflect the prevailing negative stereotypes towards the elderly and their roles in the society. The other is how we are explaining the phenomenon of ill-treatment of the elderly in the larger context of socio-economic realities.

The role of traditional medicines as well as the close link between the health of the ageing population and Ayurveda are examined by Unnikrishnan. He observes "approach to elderly care should be based on the vision of reinforcing family and community-based care in a locally driven process harnessing

locally available resources and knowledge". Siva Raju outlines the research priorities in the field of aging. He quotes from the Research Agenda on Ageing for the 21st century adopted by the Second World Assembly on Ageing at Madrid 2002 : "There is a need to assess the 'state of the art' of existing knowledge, as it varies across countries and regions, and to identify priority gaps in information necessary for policy development".

Nair has added four articles. In State and the Elderly, he analyses the weaknesses of the existing social security measures. The indifferent attitude of the state towards the elderly has been discussed as seen from the lack of proper implementation of the National Policies since 1999. In the article on Eldercare Services, he suggests community-based services. Life Satisfaction in Old Age is a field study-based article. Mean life satisfaction score of the elderly is found to be low. Life satisfaction score of the urban elderly is double that of the rural elderly. Life satisfaction level is also associated with health status, economic condition, and belief in re-birth. The last article is on issues concerning neglect of the older persons in a society of indifference.

Elder care in India meant homes for the aged till 1979, when Helpage India and the Centre for the Welfare of the Aged (CEWA) pioneered non-institutional services in Madras city. Ajith presents a case study of CEWA and its contribution to a new approach in promoting participatory elder care services which can be replicated in different parts of the country with region-specific adaptations. Nightingales Medical Trust (NMT) in Bengaluru has taken initiative to "take health care to the elderly at their door". Many family-based health support systems for the senior citizens belonging to different socio-economic groups are initiated by NMT. Of particular significance is the unit for therapy and rehabilitation of patients affected by Dementia and Alzheimer's disease. KalpanaSampath developed the case study

of NMT based on repeated visits and discussions with the important functionaries.

I thank Prof H.M. Marulasiddaiah, Chief Adviser, and M.H. Ramesha, Editor of SamajaKaryadaHejjegalu (Social Work Foot-Prints) for their love and support. I also thank NIRUTA Publications for publishing this book.

T.K.Nair
September, 2013

Acknowledgment

SamajaKaryadaHejjegalu (Social Work Foot-Prints), a bilingual social work journal (Kannada and English) in Karnataka with a national readership, brought out a special issue on Ageing India in April, 2013. Prof.T.K.Nair was the guest editor. The readers appreciated the articles. Hence Prof.H.M.Marulasiddaiah, our Chief Adviser, suggested the publication of the articles as a book with the addition of some more articles. Prof.Nair accepted our request. The present volume is the outcome of the suggestion of Prof. Marulasiddaiah.

We are indebted to Prof. Nair for his enthusiastic co-operation. I am grateful to Prof. Marulasiddaiah,our mentor, who is ever willing to guide us. I am very much thankful to our Niratanka team for their hard work.

M. H. Ramesha
Publisher
September, 2013

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Old Age

T.K.Nair

Aging is a long term process of change for both individuals and populations. However, the concept and process of aging are surrounded by considerable controversy and suspect evidence. Human aging is a process of differentiation and individualization. Aging has two integral elements – intrinsic and extrinsic. Intrinsic aging means those age-related processes that are internal and specific to the individual, while extrinsic aging comprises those age-related changes that are brought about by external factors related to the physical and social environment of the individual (United Nations,1982). Older persons, who were born at a particular historical time, and in a particular region and society, belong to a cohort sharing similar social and historical experiences, life-styles and other characteristics which differentiate them from other older persons born at different historical periods in diverse social situations. Individuals derive social meanings and develop expectations regarding themselves, their families and their society as they grow older from these processes of aging and within the context of social, historical, cultural and economic situations.

Old age is a relative concept which varies from society to society. In fact, there are several explanations of old age and we are likely to slip unknowingly from one to another. Though aging is a universal process, identifying the chronological threshold to old age is not possible. Depending on the expectation of life, the definition of old age is found to vary from about 40 in some developing countries to 70 and beyond in some developed countries.

The common assumption is that the passage of time , as measured by the chronological age , is a reliable index of changes in our minds and bodies, and in our abilities and limitations. But

this assumption is highly erroneous which is well illustrated by the example of compulsory retirement (Kastenbaum, 1979). The age of 65 is still the most frequent cut-off point for compulsory retirement in developed countries although more diversity has been shown lately. It is the institution of retirement which clearly labelled a section of persons old. Social historians contend that the social constructs of 'youth 'and 'old age' have in fact grown up after the industrial revolution (Aries,1962). There is no scientific support for retirement at any particular chronological age. These age markers have no foundation in any biological reality. Instead, political and economic reasons have been responsible for the age-based retirement practice. In India, the mandatory age of retirement of most of the personnel in government service ranges from 55 to 60. Only a small section could work till 65.

The World Assembly on Aging held in 1982 under the auspices of the United Nations adopted the definition of aging population as persons 60 years and older without obscuring the great individual, societal and temporal differences in actual and perceived characteristics of the elderly population. The United Nations (1985) report adds that such a demarcation is convenient only for statistical analysis .The Census of India has been adopting the age of 60 years to classify a person as old. Gerontologist Neugarten (1974) points out that, with increased survival ratesand improved health, it is becoming apparent that there are two, rather than one, strata of aging population, which she has distinguished as the young-oldupto 74 years) and the old-old (75 years and above) . **Ayurveda**, the traditional system of Indian medicine, divides human life span into ten stages and categorizes the aging persons into two broad groups :**Vriddha** (60 to 80 years) and **Jaratha** (above 80 years) .

The definition of old age is dependent on the cultural norms and social context of any society. In India, **Shashtiabdapurthi**, which means the completion of 60 years, is traditionally celebrated as a significant milestone, while the completion of 70 years is celebrated as **Sapthadi**, which is an achievement in

the life span of an individual. It is the duty of the offsprings to celebrate these milestones. But these are observed only by the well-to-do and those belonging to the upper castes. In most of the societies under the influence of Chinese culture, the sixty-first birthday has been associated with the beginning of old age (Maeda 1978). In ancient China, the calendar year was named with the combination of two sets of Chinese characters – one consisted of twelve characters and the other five characters. Therefore, on becoming sixty-one years old, the name of that year becomes same as that of the year of birth. Hence the sixty-first year after birth is called **Kanreki** (return of the calendar) which is often regarded as the beginning of second childhood. In Japan many people used to hold a passing rite to mark **Kanreki**. At the time of the ceremony of **Kanreki**, the person becoming sixty-one used to be presented by the children and relatives with a red vest designed to signify the coming of second childhood. Generally speaking, people of sixty years of age and over are not obliged to work to earn money. In other words**, kanreki** signifies the social sanction permitting entry into **Inkyo,** meaning retired life, though most Japanese elderly people continue to work. But now the concept of old age is changing greatly in Japan. Age sixty marks a universally accepted point in time for entry into the oldest generation in China (Friedmann, 1983). Consequently, in terms of social functioning, the years between fifty and sixty are a transition period in which Chinese men and women come increasingly to be seen by others and by themselves as old, while the years after sixty mark a clearcut turning point and are virtually always designated as the years of old age.

The marriage of one's children –particularly of one's sons – marks the beginning of old age in Indian society far more clearly than does the passing of a specified number of years. This is especially so for women (Vatuk, 1975). The arrival of grandchildren is strongly associated with the onset of old age in Indian and many other societies. The birth of a first grandchild also encourages self identification as an old person. For those persons who had their child at about eighteen and whose first

born also had a first child at eighteen, grandparenthood can come as early as age thirty-five or thirty-six. The effects of the family life cycle may have different implications for people living in different cultures. In societies, where marriage and child bearing occur at young ages, persons may achieve the "old age" status of grandparent while in their thirties as discussed earlier. In other contexts, where childbearing is delayed because of the desire of young women for education and work experience, persons attain this status at more advanced ages. Thus, even if persons are defined as "elderly" with reference to similar social roles, there are great differences among societies in the chronological age at which such roles are attained (United Nations, 1985).

Society has another way of classifying people by age. Anthropologists refer tothis as age-grading. It has been the most important basis of age distinction in many societies. Age is a very important element of social organization that anthropologists are convinced that age-grading is a universal feature in the assignment of social roles, rights and responsibilities in modern as well as pre-industrial societies though the nature of the criteria used in the distribution of roles varies. As people encounter the sequence of age-graded roles, rites of passage are one of the mechanisms used by society to indicate their movement from one phase of the life cycle to the next. Originally such rites were celebrated by highly ritualized ceremonies and had as their function the provision of an institutionalized means for facilitating the cessation of certain behaviour and the introduction of a new set of expectations (Hendricks & Hendricks, 1977).

Age-grading can be as powerful as chronological age in shaping a person's life. The rules of behaviour are often quite different for the various grades. This means that moving from adulthood to old age can have different implications, according to the rules that characterize a particular society's age-grading. Age-grading establishes guidelines as to who should do what kind of work and who owes what kind of obligation to whom, and so on. In a thoroughly age-graded society, everybody has a

pretty good idea of what he or she is supposed to be doing at a particular time of life. Kastenbaum (1979) observes that becoming an elder is often an improvement in status for the woman in age-graded societies.

A contribution towards an integrated concept of age was made by Birren (1959), in differentiating the concepts of biological, psychological and social age. Biological age refers to the position of an organism with respect to its remaining potential longevity. Psychological age refers to an organism's level of adaptability, that is, the state of those capacities which permit the individual to adapt to external and internal environmental demands. Social age is the individual's position in expected age-graded social roles and social habits. The concept of functional age has been added to these three different concepts of age.

A person's functional age is viewed as a composite index of his potential biological, psychological and social capacities, and his current or manifest ability to adapt competently and efficiently to environmental demands of working or living conditions. In other words, the more these three dimensions of an individual's functioning enable him to adapt successfully, the "less old" he or she is.

There is a plethora of terms in gerontological literature to refer to persons as they grow older, indicating the uncertainty prevailing in all societies towards the later years of life. 'Old', 'aged', 'elderly', 'mature' , 'senior citizens' , 'old old' and 'older people' are the commonly used terminologies. Some prefer to use the adjective 'older' to 'old' which (whether as noun or adjective) is falsely suggestive of the existence of a group clearly distinctive from the not-old. The same objection applies to the terms 'aged' and 'elderly' whereas the word 'older' does not have such dichotomous reference as we are all older than some and younger than some others. Even 'older' is extremely vague as far as chronological precision is concerned; so are the other age-terms (The Open University, 1979). The World Assembly on Aging preferred the term "the aging" as it highlights

the process of continuous aging of individuals even when they are already "aged" or "elderly"(United Nations, 1985).

Lesnoff-Caravaglia (1986) is vehemently critical of such terms. She observes that not only do meaningless euphemisms abound, but researchers adopt confusing labels such as the young old, the old old, the oldest old, the mature, the elderly, the very old, the aged, senior citizens, or the "risky" versus the "frisky" built upon their own characterizations of aging. She offers the following categorization scheme (developed jointly with Marcia Klys) : septuagenarians (70 to79 years old), octogenarians (80 to 89 years old), nonagenarians (90 to 99 years old), centenarians (100 to 109 years old), and centedecianarians (110 to119 years old). Yet the difficulties in finding a satisfactory terminology of "old age" continue. Perhaps this reflects the general unease in all societies about old age.

The Hindu scriptures divide the life of a man into four stages or **asramas** :**brahmacharya, grihastha, vanaprastha** and **samnyasa**. The first is the stage of study, discipline and celibacy, and the second that of the householder. The third stage, **vanaprastha**, starts when the hair of the householder turns white and he sees his son's son. He should relinquish his responsibilities to his sons and retire from the active pursuit of material life. He should leave the family (**kula**), the home (**griha**), and the village (**grama**), and go to the forest (**vana**) to live there as a hermit leaving his wife to the care of the sons. Though the presence of wife was permitted in the forest, he should withdraw from sexual relations and bring under control his senses of enjoyment. **Vanaprastha** is the preparatory stage for the final separation from the pains and pleasures of human life. In the final stage, the individual leads the life of an ascetic casting off all attachment (**samgam**)

with the world striving for the attainment of his spiritual goals and the final salvation (**moksha**). A staff, a begging bowl, and a few rags of clothing are his only belongings. A **samnyasin** or an ascetic is a person who has made complete **(sam)** renunciation (**nyasa**)of everything; a totally detached person

(Prabhu, 1961,). This, however, has been the scriptural ideal, but not the usual social practice. It is unlikely that the scriptural prescriptions of detachedness were ever practised to any significant extent. Even in the remote past, only a negligibly small number, that too belonging to the higher castes, would have adhered to the scriptural norms. In fact, observance of the four **asramas** was expected only of those who were born into the twice-born castes – **brahmans** (priests), **kshatriyas** (rulers) and **vaishyas** (merchants).Further, the scriptures do not articulate whether the women should observe the four **asramas**. The woman, according to the laws of Manu, should remain under the control of her father in childhood, under that of her husband in youth, and on the husband's death under that of her son. The **vanaprastha and samnyasa** stages, though not followed by most persons, have, however, a profound influence on the thinking and behaviour of people.

To sum up, it is evident that old age defies any specific definition. It is not a mere statistical categorization or fact. The social definition of old age depends on the norms of a particular society. Ageing and being an older person are essentially social and cultural phenomena.

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Aging Population in India: The Health System Role of Traditional Medicine

Unnikrishnan Payyappallimana

Introduction

India has experienced a major demographic transition in the past few decades resulting in a substantial increase in the aged population. Consequently there is increasing burden on the health system. Neither the current healthcare infrastructure nor the professional capacity is equipped to handle this situation. This is further challenged by the fact that there is no social security system in the country and over 80 percent of the health care is accessed through out of pocket expenditure. Changing social support systems, rapid urbanization, deteriorating environment further complicate the situation.

In this context, the article explores the relevance of traditional systems of medicine in the country for improving healthcare for the elderly population. The article briefly highlights certain unique principles and features of traditional systems of medicine in geriatric care by focusing on Ayurveda, the most popular traditional medical system in the country. The article takes two fold approaches to address the challenges i.e. from the point of view of individual care what measures are desired and from a health system focus what policy directions are needed to integrate these systems into geriatric care.

Indian life expectancy has increased by 25 years in the last 5 decades. This has resulted in tripling of elderly population in the country. India is going to become the second largest country in the number of elderly in the world. It is expected that by 2026, 12.4 percent of the population will be in the above 65 age category (Patwardhan 2012, Dey et al. 2012). Extrapolated figures indicate that elderly population (60+ age group) will be

100 million in 2013 and will raise to 198 million by 2030 (Government of India 2011). Two thirds of the elderly population live in rural areas and around half of them have poor socio economic status thus making health service a major challenge (Dey et al. 2012). Due to the diverse stages of social, political and economic development there is considerable disparity among Indian states in the demographic transition and their consequences. It is anticipated that the South India will face a faster transition as compared to the North owing to this. Another critical fact to take note of is that around half of the elderly population is dependent and 70 percent of elderly are women (Dey et al. 2012). It is estimated that 51% of Indian elderly will be women by 2016 and compared to males, women have poorer health status (Government of India 2011).

Health Systems Challenges in an Aging Society

International instruments such as the United Nations Human Rights Commission, Millennium Development Goals (MDGs) and the World Health Organization (WHO) have increasingly acknowledged access to appropriate healthcare as a human right. At the same time the situation of the aging population in the country is challenged by the fact that the health system is not adequately equipped to take care of these emerging needs. There is a huge out of pocket expenditure of almost 83% for outpatient care which is not covered by any insurance at all (Duggal 2007; 2009). Availability, accessibility and affordability of health services continue to be major issues. Declining social support systems, reduction in disposable income post-retirement, family nuclearization, lack of appropriate social security policies, increasing chronic disease morbidity, high diversity and heterogeneity in different regions in the country, reduction in post retirement earning, gender, caste and religious based inequities are some of the key contributing factors. Elderly health is also dependant on several other factors such as marital status, education, economic freedom, sanitation and so on (Dey et al. 2012). According to the 2004-2005 National Family Health Survey,

only 10% of the households had atleast someone in a family covered under any type of health insurance. Only the privileged groups of the society avail insurance coverage and most needy are left out. Often elderly are excluded from insurance coverage due to certain age limits or based on their previous health status (Dey et al. 2012). Due to reduction in income postretirement most are unlikely to be able to pay the insurance premium regularly.

Being a transition economy with huge diversity and disparity, the pattern of morbidity has been quite unique in the country. While infectious diseases continue to exist, chronic diseases have already reached epidemic proportions. This places a huge stress of the health system. According to the 60th round National Sample Survey around 8% of the elderly population is confined to home or bed and 27% of those aged 80 years are bedridden (NSSO 2006).

Traditional Health Systems and Their Role

The following section gives an overview of traditional systems of medicine and examines their role in addressing healthcare challenges of elderly. Traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being." (WHO 2002) Further the term complementary and alternative medicine (and sometimes also non-conventional or parallel) are used to refer to a broad set of healthcare practices that are not part of country's own tradition, or not integrated into the dominant healthcare system. This is a broad and inclusive definition which makes it difficult to find a region or a country without any form of traditional medicine. It is often known through a variety of names such as traditional medicine, alternative medicine, complementary medicine, natural medicine, herbal medicine, phyto-medicine, non-conventional medicine, indigenous medicine, folk medicine, ethno

medicine etc., based on the context and the form in which it is practiced. Chinese medicine, Ayurveda, Herbal medicine, Siddha, Unani, Kampo, Jamu, Thai, Homeopathy, Acupuncture, Chiropractic, Osteopathy, bone-setting, spiritual therapies, are some of the popular, established systems (Payyappallimana 2010).

There is an emergent interest in both developed and developing countries to integrate traditional medicine/ complementary and alternative medicine (TCAM) in public health systems. Diversity, flexibility, easy accessibility, broad continuing acceptance in developing countries and increasing popularity in developed countries, relative low cost, low levels of technological input, relatively low side effects and growing economic importance are some of the positive features of traditional medicine (WHO 2002, Payyappallimana 2010).

Though these systems differ in their approach to clinical principles or management methods they share a common worldview. According to this the macrocosm (outside universe) and microcosm (living being) are inherently related and have common elements. These systems also have similar perspectives such as ecological centeredness, an inclusive approach to non-material or non-physical dimensions, and holistic approach to health management considering physical, mental, social emotional, spiritual, ecological factors in health and wellbeing. "Fundamental concept is that of balance - the balance between mind and body, between different dimensions of individual bodily functioning and need, between individual and community, individual/community and environment, and individual and the universe. The breaking of this interconnectedness of life is a source of dis-ease,"(Bodeker 2009: 37).Other unifying attributes are their popular and public domain character and orientation to prevention and self help. Mostly these systems focus on the functional aspects of health and diseases, whole system approach to health, multi-causality, subjective, qualitative, individualized and personalized management and consider both physician and patients both as active agents in healing.

According to WHO between 60-80% of the population in developing countries and a growing percentage in developed countries continue to avail services of traditional medical systems (WHO 2002). However the slow official response shows the lack of correspondence between public choice in health seeking behavior and the policy processes in different countries. Proof of efficacy, quality, safety and rational use continue to be major challenges in the sector. Increase in chronic diseases, better awareness about the limitations of conventional medicine, growing interest in holistic preventive health, increasing evidence of clinical efficacy, better clinical care, easy access especially in rural areas and cost efficacy are some of the key reasons for the resurgent interest in traditional medicine. In countries like India the per-capita ratio of practitioners of TCAM is higher compared to conventional medicine. In rural areas easy access, availability and cost are key aspects of utilizing traditional medicine whereas in urban areas it depends on concerns about chemical drugs and interest in natural medicines, limitation of conventional medicine, greater information access are some of the reasons for accessing traditional medicine. Thus in a public health context availability, accessibility, affordability, utility, quality, efficiency and equity become relevant in accessing healthcare (Payyappallimana 2010).

Indian Context of Traditional Medicine

In the subcontinent varied forms of codified medical systems such as Ayurveda, Siddha, Unani or Tibetan medicine (Gso-wa-rigpa) have long coexisted along with a rich non-codified folk form of knowledge. There are also several allied disciplines of traditional medical knowledge such as yoga and several newly introduced knowledge streams. The codified knowledge systems like Ayurveda have evolved in last 3-4 millennia and have unique worldviews, conceptual and theoretical frameworks for health management. The current available oldest Ayurveda literature is codified in 300 BCE which

shows its antiquity. These systems have their distinctive understanding of physiology, pathogenesis, pharmacology and pharmaceuticals which are different from Western medicine. These systems have been institutionalized through national councils, uniform syllabus and education systems. In India there are around 800,000 licensed practitioners belonging to these medical systems, a huge human resource for any public health intervention. Much more diversity is available in the folk knowledge traditions otherwise known as local health traditions which are community specific and ecosystem specific. They use locally available medicinal plants and other resources for healthcare. They include an array of practices such as household level health practices (home remedies, food and nutrition, health related rituals and customs etc.) to specialized healers treating fractures, poison, pediatric ailments, skin disorders, mental health and so on. They are mostly orally transmitted, and highly dynamic. Though they differ substantially based on the ecosystem in which they are practiced they share common value systems and similar modes of transmission in communities. These are not legally recognized and often considered invalid yet continue to exist in communities due to social legitimacy and patronage.

Apart from these native traditions there also exists an extensive machinery of homeopathy practitioners which has been institutionalized in India and comes under the department of AYUSH[1], the Ministry of Health and Family Welfare. The traditional medical resources also include allied disciplines such as yoga, various approaches of meditation, breathing, martial arts, *marmachikitsa*, massage techniques which contribute to health and wellbeing. There are also new forms of complementary and alternative medical (CAM) knowledge which have been imported from other countries in the recent

1. AYUSH department under the Ministry of Health and Family Welfare is the apex body for regulating Ayurveda, Yoga, Unani, Siddha and Homeopathy systems in the country.

decades and have become popular like acupuncture, phytomedicine or herbal medicine, osteopathy, reiki, shiatsu, and so on which do not have formal recognition yet practised in India.

Life, Health and Aging in Ayurveda

This section examines how Ayurveda, a major Indian traditional medical system views aging and what healthcare response is feasible from the point of view of Ayurveda. CarakaSamhita, the olderst traditional treatise available today starts with a chapter on long life (*deerghamjeeviteeyam*). The mythological origins of ayurveda according to this chapter is that great ascetics disturbed by diseases in their religious observances due to worldly indulgence, gathered in the abode of Himalayas to seek a solution to the problem. Wishing for a long and healthy life they sent Bharadvaja as their representative to Indra, the king of devas, who had received the knowledge through a lineage originating from Brahma. Brahma in turn revealed this knowledge of life to the ascetics through Bharadvaja. Whereas the mythical origins and anecdotes may have layers of meanings intertwined in the cultural context what is most interesting is Ayurveda's pursuit for healthy and long life imprinted in these lines.

The term Ayurveda is comprised of two words Ayu (longevity of life) and veda (knowledge), the word Ayu is further explained as *sukhaayu* (happy life), *hitaayu* (sustained happiness), and *deerghayu* (long life) thus extending the definition of longevity to include a holistic approach to health and wellbeing. This perfectly signifies the role of Ayurveda in geriatric care. Health according to Ayurveda is a balance of structural and physiological principles (*dosa*s and *dhatus*) of the body, excretory mechanism (*mala*), and a balance of self (*atman*), sense organs (*indriya*) and mind (*manas*). Ayurveda has primarily a predictive and preventive approach to healthcare management with self awareness and self reliance as its focus. From this perspective health is a state when one is established oneself (*svastha*). This is

based on the understanding that each individual is born with a specific constitution and predisposition for health and disease. Maintaining the balance of one's constitution (which is unchangeable though tendencies can be modified to certain extent) is healthy state while promoting a positive approach to health and wellbeing.

Though the exact cause of aging is not discussed in detail, it is mentioned that it is a natural state of 'disease' (*svabhavabalaroga*) among other such six other states such as hunger, thirst, sleep, and death. Describing that no cause is needed for natural decay, Caraka says that the growth or deterioration depends on two factors such as *daiva* (effects of the past) and *purusakara* (efforts of present life). By stressing the importance of time (*kala*) Caraka says growth depends on place and time of birth; quality of seed and soil; diet; mind; natural mechanism; physical exercise; cheerfulness etc., which are essential for growth (Tiwari and Upadhyay 2009).

According to most Indian traditional medical systems there are three *dosas* (roughly correlated as humors) in the body namely *kapha* (nourishment principle), *pitta* (transformation), *vata* (movement and destruction). Starting from early stage of life, nourishment, transformative and movement and destruction factors will be strong respectively. In other words towards late stages of life *vata* principle manifests strongly in the body thus leading to diseases of neuromuscular and musculoskeletal conditions. Apart from this, each individual by birth acquires either singular or a combination of the characteristics of these *dosas* known as *prakriti* (physical and mental constitution). Similarly every factor such as seasons, geographical regions, tastes, food items, medicinal plants and so are classified on the basis of the relative preponderance of these *dosas*. These are cardinal principles in understanding the predispositions of health or disease, diet, lifestyle or suitable medicines for an individual. Equilibrium of these principles is the desired state of health.

Geriatrics is one of the eight core branches of Ayurveda since its written history. *Rasayana* or *jarachikitsa* mainly deals with

Elder Care Services

T.K.Nair

Social services for the elderly all over the world would fall into two broad categories: institutional care and community-based services.

Institutional Care

Institutional care in 'homes for the aged' emerged as a favoured form of care of the elderly by the state, and the religious orders and voluntary organizations when the family was unable, negligent or unwilling to provide care to the older members. Institutionalization isolates the elderly from their homes and the community, and hence is an undesirable form of care of the elderly.

The **dharmasalas, ashrams, maths and sadavartas**, that have been in existence in India, are quite different from the 'old age homes'. These are rest homes and retreats established by the religious institutions, erstwhile rulers, and pious individuals for the benefit of persons who wish to spend time in a religious atmosphere and to devote themselves to spiritual pursuits. They are numerous at pilgrimage sites and at other places of special religious significance to Hindus. Most such retreats are open to persons of all ages and both sexes, and many cater mainly to temporary visitors or pilgrims. But some are specifically designed for the longer term needs of older persons who intend to retire from active participation in worldly affairs and to concentrate on spiritual matters. Most of these retreats are supported by charitable donations, and provide accommodation and food to the residents free of charge, though some are intended for older people with means. Some accept an older person's remaining wealth and property in return for life-time shelter and care. Elderly persons, who have no family or who opt to live

among other older people in a religious atmosphere, are also looked after by these institutions.

In the 1500s and 1600s, those who were not part of the domestic work force in England were considered to be "problems" ; these included vagrants, criminals, prostitutes, paupers, beggars, lunatics, orphans, the aged, and the sick. Estes and Harrington (1981) are of the view that the development of social control systems such as institutionalization to handle those who could not or would not work was the response of capitalism to deal with these "problems" . The Poor Law of 1601, often referred to as "43 Elizabeth", confirmed the responsibility of the parish (the local community) for the maintenance of the poor who were not supported by their relatives. The law distinguished three classes of poor: the able-bodied poor, the impotent poor and children. The able-bodied poor, called "sturdy beggars", were forced to work in the "house of correction" or "workhouse". The impotent poor were people unable to work : the sick, the old, the blind, the deaf-mute, the lame, the demented, and mothers with young children. They were placed in the "almshouse" where they were required to help within the limits of their capacities. If the impotent poor had a place to live and seemed less expensive to maintain them there,the overseers of the poor could grant them "outdoor relief", usually in kind, sending food, clothes, and fuel to their homes (Friedlander, 1963). The Colonies adopted the Elizabethan Poor Law. However, in the United States of America, most of the almshouses and workhouses were established in large cities. In addition to outdoor relief in kind, the paupers were "farmed out" or "sold out" to the lowest bidder. A special type of farming out was the placement of widows, and infirm and aged paupers, for short periods, from house to house (Friendlander, 1963).The almshouse was the progenitor of the "home for the aged". Many almshouses were, in course of time, converted into or rechristened as homes for the aged. Initially religious and voluntary organizations have started "old age homes". The almshouse finally became a "home", achieving a "new status in the philosophy of scientific charity" (Haber,

1983). In the second half of the nineteenth century, organizations such as the "New York Association for Improving the Condition of the Poor" and their successors advocated institutionalization for all aged paupers. Their volunteers actively attempted to place every needy elderly person, including even those who resisted their charitable assistance, in institutions. By the beginning of the twentieth century, the segregation of the elderly into "homes" and "asylums" had begun to assume institutional form. Proprietary homes with high profit motives also began to flourish.

Most of the developed nations have a type of residence that can be described as a home for the aged, which houses older people in need of assistance and provides help with meals and housekeeping as well as with bathing, dressing, and other self-maintenance functions. People with needs for daily medical or nursing care are not ordinarily placed in homes for the aged, but are put in nursing homes. Another common form of institutional care for the elderly is the mental hospital. The fourth type of institutional care for the elderly is the geriatric hospital, which is a central feature of the British care system (Lawton, 1982).

Institutionalization represents the ultimate personal failure for the elderly and their family. "In fact, two-thirds of the elderly view institutions as the least desirable alternative possible, a sort of confession of final surrender, a halfway stop on the route to death" (Hendricks and Hendricks, 1977). There is adequate empirical evidence to prove that institutionalization is deleterious to the emotional health of the elderly, though some may have the benefit of a sheltered environment. The spectacle of older people living collectively, awaiting death away from family, is the ultimate tragedy of life (Puner, 1974).Townsend (1962), who made a well-known survey of residential institutions and homes for the aged in England and Wales, provides a mass of empirical data to portray the misery of many elderly residents in such institutions. His observations on the effects of institutional life on the residents are very disquieting.

> In the institution people live communally with a minimum of privacy, and yet their relationships with each other are slender. Many subsist in a kind of defensive shell of isolation. Their social experiences are limited, they lack creative occupation and cannot exercise much self-determination, and they are deprived of intimate family relationships. The individual has too little opportunity to develop the talents he possesses and they atrophy through disuse. He may become resigned and depressed and may display no interest in the future or in things not immediately personal. He sometimes becomes apathetic, talks little and lacks initiative.

Townsend based on the strength of his survey data, asserts in an unambiguous manner that homes for the aged are not necessary.

Ideology of Deinstitutionalization

Two ideologies responsible for segregation of the elderly, according to Estes and Harrington (1981), are separation and medicalization. The first is predicated on the belief that older people are special and different, with needs requiring special and different old age policies and services; and the second is based on the premise that old age is a process of inevitable physical decline that is best treated by medical interventions. The ideology of separatism as the best way to approach the "old-age problem" has justified age-segregated programmes such as congregate housing, residential care and nursing homes for the elderly. The medicalization ideology, with its orientation toward individual rather than structural aspects of aging, has obscured an understanding of aging as a socially generated problem.

The highly visible and growing economic costs of institutionalization, and the individual as well as the social costs of stigmatization resulting from segregated care led to a global trend towards deinstitutionalization. In the West, the pressure for moving mental patients "back to the community" in 1950s was so strong that it has become an important ideology, around

which a diverse number of interest groups and professional bodies have converged. Social scientists have concluded that the institutions themselves were obstacles to the treatment of the mentally ill and urged community mental health programmes instead. Critiques of mental institutions such as Goffman's (1961) "Asylum" brought about a consensus that mental hospital care was simply custodial care, and not therapeutic.

The emergence of the deinstitutionalization ideology has profound influence in the advocacy for shifting the elderly from nursing homes and residential institutions back to the home and the community. Estes and Harrington (1981) are of the view that the pressures for deinstitutionalization of the elderly and the new ideology of "alternatives of institutionalization" in America are influenced by a combination of factors such as the growing concern of aging advocates, fiscal crisis in government, the powerful interests of the health care industry, and the efforts of health and social services agencies to command a large share of policy dollars. They warn that in the enthusiasm for deinstitutionalization and community-based services, the focus should not merely be on services. The political, economic and social factors that disenfranchise the elderly in society should not be lost sight of.

Community Care of the Elderly

Community care of the elderly in simple words is any form of care of persons outside of an institution by means of health and other social services based in the community. A number of research experiments have shown that it is possible to keep elderly people with very high levels of disability in the community (Means and Smith, 1985). Since there is not a better substitute for the family as a source of support for the elderly, community-based programmes have the advantage in facilitating the involvement of the families in enhancing the well-being of their elderly members and integration of the elderly in society. Community-based services in the Western countries include home-helps (also called homemakers, home-health aides), portable meals (or meals on wheels), friendly visitors, day care (also called geriatric day hospitals), respite services, and

substitute family care (foster homes) (Beattie, Jr., 1976). Bell (1973) identifies five basic components of a community care programme in a given geographic region: health maintenance, home-help, mobile meals, transportation services, and counselling, crisis intervention, and advocacy.

Community is an area in which a group of people live, or a group of people living in an area, or a group of people who have close ties or common interests. It is more than a physical place, it is a vehicle for social participation and collective action (Checkoway, 1988). "Care" does not mean something given by an active younger person to a passive older person. The word can also mean a service which is given to a person by an organization. It also includes something which elderly people can actively take part in. Similarly, community care programme for the elderly does not at all imply that everything is done for them and they remain as passive recipients. On the other hand, the programme envisages the active participation of the older persons in decision-making and implementation.

Checkoway's Five Models of Community Practice

	Goals	**Strategies**	**Examples**
Community Planning	Set goals; solve problems	Plan programmes at the community level	District planning councils, area aging agencies, municipal aging offices, elderly resident councils
Community Advocacy	Represent interests in established institutional arenas	Legislative lobbying, administrative advocacy, judicial representation	Elderly advocacy groups, legislative lobbyists, agency consumer repres--entatives, legal services attorneys

Community action	Alter power relations; reallocate resources; create change	Identify issues, and organize people for social and political action	Retired persons' associations, elderly consumer groups, elderly residents' organizations
Community education	Develop knowledge, skills, and attitudes ; increase confidence, competence, and capacity	Raise conscious--ness and develop capacity around awareness of problems and causes	Adult learning, self-help, Education and training progra--mmes, media campaigns
Community service	Design programmes; deliver services	Develop community-based programmes and services	Churches, voluntary associations, neighbourhood organizations

Social work, according to the National Association of Social Workers (1973), is the "professional activity of helping individuals, groups, or communities to enhance or restore their capacity for social functioning and to create societal conditions favorable to their goals". "Community care" has been a slogan in social work for about five decades. Probably the most clear element in the origins of community care is the movement for deinstitutionalization of the social services. Community care is also referred to as social care in the community. It is defined as "those aspects of social work concerned with enabling resources, which are or might be available, to be used more effectively in the provision of social services to clients" (Payne, 1986). Community care is concerned with all kinds of resources: personal, economic, social and political. Social workers are a significant part of the provision of community care because they help people to make effective use of their own personal resources

Old Age in an Indifferent Society

T.K.Nair

Demography of Aging

Longevity is a triumph of humanity. It is the result mainly of declining fertility and mortality rates, and increasing survival at older ages. The global population of persons aged 60 years or over is projected to increase to one in five by 2050 according to the estimates of UNFPA and Helpage International (2012). The demographic profile of India in the UNFPA report poses great social, economic and political challenges to the central and state governments, families and non-governmental organizations.

	2012	2050
Number of persons aged 60 and above (in million)	100.213	323.092
Percentage of persons aged 60 and above	8.0	19.1
Number of persons aged 80 and above (in million)	9.249	44.218
Sex-ration :2012 (Men per 100 women)	92 (60+) 82 (80+)	
Life expectancy at birth: 2010-2013	64 (Men) 68 (Women)	
Life expectancy at age 60 : 2010-2015	16 (Men) 18 (Women)	
Percentage of currently married : 2011-2012	83 (Men) 40 (Women)	

Internationally comparable statistics on population aging for 195 countries enable countries to be ranked according to life expectancy at birth, life expectancy at age 60, and healthy life expectancy at birth. Japan ranks first in all three categories: life

expectancy at birth of 84 years ,life expectancy at age 60 of 26 years, and healthy life expectancy at birth of 75 years (average figures for men and women) . This provides the norm against which other countries can be ranked. The report card for India shows:

- Life expectancy at birth : 66 years. World ranking :143/ 195
- Life expectancy at age 60: 17 years. World ranking : 141/195
- Healthy life expectancy at birth: A newborn can expect to live 53 years free from disability. World ranking : 122/177

In less than four decades, India will witness more than a three-fold increase in the elderly segment (60+) of its population, and quite strikingly, nearly a five-hold increase among the "old old" from 9 million to 44 million. Gender-wise, there is a distinct feminization of old age with life expectancy more skewed for women than for men. More significantly, widowhood is a serious reality as women grow older. Theirs is a life time of gender-based discrimination. As the number and proportion of the elderly grow faster than any other age group, there are serious concerns about the capacities of the central and state governments to address the social, economic and other challenges associated with the demographic transition. In the developed countries, economic development preceded population ageing. But in India, the reverse trend is being witnessed. The steadily increasing elderly population in India raises many questions. How will we, and the future generations, deal with the challenges posed by the aging of our population? Can it be ensured that growing old will not mean, for the majority, a further sliding down into poverty, starvation and dependency? How can families be supported so that they will be able to provide satisfactory quality of care for older members? How can the elderly themselves be empowered to look after themselves effectively?

Family and the Elderly

Indian family has been undergoing changes in its structure and functions. Some sociologists assert that the joint family is breaking down, while some other social scientists are of the view that joint family with joint residence was not the norm. They say that joint family values are not to be interpreted as joint residence.

Joginder Kumar (1974) observes from his study of families from TamilNadu, Delhi, Uttar Pradesh and Rajasthan :

> There is considerable evidence that in North India, the general pattern of the establishment of a nuclear family is the result of the breakage of existing joint families. In contrast to this, in the southern part of India, the tradition appears to be the establishment of a separate home, shortly after marriage.

The first large scale rural study of the elderly was carried out by Nair (1980) in 200 villages selected on a probability sampling basis in Tamil Nadu state, and the findings were as follows:

Type of Family*	Per Cent of Families
1. Single person household, subnuclear, supplemented subnuclear.	22.63
2. Nuclear, supplemented nuclear	59.95
3. Lineal joint, supplemented lineal joint, collateral joint, supplemented collateral joint, lineal collateral joint, supplemented lineal collateral joint.	15.22
4. Others	2.20

*Classification by Kolenda, Pauline.(1987). **Regional Differences in Family Structure in India.** Jaipur :Rawat Publications.

Even in tribal societies, the joint families are in a minority. A study of Kota tribe (Varadharajan, 1982) in Tamilnadu indicated that only 10 per cent were joint families.

In the book "No Aging in India: Alzheimer's, the Bad Family, and Other Modern Things", Cohen shows that old age is a cultural construct participating in other forms of knowledge

and power: biomedical, sociological, colonial, and historical. Through these imbrications and excesses, the old person is no longer seen as himself or herself, but instead as a metaphor for the moral decay of the family and the nation. Cohen initially went to Benares looking for the etiology of senile dementia, but to his surprise, he found a set of languages and ideologies that denied the very existence of the plaques and tangles he was searching for. There was no aging in India – at least not until Western ideologies had seeped into the fabric of the nation. Alzheimer's was not a disease of the brain, but a disease of the family. The decay of family ties, and not some etiologic agent of disease, was seen as the causative factor of particular forms of dementia. Increasingly, Cohen became aware that Alzheimer's was not a fixed, ontologically secure entity but a "set of local and contingent practices rooted in culture and political economy". What began as a simple anthropological study became a much larger exploration of how modernity and discourse shape the treatment and alienation of aging people.

The family in India continues to be the provider of care for the elderly though the quality of care often is not satisfactory. The capacity of the family to provide care to the older members depends on three factors: the social and economic situation of family; whether it comes within the ambit of a social security system or not; and the nature and structure of the family itself (Chawla, 1988). In many families, though the elderly and other dependants are taken care of, they are "looked upon sometimes as people who do not have legitimate claims for their support by the family" which affects the emotional security they need (Devanandam& Thomas, 1966).

Income Security

Most of the elderly persons, having worked in agricultural and other unorganised sectors, have no source of income in their advanced years. Since a large number have always started their life in poverty, they have not saved anything during their working

years. The social security benefits are available only to a small section of the population and the quantum of social assistance to the destitute elderly is meagre. Hence "to be elderly under conditions of poverty can only spell continuous vulnerability, and a life devoid of even the most rudimentary human dignity" (Chawla, 1988).

Djurfeldt and Lindberg (1980), two Swedish scholars, undertook an intensive study of the introduction of western medicine in a village (Thaiyur) situated near Chennai city, and they observed that death is often an undramatic "natural event" in old age for the under and malnourished villagers who spent many years in hard labour.

> We remember that "old age" is the most common cause of death among adults. We now understand part of the reality behind that classification. Sometimes death in old age is a euphemism for death due to starvation.

Currently available old age pension schemes for the poor, which are being implemented by the states, are grossly inadequate in scale and coverage, and illiberal in their qualifying criteria. Social assistance for the elderly has been premised on the assumption that only the destitute older persons need state support. Thus, old age pension schemes seem to be aimed at substituting the family rather than strengthening it by enlarging its capacity to look after the needs of the elderly members. A major reform of these schemes should be topmost in the social security agenda.

Corruption is rampant at different stages of the OAP scheme across the Indian "bribe republic". For instance, the unholy nexus between the taluk office officials at Coimbatore and the document writers operating outside charging Rs.3,000 as bribe for speeding up action on the old age pension application was reported in the newspapers.

India need not wait until it becomes affluent to evolve an effective social protection floor. In our context, social security has to be integrated with anti-poverty programmes. While anti-

Older persons are resources of the community. They should not be viewed from the social-problem perspective. Their needs are to be addressed as their rights that are due from the state and the society. Prof.T.K.Nair's book takes a critical look at many issues concerning India's elderly.

- Prof. K.V.Ramana,
Formerly Vice-Chancellor,
Andhra University.

Old People in an Indifferent Society is an excellent collection of articles edited by Prof.T.K.Nair.

- Prof.H.M.Marulasiddaiah,
Formerly Professor of Social Work,
Bangalore University.

International Federation on Ageing (IFA) is a global non-governmental organisation. IFA's mission is to respond to the need for information on policies and practices across the world, and to provide a reliable platform for information exchange. Prof.Nair's book Old People in an Indifferent Society would stimulate debate on different aspects of ageing in India.

- Dr.K.R.Gangadharan,
President,
International Federation on Ageing

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ISBN 819233263-2

Price : 200/-