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Health Of The Elderly In India: Challenges Of Access and Affordability

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Abstract

The elderly population in India is increasing rapidly, creating major challenges related to healthcare access and affordability. Most elderly people live in rural areas and belong to economically weaker sections of society. Many suffer from chronic diseases, reduced mobility, and lack of proper healthcare facilities. Social factors such as gender inequality, widowhood, illiteracy, and dependency further affect their health conditions. The study examines the major barriers faced by elderly people in accessing affordable healthcare services in India. It also analyzes the role of income, employment, insurance coverage, and social support in determining healthcare access. The research is based on descriptive and analytical methods using secondary data from reports, surveys, and health studies. Findings show that limited financial protection, low awareness of welfare services, and inadequate rural healthcare infrastructure increase the vulnerability of elderly people. Government initiatives such as Ayushman Bharat have improved insurance coverage, but significant gaps still remain. The study concludes that stronger healthcare policies, improved awareness, and accessible geriatric care services are essential for ensuring healthy aging in India.

Key Words: Elderly Health, Healthcare Access, Affordability, Rural Elderly, Health Insurance, Geriatric Care, Social Security, Healthy Aging, India, Public Health.

Introduction:-

A few important characteristics of the elderly population in India are noteworthy. Of the 12% of the population who are elderly, 2/3rd living in villages and nearly half are of poor socio-economic status. Half of the Indian elderly are dependents, often due to widowhood, divorce, separation and a majority of the elderly women of

the humanity of the elderly living alone, more are women than men. Thus the majority of elderly reside in rural areas belong to low SES and are dependent upon their families.

While the Southern states (Andhra Pradesh, Karnataka, Kerala, and Tamil Nadu) may be considered the biggest drivers of aging in India, other Indian states (notably, Haryana, Himachal Pradesh, Maharastra, Orissa and Punjab) are also experiencing an elderly population boom, largely in rural areas. Large-scale studies of the health behaviours of the growing elderly Indian population are scares. However, information gathered from numerous surveys and regional and local studies point to the high prevelance of several risky behaviours, such as tobacco and alcohol use and physical inactivity.

The elderly experience a greater burden of aliments as illness, sickness, injury and poisoning compared to other age groups. The elderly most frequently suffer from cardiovascular illness, circulatory disease and parasitic diseases. The mixed disease burden among the Indian elderly places uniques demands on the country's public healthcare system. In India, we began with a perusal of the larger health scenario in India. Finding that "healthcare, far from helping people rise out of poverty, has becomes an important cause of household improvements in recent decade, hide vast regional and social disparities.

The aim of this research, therefore, is to characterize and describe specific challenges in the domains of access and affordability, and the likely determinants of such challenges that must be addressed in the design and implementation of future heath policymaking for elderly people in India.

Social determinants of Access:- A closer look at the literature on access to healthcare reveals variation across an age gradient. Older Indians have reported higher rates of out-patient and inpatient visits. The age gradient in elderly health access is overlaid by social determinants of health. For one, there is a feminization of the elderly population according to 2001 census. The gender ratio among the Indian elderly aged 60 years and older is 1028 females for 1000 males. Unmet health needs are more pronounced among the 33.1% of the elderly in India who in 2001 were reported to have lost their spouses of whom a larger relative proportion is female (~50% widow and male ~15% widower).

In addition to gender and marital status, religion, caste, education, economic independence and sanitation have bearing on elderly health. Number of disease suffered by an elderly person, calculated independently for rural and urban populations, including age, gender, literacy, availability of drinking water and a toilet facility and household monthly consumption expenditure. Another study of Uttar Pradesh and Maharashtra found that OLDER elderly (70+ years old) were significantly less likely to seek treatment compared to the 60-69 age category likely to seek treatment in UP and Maharashtra, respectively.

The stigma of aging, as well as the health and social condition the elderly commonly face is another social barrier to access health, manifest in the Indian case in unique ways [World Health Organisation, 2002]. Patel and Prince's qualitative study (2001) on the cultural perception of mental health needs among the aged in Goa, India, revealed that despite being frequently observed in the elderly population certain mental health deficits were not acknowledged as health needs. Conditions like dementia are viewed as normal aging and depression construct as the result of neglect by family. Such cases were therefore not considered the purview

of health professionals and were more frequently acknowledged and addressed by community heath services in the medical sector are limited and thus most care and support was provided ad-hoc informally, and in the family. Consequently, "dependency anxiety" was a common phenomenon among the elderly, Elderly felt the need to curtail their dependence upon the family and felt anxious about informing them about their health problem.

Physical Determinants of Access:- A key physical barrier to access is that many elderly require home-based care, a need arising from illness-related confinement following an age gradient. Elderly confinement to the home is consistent in both rural and urban areas. Sample survey data suggest that as many as 64 per 1000 population in rural areas and 61 per 1000 population in urban areas are confined to the home. For those aged 80 and older, as many as one in five are confined. Reduced mobility hinders health-seeking.

While health-seeking is hindered, health needs tend to increase through the life course and across geographies. According to NSSO data, 28.3% of the aged in rural areas and 36.8% in urban areas suffer from one disease or another. The greater reported morbidity in urban areas is misleading. Census data reveal higher proportions of people aged 60 and older in rural areas (7.7%) as compared to urban areas (6.7%) meaning that in absolute terms, the need for evenly care is slightly higher in rural areas. Moreover, higher rates of morbidity and hospitalization in urban areas are to be expected given that most geriatric services are in urban areas and at the tertiary level. In contrast, the lack of infrastructure and health service reach in rural areas is worrisome since of the 72% of the elderly population that is not working, 69% is rural. Moreover longitudinal data suggest the greatest deterioration in health status has been of females living in urban areas.

Even in cases where services are available uptake is low because of lack of health promotion and community outreach. Goel and colleagues undertook a survey of elderly in Meerut, UP. 53% were even aware of generic welfare service available in their area and only 4% reported ever using them. Even in South India, where healthcare utilization is generally higher, evidences suggests similar trends. Another observational found that only 30% were aware of geriatric welfare services and 14.6% had used them.

Affordability:

A complex Conundrum. Affordability through income, employment and assets:- India has no population-wide mechanism of social security. Given the scenario, Indians have to work as long as possible in order to support themselves. Employer insurance and pension schemes are available only to as low as 9% of rural males and 41.9% of urban males who are in the formal sector; among females, the figures are lower still (3.9% rural, 38.5% urban). The Worker Population Ratios (WPRs) depicts that 56.79% of elderly males and 16.32% of elderly females were engaged in employment.

In view of increasing the financial security of the elderly, higher tax exemption has been provided for the elderly and the exemption age has also been reduced from 65 to 60 in the 2011 budget. Also a new category called "very senior citizen" for elderly above 80 years of age has been introduced for greater tax exemption. In the absence of state-level measures of providing social security, security in old age may be assured through movable or immovable property assets. In India, which is largely patriarchal, the ownership of land, house or

property is mostly owned and devolved among men with exceptions of land, house or property is mostly owned and devolved among men with exceptions on the Southeast coast and in the Northeast. In case of women, the basis of property rights not only is generally weak but also seems to be eroding.

Paying for Healthcare:- Apart from individual-level socio-economic issues that adversely affect affordability, a number of systemic factors underpin the reduced ability of people, particularly the elderly to pay for healthcare payment are available in India, 83% of healthcare expenses are private out-of-pocket expenditure. India's relatively unaccountable and inefficient public system of healthcare has led to the evolution of a highly varied, unregulated and mostly expensive private sector that provides most healthcare, rendering Indians Increasingly vulnerable to catastrophic health expenditure and poverty. According to 2022 estimates, per capita expenditure on health is 6602 Indian Rupees.

Financial protection for health spending in India is largely in the form of saving and insurance. However insurance in India is limited not only by its low coverage of conditions but also by low coverage of populations. The National Family Health Survey of 2023-24 indicate that Health insurance coverage increase by 10% to 50% due PM-JAY: Ayushman Bharat Scheme which provide ₹ 5 lakh per family per year for secondary and tertiary care to the poor people.

Insurance companies often explicitly exclude the elderly due to age limits or eligibility restrictions for those with pre-existing conditions. This results in heightening the estrangement of the aged from a healthcare system and policy environment that has historicallylagged in supporting the financially weak.

Universal health coverage: Strategic directions and data needs:- A pathway to national health reform has been envisioned by the NITI Aayog for India. Universal health coverage reforms pertinent to access include the provisions of additional human resources at the Sub-Health Centre level as well as the introduction of an additional Community Health Worker in rural and low-income urban areas. These reforms would ensure that in addition to existing priorities of maternal and child health, emerging priorities in NCD control, as well as action on social and physical barriers to access, can be addressed locally Village Health and Sanitation Committees and their

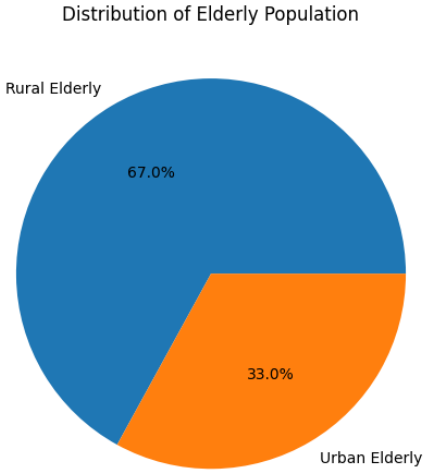
A number of Regulatory mechanisms under the aegis of a newly proposed National Health Regulatory and Development Authority will ensure health system support, acceleration and continuous health system evaluation. This process may benefit, again

from the growing base of research on elderly users of the health system, who may have a longer duration of interaction with the system as well as great variation in terms of social determinants. Health systems evaluation will additionally have to reflect age-specific morbidity and mortality patterns, as well as that of intersectional elderly groups (the widowed elderly, aged of religious minority status).

Ensuring the functioning of entitlements to health under the UHC is an increase in overall health spending from 1.2% of Gross Domestic Product to 3% by 2022, funded through general taxation. The creation of State essential Drugs and Medical device lists—for both allopathic and traditional medicine system—is also

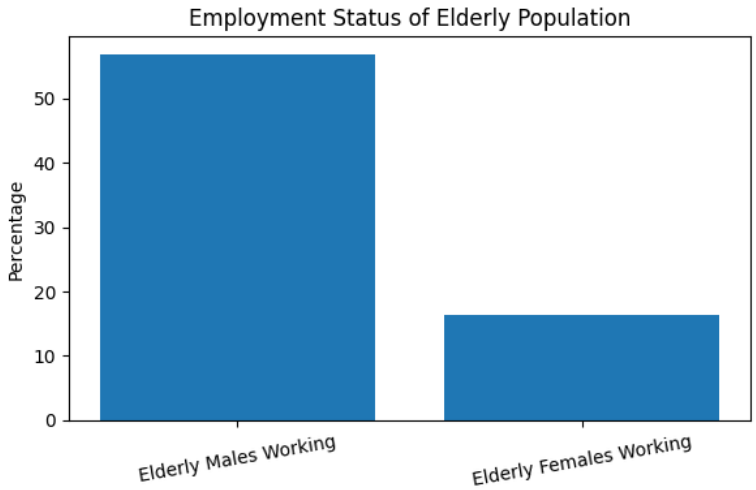
proposed to ensure that price inflation is curbed for critical products. Pattern and priorities will have to be determined based on routine and careful examination of the evidence among the Indian elderly.

Distribution of Elderly Population



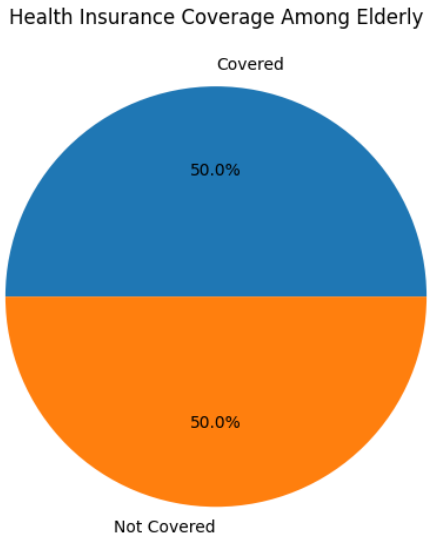
This pie chart shows that nearly two-thirds of the elderly population in India resides in rural areas. Rural elderly people often face limited healthcare access and financial insecurity compared to urban populations.

Employment Status of Elderly Population



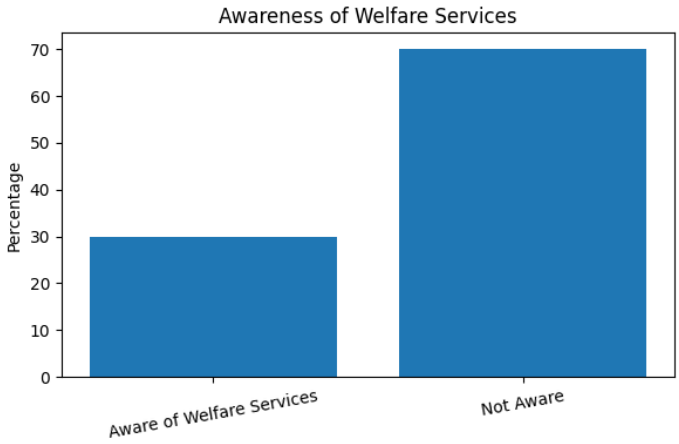
The bar chart highlights the difference in employment among elderly males and females. A significantly higher percentage of elderly males remain employed compared to females, reflecting economic dependency and gender inequality.

Health Insurance Coverage



This chart represents health insurance coverage among the elderly population. Although insurance coverage has improved through government schemes like Ayushman Bharat, many elderly people still face difficulties in accessing affordable healthcare.

Awareness of Welfare Services



The chart shows that awareness regarding geriatric welfare services remains low among the elderly. Lack of awareness reduces the utilization of healthcare and support services.

Conclusion:- The growth of the elderly population in the coming decades will bring with it unprecedented burdens of morbidity and mortality across the country. As we have outlined key challenges to access to health for the Indian elderly include social barriers shaped by gender and other axes of social inequality. Physical barriers include reduce mobility, declining social engagement and the limited reach of the health system. Health affordability constraint include limitation in income, employment and assets, as well as the limitations of financial protection offered for health expenditures in the Indian health system.

Recommendations under the UHC framework have prioritized primary and secondary prevention and health promotion. With the goal of creating enabling environment for healthy lifestyles. early detection and routine

screening among the aged and avoiding institutionalization. In order to ensure these needs are met a concomitant program of dedicated research is required on how various UHC elements effects and may cater more appropriately to growing demographic of Indian elderly.

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