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Health Care

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Context:

India is home to 1/8th of world's older persons (60+) and accounts for 100 million of them which is 9% of total Indian population. Majority of Indian older persons live in rural areas and like many countries, in India also there are more females than males in 60+ age groups. Human life expectancy is steadily on the rise and increasing number of persons is achieving longer survival. This sense of triumph however is also accompanied by presence a variety of physical and mental health problems in addition to psycho-social and financial problems. Older people are increasingly liable to become physically, financially and emotionally dependent on others. The socio-economic challenges of old age negatively impact their health status also.

2. Older persons suffer from a host of chronic age-associated *non communicable diseases.* These conditions can be broadly divided into three groups: preventable chronic metabolic-vascular diseases related to life style factors such as diabetes, high blood pressure, heart disease, stroke etc.; diseases related to prolonged exposure to environmental risk factors such as cancers various organs, chronic obstructive lung diseases etc.; and diseases related to the biological decline of ageing such as dementia, cataract, sensory neural deafness, prostatic enlargement, osteoporosis, arthritis etc. In addition due to decline in immunity and changes in organ structures older people are also at high risk of developing various *infectious diseases* like tuberculosis, pneumonia, urinary tract infection, diarrheal diseases, dermatitis etc. Older persons are also prone to deficiency of multiple nutrients, among them deficiency of fibres, vitamins, iron and trace elements are of significance from health status point of view. Consequent to above mentioned morbidities, older people are prone to multiple disabilities involving mobility, vision, hearing and chewing which often result in falls, fractures, immobility and frailty. Older person also are susceptible to a host of mental health problems possibly more than younger individuals in the form of depression, dementia, anxiety

disorders etc., in addition to sense of neglect, loneliness, isolation and discrimination. Forgetfulness or loss of memory (not conforming to dementia) is frequent concern in old age. Issues like fear of ill health, terminal life in pain and distress, death of self or spouse or children are some of the universal concerns of old age. Since health is not only a state of physical and mental well-being, but also a state of emotional, social, financial and spiritual well- being, it is expected that old age health care has to address all these issues.

3. Health in old age is often considered as a constellation of disease and disabilities by not only the lay public but also medical professionals, researchers and policy makers. On the other hand health in later years is a reflection of genetic endowment, life style and the environment in which one has lived. So a life course approach to old age with emphasis on health promotion and disease prevention is essential to achieve active and health ageing, as has been advocated by the World Health Organization. Achieving active and health ageing requires awareness in the population and policies and programmes by the state.

This paper deals with health and health care issues in old age from active and healthy ageing perspective.

II. Urgent Issues:

4. **Public Health Care**: Majority of older persons are poor and live in villages and need affordable and accessible health care. Primary health care system therefore needs strengthening and National Program for the Health Care of the Elderly (NPHCE) needs to be expanded all over the country and implemented by the states in toto.

5. **Private Health Care and Health Insurance**: In the foreseeable future public health care alone cannot provide universal health coverage and heavily needs supplementation from the more expensive private health care. Innovations in health care insurance are therefore urgently needed to create insurance policies that are elder and poor friendly.

6. **Integrated System of Medicine**: With maintenance of health and prevention of disease and disability as the main objective, *Ayurveda* and other indigenous systems of medicine are often utilized as affordable and effective source of health care by older persons including those living in rural and remote areas. These systems need to be promoted and offered to older persons as an alternative or complementary to modern system of medicine.

7. **Care of the very old, lonely; and those with dementia and terminal illnesses**: There is an urgent need to evolve policies and programs for effective provision in the areas of home care, palliative care, respite care, long term care and hospice care to address the needs of these patients, who are at a greater disadvantage

8. **Training of Health Care Providers**: Enormous burden of physical and mental health related morbidity of older population in India requires a very large number of trained health care givers to deal with these problems in diverse settings such as within older persons' own homes, families, communities, hospitals, nursing homes, old age homes, day care centers, assisted living facilities, chronic care facilities etc. Training is needed for both formal and informal cares as well as for the older persons to care for themselves.

9. **Creation of Mass Awareness**: There is a need to sensitize the society as a whole to various issues concerning health of the elderly viz their, social, psychological, economic, and spiritual needs in old age. Political leaders, bureaucrats, professionals, families, public at large and the older persons themselves need to be targeted through various information education and communication media. Education on health promotion and disease prevention based on life course approach should be specially focused.

III. Relevant Provisions of Health Care in the NPOP, 1999 and MWPSC Act, 2007:

10. The National Policy for Older Persons, 1999 provides the following health care measures:

(i) Health care needs of older persons be given high priority. The goal should be good affordable health services, very heavily subsidized for the poor and a graded system of user charges for others. It will be necessary to have a judicious mix of public health services, health insurance, health services provided by not for profit organizations including trusts and charities, and private medical care. While the first of these will require greater State participation, the second category will need to be promoted and the State, the third category given some assistance, concessions and relief, and the fourth encouraged and subjected to some degree of regulation, preferably by an association of providers of private care.

(ii) The primary health care system will be the basic structure of public health care. It will be strengthened and oriented to be able to meet the health

care needs of older persons as well public health services, preventive, curative, restorative and rehabilitative, will be considerably expanded and strengthened and geriatric care facilities provided at secondary and tertiary levels.

(iii) The development of health insurance will be given high priority to cater to the needs of different income segments of the population and have provision for varying contributions and benefits. Packages catering to the lower income groups will be entitled to state subsidy.

(iv) Trusts, charitable societies and voluntary agencies will be promoted, encouraged and assisted by way of grants, tax relief and land at subsidized rates to provide free beds, medicines and treatment to the very poor elder citizens.

(v) Private medical care has expanded in recent years offering the latest medical treatment facilities to those who can afford it. Where land and other facilities are provided at less than market rates, bodies representing private hospitals and nursing homes will be requested to direct their members to offer a discount to older patients.

(vi) Difficulties in reaching a public health care facility will be addressed through mobile health services, special camps and ambulance services by charitable institutions and not for profit health care organizations. For the old who are chronically ill and are deprived of family support, hospices supported or assisted by the State, public charity, and voluntary organizations will be necessary.

(vii) Assistance will be given to geriatric care societies for the production and distribution of instruction material on self-care by older persons and material for the use of family care givers.

(viii) The concept of healthy ageing will be promoted. It is necessary to educate older persons and their families that diseases are not a corollary of advancing age. On the contrary, preventive health care and early diagnosis can keep a person in reasonable good health and prevent disability. Health education programs will be strengthened. Programs will also be developed targeting the younger and middle age groups to inform them how life styles during early years affect health status in later years. Mental health services

will be expanded and strengthened. Families will be provided counseling facilities.

(ix) Non-governmental organizations will be encouraged and assisted through grants, training and orientation of their personnel and various concessions and relief to provide ambulatory services, day care and health care to complement the efforts of the State.

(x) The policy recognizes the importance of trained manpower. Medical colleges will be assisted to offer specialization in geriatrics. Training institutions for nurses and for the paramedical personnel need to introduce specific courses on geriatric care in their educational and training curriculum. In service training centers will be strengthened to take up orientation courses on geriatric care.

11. Chapter IV of the Maintenance and Welfare of Parents and Senior Citizens Act, 2007 envisages that the State Government shall provide:

(i) beds for all senior citizens in Government hospitals or hospitals funded fully or partially by the Government as far as possible;

(ii) separate queues for senior citizens;

(iii) facility for treatment of chronic, terminal and degenerative diseases is expanded for senior citizens;

(iv) research activities for chronic elderly diseases and ageing is expanded;

(v) Earmarked facilities for geriatric patients in every district hospital duly headed by a medical officer with experience in geriatric care.

12. Chapter III of the Maintenance and Welfare of Parents and Senior Citizens Act, 2007 envisages that the State Government may establish and maintain such number of old age homes at accessible places, as it may deem necessary, in a phased manner, beginning with at least one in each district to accommodate in such homes a minimum of one hundred fifty senior citizens who are indigent. It may also prescribe a scheme for management of old age homes, including the standards and various types of services to be provided by them which are necessary for medical care and means of entertainment to the inhabitants of such homes.

IV. Assessment of the Relevant Schemes and Programmes

13. **Public Health Care**: Parameters to evaluate health care viz. availability, accessibility, affordability, acceptability and quality of health care in the existing primary health care system are not robust. Though the primary health care system has been strengthened after implementation of National Rural Health Mission since 2005, there was no qualitative or quantitative change in old age care in grass root level, as the Mission focused mostly on maternal and child health.

14. **National Program for the Health Care of the Elderly (NPHCE):** Responding to the social needs, national policies and legislations; and international commitments, Ministry of Health & Family Welfare, Government of India, launched the National Programme for Health Care of the Elderly in 2010. The vision of the NPHCE is to provide accessible, affordable and high-quality long-term, comprehensive and dedicated care to an ageing population; creating a new "architecture" for ageing; to build a framework to create an enabling environment for "a society for all ages" and overall to promote the concept of active and healthy ageing. Specific objectives of NPHCE are to provide an easy access to promotional, preventive, curative and rehabilitative services to the elderly through community based primary health care approach, to identify health problems in the elderly and provide appropriate health interventions in the community with a strong referral backup support, to build capacity of the medical and paramedical professionals as well as the care-takers within the family for providing health care to the elderly, to provide referral services to the elderly patients through district hospitals, regional medical institutions and to promote convergence with National Rural Health Mission, AYUSH and other line departments like Ministry of Social Justice and Empowerment.

Core strategies to achieve the objectives of the programme include community based primary health care approach including domiciliary visits by trained health care workers, dedicated facilities at District Hospitals with additional human and material resources, dedicated tertiary care facilities at regional medical institutions to provide state of the art care and a platform for postgraduate medical training and undergraduate of health personnel at all levels. In addition the NPHCE also aims at promoting health awareness for the advancing years through mass media, folk media and other communication channels to reach out to the target community. The programme has been initiated in 100 backward and remote districts over 21 States with 10 bedded wards in each district hospital, dedicated service at CHC/PHC level, home visit, distribution of medicines, aids and appliances at the most peripheral dispensaries in the health system. In addition 8 regional medical institutions in different parts of the country were strengthened with tertiary services in 30-bed wards, daily out-patient

service, post-graduate courses in geriatric medicine, focused research in old age health and training facilities for different levels of health workers.

NPHCE needs to be expanded to all districts of the country and all large states should have a regional institution to ensure dedicated old age services and to enhance trained man-power in old age care. There is a need for greater integration of NPHCE with other old age care programmes at central and state level and closer partnering with family, community and civil society organizations working for older people.

NPHCE should also be linked to the Integrated Programme for Older Persons (IPOP) of the Ministry of Social Justice which provides basic amenities like shelter, food, medical care, and entertainment opportunities. Access to some of the projects/programs under the revised Scheme of IPOP for assistance are Maintenance of Old Age homes, Respite Care Homes, Continuous Care Homes, Mobile Medicare Units, Running of Day Care Centers for Alzheimer's Disease/Dementia Patients, Physiotherapy clinics for older persons etc can make qualitative change in the lives of older people.

15. **Private Health Care and Health Insurance**: Quality private health care is at best a dream and very few can afford it. Health insurance is an important pillar to achieve this dream. Insurance can also give coverage for universal health care. Presently, however, permissible entry age into health insurance excludes many older persons and denial of proposals and renewability without satisfactory reasons needs supervision. Rashtriya Swasthya Bima Yojna (RSBY) needs reforms to ensure that older persons from any district are compulsorily included. Finally, there is no effective coverage for different components of health care such as OPD care, long term care, palliative or terminal care.

16. **Access to AYUSH System of Medicine**: Practitioners of indigenous systems of medicine are consulted in good measure especially in rural areas because they are readily available there and care provided by them is more affordable. Indigenous systems such as Ayurveda and other methods of therapy are practiced with maintenance of health and disease prevention as their main objective and are therefore elder friendly. Many symptoms can be effectively treated by these systems but a health care provider coming from a particular stream of therapy and without an integrated holistic training is not able to fully handle a medically compromised subject.. There is a need for creating awareness of such treatment options among older people and their care givers.

17. **Long term care and palliative care**: Existing primary health care structure does not address issues of home care, family based care, palliative care, respite care

and long term care which are important for vulnerable older persons. In spite of the fact that loneliness, isolation, bereavements and depression are a part of life in old age and that Alzheimer's disease together with its sinister effects is now a major challenge affecting millions of older persons and their families in India, care of such older persons has not been given the required priority in our country. While strengthening the mental health services the concerns of older people also needs to be taken into consideration.

18. **Training of Health Care Providers**: In the existing primary health care system, health care providers do not have the training and competence to take care of older persons. The concept of "Age Friendly Primary Health Care" advocated by World Health Organization has identified the issues that affect old age care in Primary Health Care and has also recommended ways and means to address these issues. This concept needs to integrate into the functioning of Primary Health Care all over the country. Currently, several players both from Government and NGOs are providing training to a variety of health and social care providers. The NPHCE envisages training of health care workers at all levels as an important activity and has provided funds for that. The training activities in National Initiative on Care for Elderly (NICE) project developed by National Institute of Social Defense wing of the Ministry of Social Justice and Empowerment can be dovetailed into NPHCE activities to develop a cadre of frontline personnel of geriatric care givers and thus to generate a skilled manpower.

19. **Creation of Mass Awareness**: Acceptance of failing health and dependency as a part of old age is a highly prevalent mindset among older persons and the people around them. A sense of fatalism seems to set in old age so that the initiative for accessing health care is lost. They come to believe that it is all a part of ageing and nothing can be done about it. Consequently, they become indifferent to many things in life including the simple and affordable self-care practices like care of their own food, engagement in physical and mental exercise, social and spiritual relaxation and even for undergoing regular health check-ups. Awareness of diverse issues of ageing for public at large and health education targeted for specific segments of population are required.

V. Need for the Future

20. The short-term and long term future strategies are:

A. Short Term (next 3 years)

(i) **Creating mass awareness -** Disseminating information about older persons' health issues to older persons and their families, public at large, legislators,

bureaucrats, police and school students though electronic and print media. A weekly program of one hour duration should be introduced in Doordarshan.

(ii) **Health care system –**

a) Strengthening of Primary Health Centres through implementation of NPHCE interventions, with other national health programmes, state/ local health programmes, NGOs, and with private sector through public private partnerships so as to render them capable of providing basic and specialized geriatric services including home care and palliative care, and rehabilitation care and services.
b) Reaching the isolated and immobile older patients through mobile medical units from District Hospital or CHCs or NGOs.
c) Making provisions in RSBY or similar insurance schemes to provide a financial assistance for medical expenses in accidents/injuries, heart attacks, stroke, cancer, cataract surgery and other disease conditions;
d) Provision of separate beds, OPDs, helpdesk, registration and pharmacy counters for older persons and a dedicated nodal officer in each District Hospital; and
e) Setting up help lines for older persons at national and district levels.

(iii) **Health Care Provider –**

a) Imparting training to medical professionals and paramedics in medical and nursing colleges and to family and community cares in regional training institutions of central and state governments ;
b) Old age disability and impairment screening services every six months for 80+ persons to be provided by health workers provided in NPHCE; and
c) Encouraging the use of cost effective assistive devices developed and marketed at an affordable cost with assistance of Department of Science and Technology for old age disabilities.

(iv) **Community and NGO initiatives–**

a) Setting up day care/recreation centers at convenient distances which could also function as awareness/health education centers (e.g. awareness of bad effects of tobacco use, unhealthy diets, alcohol and physical inactivity) and as social and cultural centers;
b) Arranging health camps in the community; and

c) Provision of nutritional supplementation for the oldest old, widowed elderly and disabled older persons below poverty line (BPL).

B. Long Term (next 5 years)

(i) **Health Insurance -** Providing fully subsidized care for the poor and for 80+ and a graded system of chargeable care for other users through innovative health insurance schemes. Also increasing the cover to Rs.1 lakh in place of existing Rs. 30000/- under Rashtriya Swasthya Bima Yojna (RSBY).

(ii) **Infrastructure Development –**

a) Regulating and monitoring of establishment and management of health establishments in incorporating "Age Friendly Health Facility" principles in the country through a set of uniform guidelines; (b) Setting up of National Centre of Alzheimer's Disease and Dementia;

b) Setting up of memory clinics, day care centers, respite care facilities for demented and disabled older patients in District Hospitals and regional institutes under NPHCE; and ; and

c) Setting up of National Institute of Ageing**.**

(iii) **Legislations should be enforced**

(a) Earmarking 10% of facilities e.g. indoor and OPDs earmarked for older persons in all private hospitals and this condition should be mandatory for licensing a private hospital;

(b) Dementia should be declared at par with physical disabilities;

(c) Measures should be taken to strengthen human rights obligations and duties, and to bring public, private and voluntary health care facilities within the scope of human rights legislation.

The views and opinions expressed in this paper are those of the Authors and do not necessarily reflect the views and opinions of the Government.