# The Responsiveness of Health Institutions for Elderly: A Comparative Study of India and China

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Over the past century life expectancy has increased dramatically and the world will soon have older people larger than children. Although aging is occurring in every country, the top 10 countries with highest share of aged is developed country but the picture will change by 2050. India and China will be one among the developing countries which would converge with developed countries by 2050 in terms of growth of aged population. China will have more than 40% of its population 60 and older, outpacing the increase in the United States (World Economic Forum, 2012). The pace of this change means that the developing countries like India and China will have much briefer periods to adjust and establish the infrastructure and policies necessary to meet the needs of their rapidly shifting demographics. It also means that unlike developed countries, they will need to cope with getting old before they get rich (World Economic Forum 2012).

Greater longevity means people have both more productive years and more years of suffering, however this is still debatable. Studies from UK and USA suggest extension of healthy active lives (Fries, 1980, Manton et al., 1997). A survey in Mexico reveals that aging is associated with extended periods of morbidity (Castro et al. 1998). Wherever this is the case, it will increase pressure on health infrastructure and health spending. The major challenges of population aging include the increased economic and social demands, rising burden of chronic disease, increased risk of disability, care providing to aged, the feminization of aging, ethics and inequities and forging a new paradigm with an intergenerational approach (WHO, 2002).

As part of an objective to promote active, positive aging, elders must not be forced into the role of passive dependents, but should be afforded wide rage social and economic opportunities (Sherlock, 2000). The Ottawa charter defined health promotion as the process of enabling people to increase control over, and to improve their health (WHO, 1986). Opportunity and ability of older persons to have control over their own health, determinants of health and decision in health care not only improve health but also are essential for human dignity and integrity throughout life. In any health aging program or practice, older people's autonomy and personal control should always be taken into account (SNIPH, 2007).

However, hospitals and other acute- care settings are not ideally designed to care for older persons in many aspects. Parke and Stevenson (1999) noted that hospitals tend to be structured according to the needs of health care providers rather than older persons and their families. Evidences includes raised beds and stretchers that make getting up and down difficult and risky, cold shiny and slippery floors, small size clocks calendars and signage, unfamiliar and unanticipated routines and procedures (Chiou and Chen, 2009). Primary health centers, which play a critical role in providing outpatient services to older persons, were also found to be flooded with barriers to care. WHO conducted a series of focus groups on older people and care providers in different parts of the world, the common concerns were negative and humiliating experience at health center, lack of trained health personnel, gendered attitude, language barriers, obstructive management system which put obstacles in services delivery, cost of waiting time, inadequate time for complete assessment and treatment, lack of continuity and fragmentation of services, lack of special clinic or consultation hours for older persons and physical barriers to reaching the care facility as well as to navigating it (WHO, 2004). These problems exist in hospitals as well.

The positive impact of access to healthcare on health and survival among elderly is well documented in developed countries. However whether the elderl friendly health care services are existing in developing countries or not is still unrevealed due to the limited research in this area. China a developing country with the largest population in world, has been transforming its antiquated health care system during the past few decades in response to rapid population aging. Yet in recent years the lack of access to healthcare has been identified as the top concern by most citizens in China (Gu et al., 2009). India seems to severe lack in elderly centric policies, the existing policies are for namesake and cosmetic like old age pension scheme for poor elders by Ministry of Social Welfare and Empowerment, separate queues for older persons in government hospitals, setting up of geriatric departments in 25 medical colleges by Ministry of Health and Family Welfare.

In the light of the above discussion the overall aim of this study is to determine the support needs of health care of older people. More specifically it set out to answer the following questions.

1- What support and services older people have at health institutions?
2- What is the responsiveness of public health institution to the old age people reach to the health institution for health services?
3- What are the further support and services do they want to make access to health care easier?
4- How would they prefer the disposal of health services for them?

*Data Source*- Availability of appropriate data sources on health issues is the most difficult part in researching on health issues. The latest round of health data on morbidity and utilization of health care services by elderly, available in India is 2004 data by NSSO, which is apart from being old also not comparable across countries. However WHO attempted to fill this gap in data

in the developing countries. It has developed the Study on Global Ageing and Adult Health (SAGE). The core SAGE collects data on adults aged 18+ years, with an emphasis on populations aged 50+ years, from nationally representative samples in six countries: China, Ghana, India, Mexico, Russian Federation and South Africa. By now WHO is running the fourth round and data from wave 0, 1 and 2 is available in public domain. The present study will make use of micro data Wave 2 of India and China.

*Expected Results*: A preliminary analysis of data provides some indications of expected results. It appears that both countries have health institutions which are quite unfriendly to elders. In fact, health institutions are oblivious of health needs of elders. However, this unfriendliness is higher in India. Public health institutions have multiple response pattern, which varies from context to context and disease to disease. Generally it is found to be responsive in acute diseases, but quite cold in response in chronic cases. The support needs of elders are different in India and China. While familial support is higher in India as compared to China, income support is missing in former. Higher health cost appears to be a greater impediment in India than in China. Somehow the cost of treatment for elders is still lower in China than in India. This difference is partly due to the fact that disease pattern of elders is different in China as compared to India.

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