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# **AGEING OF POPULATION**

AUTHORED BY - AARUSH SHRIKANT PATIL

## **Abstract**

This study covers the underlying reality of the world, especially India, we look through the problems of the problem of Ageing Economy, the elderly population has seen a tremendous growth in the recent time all over the world, including India, which contains the world's second most oldest population despite being a small percentage the whole population, however this is soon going to change as we have seen in the modern time due to the advancement in medical field in this century and the decrease in the fertility rates of the country due to better education and family planning, which looks fine but it leads to a greater population of the elderly which means rising health expenditure costs, catastrophic health expenditure (CHE), it can be observed that rising level of elderly population has led to higher per capita expenditure throughout the years and an increase in the government expenditure can be seen as well as the government has formulated multiple policies and schemes to help the elderly population

## **Introduction**

### **2.1 Historical Background**

Population Ageing is an increasing median age in a population because of various reasons, including declining fertility, rising life expectancy, in the current scenario most countries have shown an increase in the both of these aspects, while we can see rising life expectancy, it is due to the fact that, medical science has progressed at an unprecedented rate in the recent times especially after world war 2 and while it has been noticed the most in the most the western developed nations, it has also been the case for developing nations such as in Africa, Asia, including India itself.

Although it has been a global phenomenon yet but it has rapidly approached at a pace which is concerning and is going to become a global issue in the near future. (Chakraborti, 2004).

### **2.2 Definition**

Population ageing is the most significant result of the process known as demographic transition. Reduction in fertility leads to a decline in the proportion of the young in the population which

poses a lot of serious problem for the future, reduction in mortality rate i.e. the ratio between deaths and individuals in a specified population and during a particular time period. Population ageing involves a shift from high mortality / high fertility to low mortality/low fertility which ultimately leads to older population (Prakash, 1999)

## **Main Body**

### **3.1 Ageing Population in India**

There is a likelihood that there will be an increase of nearly 34 million elderly people in 2021, a 41 percent increase over a decade, according to the national statistical office (NSO)' elderly India 2021 report

It is predicted that there will be 93 million males and 101 million females which is a big jump from 67 million males and 71million females in 2011. It also suggested the need for a plan to changing the population structure.

The report stressed the 2017 United Nations Report on World Population Ageing, which claimed that by 2030 the people aged 60 years or above are expected to outnumber children under age 10. The population share of the elderly female population is said to rise from 8.6 percent in 2011 to 10.1 percent in 2021 and it is projected to touch 13.1 percent in just a decade, 2031.

Census 1991 showed the elderly female population (29.4) outnumbered elderly males (27.3 million). The NSO report pointed out that this trend has been made stronger in the last two decade and is expected to grow even more.

The elderly Population's decadal growth (population growth rate of over a 10 period) compared to just the general population had shown a huge jump and contrast and has shown signs of concern. According to the report, the highest number of elderly people resides in Kerala (16.5), followed by Tamil Nadu (13.6 percent), Himachal Pradesh (13.1 Percent), Punjab (12.6 Percent) and Andhra Pradesh (12.4 percent) in 2021.

Bihar, Uttar Pradesh and Assam have the least proportion with 7.7 per cent, 8.1 per cent and 8.2 per cent, respectively.

A decade from now, the same five states are projected to have the maximum proportion of elderly people in its population — Kerala (20.9 per cent) followed by Tamil Nadu (18.2 per cent),

Himachal Pradesh (17.1 per cent), Andhra Pradesh (16.4 per cent) and Punjab (16.2 per cent).

Over the last decade, the highest average rise was observed in Delhi (6.60 per cent), Gujarat (4.88 per cent) and West Bengal (4.27 per cent). The least average increase has been seen in Uttar Pradesh (2.16 per cent) followed by Bihar (2.28 per cent) and Madhya Pradesh (2.53 per cent).

### ***3.2 Economic Status***

According to the report, the old-age dependency ratio has increased significantly from 10.9 percent in 1961 to 14.2 percent in 2011 and is expected to rise to 15.7 percent and 20.1 percent in 2021 and 2031, respectively.

In 2021, the female and male dependency ratios are predicted to reach 14.8 percent and 16.7 percent, respectively.

The old-age dependence ratio is the number of people aged 60 and up per 100 people in comparison to those aged 15 to 59.

According to the 2011 Census, the general old-age dependence ratio ranged from 10.4% in Delhi to 19.6% in Kerala. In 2021, this is expected to range from 12.7 percent in Assam to 26.1 percent in Kerala.

In 2031, the old-age dependence ratio in Bihar might range from 15.6 percent to 34.3 percent.

In states like Kerala, Tamil Nadu, Himachal Pradesh, and Punjab, the female old-age dependency ratio is much higher than the male in 2021, according to the survey.

According to the survey, literacy levels among senior males and females have increased over time in both rural and urban areas, but there is still a significant gender disparity, with only 28% of female elderly being literate compared to 59% of male elderly (Population Census 2011).

### ***3.3 Fertility Rates***

For the first time in history, the index fell below 2.0. That is, the average number of children a woman has during her lifetime has fallen below the replacement rate.

Total Fertility Rate (TFR) is defined by the World Health Organization (WHO) as the average number of children born to a woman "at the end of her reproductive period."

According to the report, five states score greater than 2 TFR: Bihar (3), Meghalaya (2.9), Uttar Pradesh (2.4), Jharkhand (2.3), and Manipur (2.2).

TFRs of 1.9 were recorded in Haryana, Assam, Gujarat, Uttarakhand, and Mizoram.

TFR was well below 1 in Kerala, Tamil Nadu, Telangana, Arunachal Pradesh, Chhattisgarh, and Odisha.

Meanwhile, West Bengal and Maharashtra had the lowest Total Fertility Rates, both at 1.6.

People are not generating enough children to replace the current population at this rate of fertility, i.e., total fertility rate less than 2.1, resulting in population shrinkage.

These lower fertility rates have been achieved through a variety of methods, the most prominent of which is contraception. The usage of modern contraceptives for family planning has increased from 47.8% to 56.5 percent in the five years between NFHS-4 (2015-2016) and NFHS (2019-2020). In Bihar, the rate of modern contraception has nearly doubled, from 23.3 percent in NFHS-4 to 44.4 percent in NFHS-5.

Fertility Status of India, 1971-1999

Period	Crude Birth Rate (per 1000)			Total Fertility Rate (Per Woman)		
	Total	Rural	Urban	Total	Rural	Urban
1971-71	35.6	37.2	29.3	5.0	5.2	3.9
1976-80	33.4	34.7	28.1	4.5	4.8	3.4
1981-85	33.6	35.2	28.1	4.5	4.8	3.4
1986-90	31.4	33.0	26.1	4.0	4.3	3.0
1994-96	28.2	29.9	22.5	3.5	3.8	2.6
1997-98	26.6	28.2	21.1	3.3	3.6	2.4

### 3.2.1 Health Care

HealthCare cost depends on age, usually the highest for the elderly population, according to meerding, which was concerned with the demands of the healthcare resources caused by different

illness and variation with age and sex.

Information on healthcare use was obtained from all 22 healthcare sectors in the Netherlands. Most important sectors (hospitals, nursing homes, inpatient psychiatric care, institutions for mentally disabled people) have national registries. Total expenditures for each sector were subdivided into 21 age groups, sex, and 34 diagnostic groups.

After the first year of life, costs per person for children were lowest. Costs rose slowly throughout adult life and increased exponentially from age 50 onwards till the oldest age group ( $>$  or  $=$  95). The top five areas of healthcare costs were mental retardation, musculoskeletal disease (predominantly joint disease and dorsopathy), dementia, a heterogeneous group of other mental disorders, and ill-defined conditions. Stroke, all cancers combined, and coronary heart disease ranked 7, 8, and 10, respectively.

Morbidity surpasses mortality as a factor of HC spending (Colombier and Weber). Proximity to death is of little impact, while ageing remains the most major age-related cost driver (2010).

According to Ladusingh and Pandey (2013), the cost of hospitalisation for decedents is substantially higher than for survivors throughout their lives.

Though on the contrary a number of studies, in particular by Zweifel et al (1999), Felder et al (2000) and Seshamani and Gray (2004) have negated the view that populating ageing increases the burden of healthcare costs controlling for proximity to death.

When the median age of the world's population is not adjusted for longevity, it rises from 26.6 years in 2000 to 37.3 years in 2050 and then to 45.6 years in 2100. When life expectancy improvements are factored in<sup>2,3</sup>, the adjusted median age grows from 26.6 in 2000 to 31.1 in 2050 and only to 32.9 in 2100, which is slightly less than the China region's median age in 2005. Regional disparities in ageing patterns are significant. In North America, the median age adjusted for changes in life expectancy falls throughout practically the entire century, although the traditional median age rises dramatically. Our analysis of ageing patterns is based on new probabilistic demographic projections. The probability that growth in the world's population will end during this century is 88%, somewhat higher than previously assessed. After mid-century, lower rates of population growth are likely to coincide with slower rates of ageing.

According to (Wagstaff et al. 2008), catastrophic health expenditure (CHE) has risen over time, with over 808 million people experiencing CHE in 2010.

India has the world's second-largest elder population, with 104 million people aged 60 and more. The ageing of the population generates concerns about their health and the nation's financial security (UN 2019). The elderly have become sensitive to health spending due to debilitating illnesses and financial hardship (Dandona et al. 2017). Though the prevalence of noncommunicable diseases (NCDs) is increasing among people of all ages, it is disproportionately higher among the elderly (Mini and Thankappan 2017; Pati et al. 2014; Vellakkal et al. 2013).

Sixty-three percent of India's elderly population has at least one NCD, with roughly 31 percent being multi-morbid, primarily among rural and female populations (Mini and Thankappan 2017). In India, 13% of the elderly population has an impairment that interferes with at least one everyday task (Kastor and Mohanty 2016).

The current study analyses the variables and risk factors related with functional limitations among older persons (45+ years) in India using data from the Longitudinal Ageing Study in India 2010 pilot survey. The difficulty in executing some fundamental activities of daily living (ADLs), such as bathing, eating, walking, dressing, toileting, and getting in and out of bed, is referred to as functional limitation. According to the findings, one out of every seven older persons in India suffers from at least one of the functional limitations. The most common problem cited is difficulty getting in and out of bed (7 percent), followed by walking (6.6 percent), and toileting (6.6 percent) (5.5 percent). Age and physical functionality is inversely correlated; older adults aged 60 years report more functional limitations and this becomes more noticeable for older adults aged 75 years and above. We found inverse association between functional limitations and education. High private healthcare spending as well as high out of pocket spending in India are placing a considerable financial burden on households.

The monthly per capita health spending of elderly households is 3.8 times higher than that of non-elderly households. While the health spending accounts 13 % of total consumption expenditure for elderly households, it was 7 % among households with elderly and non-elderly members, and 5 % among non-elderly households. Controlling for socio-economic and demographic correlates, the per-capita household health spending among elderly households and among household with elderly and non-elderly members was significantly higher than non-elderly households. The health

expenditure is catastrophic for poorer households, casual labourer and households with elderly members. Based on the finding we suggest to increased access to health insurance and public spending on geriatric care to reduce the out-of-pocket expenditure on health care in India.

The average PHS(Per Capita Health Spending) was 1,331 Indian rupees (INR), which varied by state-level economic development. About one-fourth of Indian households incurred CHS, which was equally high in both the economically developed and poorer states.

When compared to those between the ages of 60 and 64, people over 65 spend 1.5 times as much on healthcare (Mahal, Berman, and Indicus Analytics, 2002). When compared to homes without older members, the likelihood of catastrophic OOP expenses is substantially higher in households with elderly individuals (Pal, 2010).

Savings and insurance are the most common forms of financial protection for medical expenses in India. However, insurance in India is constrained not only by a lack of condition coverage, but also by a lack of population coverage. The National Family Health Survey of 2004–2005 indicates that only 10% of households in India had at least one member of the family covered by any form of health insurance (IIPS, 2007). Overall, the insurance market in India remains limited and fragmented in its presence. Benefits are accessed by only a few privileged sections of the population, such as those in the formal and civil service sectors like defense, civil services, and the railways, even after retirement long into old age (Acharya and Ranson, 2005; Ellis, Alam, and Gupta, 2000; Ranson, Sinha, and Chatterjee, 2006; Shiva Kumar et al., 2011). Due to their inability to pay regular insurance premiums, the elderly are often unable to use medical insurance due to a lack of employment and income. Finally, due to age limits or eligibility restrictions for people with pre-existing diseases, insurance firms frequently openly reject the elderly. This further isolates the elderly from a healthcare system and legislative climate that has consistently failed to assist the financial ly disadvantaged.

### 3.2.2 Trends Of Health Care Expenditure In India

		Public	Public	Private	Private					
Year (Base year, 2004	Population (Cr)	HE(Cr)	HE per Capita	HE(Cr)	HE per Capita	GDP(Cr)	GDP per capita	Public	Private	Total
1993- 94	89	15597	175	32278	362	1522343	17067	1.0	2.1	3.1
1994- 95	91	16522	182	35956	395	1619694	17799	1.0	2.2	3.2
1995- 96	93	16017	173	40023	431	1737740	18726	0.9	2.3	3.2
1996- 97	95	16639	176	44393	469	1876319	19834	0.9	2.4	3.3
1997- 98	96	18275	190	49240	511	1957031	20301	0.9	2.5	3.4
1998- 99	98	20394	207	54635	556	2087827	21239	1.0	2.6	3.6
1999- 00	100	22542	225	61246	612	2246276	22440	1.0	2.7	3.7
2000- 01	102	22755	223	62436	613	2342774	22991	1.0	2.7	3.6
2001- 02	104	21891	210	73760	709	2472052	23770	0.9	3.0	3.9
2002- 03	106	23954	227	78209	741	2570690	24344	0.9	3.0	4.0
2003- 04	107	24550	229	82889	773	2777813	25912	0.9	3.0	3.9
2004- 05	109	26313	242	95560	878	2971464	27286	0.9	3.2	4.1
2005- 06	111	34446	311	105244	952	3254216	29423	1.1	3.2	4.3



Punjab	159.22	324.32	344.68	0.91	1.19	1
Rajasthan	250.01	353.14	408.91	2.6	2.5	2.25
Tamil Nadu	166.07	299	447.51	1.25	1.31	1.53
Uttar Pradesh	87.88	99.59	156.58	1.21	0.95	1.19
West Bengal	101.38	236.36	206.9	1.02	1.35	0.84
Mean	131.37	224.29	262.24	1.23	1.37	1.18
Standard Deviation	40.33	81.74	98.98	0.57	0.42	0.37
Coefficient of Variation	.307	0.36	0.38	0.467	0.31	0.315

In almost all of the states (except Uttarakhand), the positive relationship between HE per capita and age is observed. The higher HE in older ages can be result of higher levels of morbidity or higher percentage of treatment seeking behaviour. Interestingly, most of the states are showing the increasing age-compositional effects on health spending during 2005-25. Among all states, Assam and Punjab have shown the highest increase during the same period. However, the states of Uttar Pradesh, Rajasthan, Odisha and Jharkhand have shown the lower age-compositional effect on health spending.

as people aged there has been observed the tendency to spend more and more money, similarly states in India such as Tamil Nadu (13.6 percent), Himachal Pradesh (13.1 Percent), Punjab (12.6 Percent) and Andhra Pradesh (12.4 percent) in 2021 has seen to be spending the most of the health care expenditure, however in some cases, states such as However, the states such as Uttar Pradesh, Rajasthan, Odisha, Jharkhand has shown greater amount of spending of health care spending on lower age group.

In almost all of the states (except Uttarakhand), the positive relationship between HE per-capita and age are observed. The higher HE in older ages can be result of higher levels of morbidity or higher percentage of treatment seeking behaviour.

### 3.3.1 Government Schemes for Elderly People

Government of India came up with various schemes for the benefit for the elderly people such as for pension, Medclaim and so on.

### **3.3.2 National Programme for the Health Care of Elderly (NPHCE)**

Introduced in 2010, this scheme concentrates on preventive as well as promotive care for the maintenance of overall health. This program was launched to address the health issues faced by seniors. The district-level objectives include providing dedicated health facilities in district hospitals, community health centres (CHC), primary health centres (PHC), and sub-centres (SC) levels through State Health Society. These facilities maybe free or highly subsidized.

### **3.3.4 Senior citizen welfare fund**

The Senior Citizen Welfare Fund (SCWF) is a fund which provides financial support to the Below Poverty Line (BPL) category senior citizens. It was introduced by the Government of India to help senior citizens who do not have any means of livelihood. The SCWF was instituted by the Finance Act, 2015. It came into effect on 18.03.2016.

The government observed that a large corpus of funds was available in the various government savings schemes. The funds fall under the category of inoperative accounts. Over time, the funds are classified as ‘unclaimed deposits. The need was felt to channelize the funds towards a useful purpose. At the same time, the need was felt to improve the lives of senior citizens. Thus, the government introduced the SCWF to address both the concerns. Unclaimed deposits invested with the government institutions would be transferred to the SCWF. The funds available with the SCWF would be used exclusively for helping senior citizens. The SCWF is an apex-level fund which is managed by the Central Government. Senior citizens can make use of the SCWF by availing of the various schemes launched under the fund.

### **3.3.5 Ayushman Bharat Pradhan Mantri Jan Arogya Yojana**

It is a national public health insurance fund of the Government of India that aims to provide free access to health insurance coverage for low income earners in the country. Roughly, the bottom 50% of the country qualifies for this scheme.<sup>[21]</sup> People using the program access their own primary care services from a family doctor. When anyone needs additional care, then PM-JAY provides free secondary health care for those needing specialist treatment and tertiary health care for those requiring hospitalization

### **3.3.6 Indira Gandhi National Old Age Pension Scheme (IGNOAPS)**

It was introduced in 1995 as part of the National Social Assistance Programme (NSAP) to provide financial assistance to the BPL elderly. The scheme was later transferred to the state in 2002–2003

for implementation with additional central financial assistance. The main objective of this scheme is to provide social security to make older people economically independent. The scheme covers the elderly age 60 and above who have little or no regular means of subsistence either from their own source of income or through financial support from family members or other sources. The central government contributes INR 200 per month to beneficiaries who are aged between 60 and 79, and INR 500 to those age 80 years and above. The state government is advised to add the matching amount or more, and their contribution varies. At present, old-age pension beneficiaries receive anywhere between INR 200 to INR 2,500 per month depending on the amount granted by the state. are some examples of the schemes.

### **3.3.7 Indira Gandhi National Widow Pension Scheme (IGNWPS)**

The Indira Gandhi National Widow Pension Scheme (IGNWPS) is implemented by the Ministry of Rural Development, Government of India. The applicant should belong to a household falling below the poverty line as per criteria prescribed by the Government of India. The pension amount is INR 200 per month, and the state government is also urged to provide the matching amount or more. The pension is credited into a post office or public sector bank account of the beneficiary and is discontinued if the widow remarries or moves above the poverty line.

### **3.3.8 Maintenance and Welfare of Parents and Senior Citizens Act, 2007**

It is a legislation, initiated by Ministry of Social Justice and Empowerment, Government of India<sup>[1]</sup> to provide more effective provision for maintenance and welfare of parents and senior citizens. It makes it a legal obligation for children and heirs to provide maintenance to senior citizens and parents, by monthly allowance. It also provides simple, speedy and inexpensive mechanism for the protection of life and property of the older persons. After being passed by the Parliament of India, it received President's assent on December 29, 2007. This act provides an inexpensive and speedy procedure to claim monthly maintenance for parents and senior citizens. This act casts obligations on children to maintain their parents/grandparents and also the relative of the senior citizens to maintain such senior citizens. The main attraction of this act is there are provisions to protect the life and property of such persons. This act also provides for the setting up of old age homes for providing maintenance to the indigent senior citizens and parents. This Act extends to the whole of India. The first case under the act was filed in November 2011 by Siluvai (age 84) and his wife Arulammal (age 80) of Tuticorin against their son and daughter-in-law for neglect, besides taking away their two homes and gold jewellery.

## **Conclusion**

It is predicted that the population of the elderly people in India will rise in a decade. A need of change in the population structure is necessary. The percentage of elderly women is more compared to elderly men, the population growth rate over a period of 10 years compared to the general population has shown a huge change and has shown signs of concern. The dependence ratio is projected to increase by 2021-31. The female old-age dependency ratio as compared to male is significantly high in states like Kerala, Tamil Nadu, Himachal Pradesh and Punjab in 2021. The literacy rate among both have increased but there is a huge gender gap. The fertility rate has dropped down below 2.0 for the very first time and as a result of this the population is shrinking. The drop is due to the use of contraceptives, use of contraceptives for family planning has increased from 47.8% to 56.5%. Health spending as percentage of GDP is quite low in India, however, showing the increasing trends over the past. Health care expenditure can be determined by the health status, socioeconomic factors and demographic factors, cost of treatment, pharmaceutical, medical technology, health insurance etc. Population ageing will encourage growth of future health spending, though its effects are low. Age structural changes are widely varied by sex, place of residence and in the diverse states of India. Therefore, with the age structural transition, growing need and availability of support system for greying population has a key role in policy for old aged people. Government came up with various schemes and welfare act for elderly people. The ageing population suffers from a variety of economic, social, and cultural problems. Hence, the state needs to provide suitable institutional and other economic support to address the socio-economic needs of the elderly.

## **Recommendation**

As we have seen through this research paper, population has been increasing at an alarming rate and its time for the government to take some measures for the future, otherwise this ageing phenomenon will greatly impact the country as we have already seen in other countries such as china and japan, where most the economics burden has been shifted on the younger population, and while this might not be bad in the short term, this further means that people are preferring smaller families and the tradition will continue, the government has to come up with a bigger budget for the health care sector, so the Out of Pocket Expenditure(OOP) has to be reduced, as this has further pushed the poor into poverty, this will help the younger population in lessening their burden and help the economy in the long run

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