# Indian Elderly among Marginal Sections Programmes and Policies in the Era of Globalisation

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*Elderly in India are not a homogeneous group. Their needs and problems are graded according to their social and economic locations and the extent of disability and vulnerability. Elderly belonging to poor and poorest categories have different needs and problems in comparison to their well off counter parts. The condition of the elderly of rural areas is different from their urban counterparts. Old age homes, income tax benefits, gratuity, provident fund, railway and air ticket concessions and other such relief measures are meaningless for the majority of the Indian elderly who live in rural areas and do not have any salaried job or taxable business. The elderly from the poor category work as long as they are physically able without any social security. They need all sorts of social, financial, medical and psychological supports. This is important to identify who are the marginal and most vulnerable and whether they come under the preview of the policy and programmes or not.*

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## Introduction

There is not a single, linear perspective to view the Indian elderly. Their conditions may be understood through several perspectives in several contexts i.e., socio-cultural perspective, economic and industrial context, psychological and physiological aspects, demographical transition and life course perspectives, historical and time perspectives, rural-urban perspectives, class and caste perspectives. One more perspective may be the inter-continental and geographical perspective i.e. the elderly in Asian countries and the European and American countries (in third world and industrialized developed countries). For the formulation of policy and programmes which perspective will be suited to locate the most marginal and most vulnerable segment of the elderly in Indian society? Which

section of the elderly is in a position to avail the existing welfare programmes introduced by government of India and the various state governments? What are the actual needs of the elderly and what sort of welfare programmes are being proposed? These are certain questions, which need proper answers.

Many welfare services introduced by the government are not beneficial to 90 per cent of the Indian elderly who live in remote villages and they have no excess or adequate transport facilities, health services, and communication services. Majority of them are involved in manual casual labour. Even in their sixties and seventies, they have to work for livelihood. One study reveals that around 64 per cent manual labourers were from the poorest and poor categories [Ansari, 2002]. When they become weak and infirm, they need all sorts of help and support. For them tax benefits, provident funds, gratuity etc have no use. The old age homes could provide shelter and support to the destitute elderly but they are not in a position to afford it. Even those who can afford to do not want to stay there because this would imply separation from their kith and kin and forsaking any meaningful engagement. Therefore, how do we escape from the symbolic welfares that seem to be overtaking the discourse on care for the elderly?

In the era of globalisation and privatisation when the pressure on the families of all classes is increasing and the state is withdrawing its financial support from social welfare, the role of community initiatives, NGOs and individual volunteers become very important. The elderly of poor households are going to be further impoverished and move towards destitution. That is where the elderly may experience negative impact of globalisation. For the better-off, increasing loneliness and neglect may become more important issues. It should be debated whether the various organisations should work as

pressure groups, advocacy centres, a form of almshouse, or work towards enhancing the capacities of the communities to look after their elderly, giving them a life of dignity and fulfilment. Whether their approach to care for the elderly should be holistic or particularised?

**Demographic Perspective**

It is claimed by demographers that the ratio of the elderly population is changing very fast. But if we locate Indian population and its ratio of the elderly people, the case is different. In India, the demographic changes are slow and limited. The percentage of aged is much lower than the percentage of children in all successive census years. In 1971 the aged were 6.0 per cent and children were 41 per cent of total population. In 1981 it was 6.4 per cent and 39.6 per cent and in 1991 it become 6.7 per cent and 37.3 per cent [Census of India, 1991]. The Indian authors' idea is based on the projection of population and not on actual population. As it was projected that by 2000 Indian elderly would be 12 per cent of its total population but 2000 has passed and yet the elderly population is not crossed 7 per cent. So the Indian authors copy the western frame reference for the Indian context, which is not suited, and they produce demographic - phobia among the Indian people and get relieved from their real responsibilities. No country among the third world particularly in the Asian region has more than 9 per cent elderly of their total population. For example, in China there was only 8.47 per cent in 1988. Some of these countries may face problems not because of increased elderly population but because of being at relatively low levels of economic productivity. Malaysia with a per-capita GNP of US $1000-2000 has an elderly population of only 5.8 per cent; Indonesia and Thailand with per-capita GNP of about $500-1000 have elderly population 6.3 per cent and 6.2 per cent;

China and Sri Lanka with per capita GNP of less than US $500 have 8.9 per cent and 8.0 per cent and India with per capita GNP around $206 has an elderly population of 6.55 per cent.

It is also important that population ageing in the developing world is accompanied by persistent poverty. The less developed countries on the other hand are unable to aid their elderly in a meaningful manner and are dependent on the great traditional social institution, the family for the case of these people who are storehouses of experience and wisdom [Mahadewan and Krishnan, 1992]. Just saying that due to demographic transition the problem of Indian elderly is increasing will not be valid. In India, where there in low productivity, poverty, unemployment, poor health facility, poor welfare infrastructures, and over all low quality of life in comparison to western countries. So to blame only demographic transition may not be pertinent for the Indian elderly.

**Modernisation and Traditional Institutions**

Another understanding about Indian elderly is based on the modernity theory– that processes of industrialisation, migration, urbanisation, higher education, employment of women etc is leading to erosion of the traditional value systems and older people are being neglected. While this trend can be observed, it is relatively weak in Asian societies, especially the rural. In Indian context, by one study [Ansari, 2002] it was found that joint and extended family constitute around 51.5 per cent, nuclear around 47 per cent and only-member 4 per cent in rural areas but the percentage of the elderly living in joint and extended families is much higher – around 84 per cent, in nuclear and single-member 8

per cent in each. But the majority of the nuclear families are among the poorest and poor and joint families among the economically well off and better off.

Even in urban India the large sized joint family is evident. Some studies indicate that even in urban set up joint family exists in significant numbers [Mukherji, 1965; Kapadia, 1966; Gore, 1965; Chadha and Willigen, 2000; Nayar, 1992]. So from the perspective of old age care: what kinds of structural changes have taken place in the different family patterns in recent times; needs deeper understanding. However, the cause of nuclearization of family is found to be landlessness, extreme poverty, low-caste community [Ansari 2000; Koleda 1984]. [Wadley 1994] a researcher writes, "There is a change in the fashion, life style, houses, food, medicines, machines but the original social values and norms are still intact in rural India."

As [Shah 1999:80] maintains that economic development of the country after 1947 has increased the possibility of accumulating household assets such as substandard houses, furniture, utensils, vehicles etc. providing a better economic base than before for development of joint households. Many more elderly are living in joint households with their one or more married sons or some other relatives today than 50 years ago. The economic condition of the households, though joint, is important for better care. So is social change responsible for the problems of elderly or something else?

The rural-urban migration is not always negative for the elderly. It is, in most cases positive for the elderly. The poor elderly are happy if their sons go out for a job. It is in the nature of a status symbol if their sons earn outside and send money. Though they have some emotional problem about the departure of sons/grandsons the income is necessary for household needs, so they make up for it. There is a class dimension. The

rich elderly may be saddened by the migration of sons/grandsons. This also depends upon the nature of migration- total family member migration, partial migration- some members' migration, permanent and temporary migration.

Development must be understood in terms of political processes, technological development, and humanitarian ideals. Historical, cultural and ideological forces have to be analysed in their interaction with the development of contemporary welfare systems that have followed very different path lines in different societies [Tornstan, 1992].

**Rural-Uraban Perspective**

Only 10 per cent of the elderly live in urban areas and 90 per cent live in rural areas, for whom majority of the schemes are not beneficial. In urban centres the hospitals are available and in case of emergency the elderly can get benefit from it though this is difficult for the poor elderly in urban areas. Contrary to this, in rural areas the elderly along with the non-elderly have to depend on unskilled, untrained medical practitioners almost the private. The clinics (mostly private) are far away for the rural people and there is no adequate transport facility to reach the towns.

Rural elderly are better in terms their social and psychological problems. They are well-respected and better-taken care by the majority of the people [Ansari, 1997]. Where as in urban areas due to fast life and work culture the family members have hardly any time to share with the elderly. The concept of neighbourhood and community feeling is hardly in practice in urban areas but the elderly of rural areas have good community interaction [Ansari, 1997]. Unfortunately we do not have statistical evidence about households belonging to this section of society but circumstantial evidence seems to be unmistakable

(Shah A.M. 1999:1180). This section of society is vulnerable. What seems to have aggravated their living conditions is the absence of strong neighbourhood relationships in large, modern cities compared to the prevalence of such relationships in villages, small town and even old sectors of large towns. These elderly persons are isolated not only from their kin but also from their neighbours. This makes their life even more miserable [Shah A.M. 1999:1180].

Actually in India, most studies on life and conditions of the elderly are highly influenced by the worldview of the western industrialised countries. There the elderly population is an alarming problem. Further, the literature largely reflects the orientation of the urban middle class elderly, which many authors mistook to generalise to the whole country, while majority of the people live in the rural areas [Shah, 1999; Desai, 1981; Mukerji, 1965; Ansari, 2000; Nayar, 1992; Hussain, 1992]. Above all, we need to improve our understanding of the non-urban middle class world. Far too often, both our understanding and consequent policy recommendation is conditioned by our middle class worldview [Editor Seminar April 2000:488].

**Economy and Market Forces**

Most of the literature shows that elderly are viewed as consumers and not as producers. But elderly in India, do physical labour and other productive work beneficial to themselves or to their households. A large number of elderly are working in unorganised sectors where there is no retirement. They have to work as long as they are healthy. In rural areas they work in their fields or sell their labour to other landed people [Ansari, 2000]. Class factor is evident among the elderly to understand their conditions. The elderly belong to poorest, poor categories and some of the middle-income groups do the

physical labour either in their own land or in others. The nature and gravity of their problems are not like the elderly who belong to the better-off and well-off categories. Like-wise the elderly who belong to the lower castes (SCs, MBCs, OBCs) are in a different position even if they are economically better-off than to the elderly of upper castes even though they are economically poor [Ansari, 1997].

The market forces also force the corporate sector to introduce 'old-age homes' the home away from home for the elderly so that they get profits out of it. They are advertising for the facilities available to their old age homes. In the same way the same NGOs which project the elderly as a burden and as consumer and also project about their increasing proportionate number as they are becoming more and more dependent upon the active age groups, which is does not seems to be true. The elderly do not want to shift to the old age homes they want to live their kith and kin even in their adverse conditions. Those elderly who are really homeless and destitute, these facilities of old age homes are not available to them because they can not pay for that.

**Health Perspective**

The health of the elderly is an important aspect, which includes all aspects of life to have a sense of well being, but their physical health is more important. Physical health includes disability, coping to disability: treatment, care, availability of treatment facility i.e. doctors and caregivers etc. In one study [Ansari 1997] it was found that majority of the elderly are dependent on local untrained medical practitioners (quacks), some of them used to consult DHMS doctors and few of them who were rich used to visit the MBBS doctors in the towns. The treatment seeking behaviour is graded according to their class

i.e. among the poorest 72.72 per cent go to quacks followed by the poor (67.56 per cent), the middle class (69.69 per cent), the better-off (55.55 per cent) and well off only, 33.33 per cent. Majority of the elderly from the well off (33.33 per cent) and better off (11.11 per cent) and few from poor (5.40 per cent) and middle (9.0 per cent) and no elderly from the poorest category go to the MBBS/MD doctors for their treatment [Ansari, 1997]. These findings show that the overall cause of taking treatment from trained doctors depend upon the financial status of the elderly.

The self perceived health problems of the elderly also vary according to their class. The perception of 'lot of problems' among the poorest was 100 per cent where as among the well off it was 66.66 per cent (Ansari 1997). But only 36.36 per cent of poorest elderly were taking treatment but among the well off this figure was 50 per cent.

Among those who are not taking treatment, the causes described were monetary (85.71 per cent by poorest, and 25 per cent by the well-off), non-availability of escorts (0% by the poorest-middle, but 40 per cent by the better-off and 25 per cent by the well-off). Some elderly did not felt need the need for treatment though they have health problems: 14.28 per cent by the poorest but 50 per cent by the well off. Here the severity of the disease of the elderly among the poorest was high whereas, among the well off, the severity of the diseases was perceived to be low.

The most severe form of disability among the elderly is called 'Alath' in local lingua in rural Bihar [Ansari 1997]. Alath is a state of complete disability and immobility when elderly can not take food even without assistance and they are lying in bed permanently. That is called terminal illness or illness before death. Alath is generally followed by death. Such kind of disabled elderly are around 5 per cent which is near the national level

proportion (Mishra U S, 1993). This state of elderly is very important from the policy point of view because all security measures are needed for this period. Among the rural elderly it is only their family members, close or distant relatives, community (neighbours), etc. are the important caregivers. In another study in rural Bihar [Ansari, 2002], there were 13.26 per cent elderly who were disabled. Out of this 5 per cent were in the state of Alath, 1 per cent blind, 2.75 per cent severely disabled and 4.60 per cent moderately disabled. A much larger number suffered mild forms of disability, which made the elderly change their life pattern and activities, but allowed them to remain completely active. Their role within family and society changes and that can cause some distress among them. So both, physical and emotional support is needed. For these disabled elderly there are infirmaries and nursing homes in the west but in India it is the family members who take care of their infirm and frail senior citizens. Besides physical health, other aspects like housing, food, clothing, psychological and societal problems, need to be taken into account for the policy formulations.

**Elderly in Marginal Section**

For Indian rural societies there may be several criteria to decide the most vulnerable category among the elderly. One category may be economic- according to this category around 49 per cent of the elderly were found under the poorest and the poor [Ansari, 2002]. Another criterion may be the caste category- according to this around 50 per cent elderly was found to be among the scheduled castes and most backward castes. The third criteria may be the special categories i.e. widow, widower, divorcee, unmarried, issueless etc. they constitute around 40 per cent. Another criterion may be the physically disabled,

where the proportion of the older persons was around 13 per cent [Ansari, 2002]. So roughly around 40 per cent elderly come under the most vulnerable and needy group and they need all sorts of interventions- services and help and thus accordingly programmes and policies should be formulated.

Though, majority of the elderly are taken care by their close relatives and distant relatives but majority of the care providers are themselves so poor and have inadequate infrastructure that they cannot provide adequate medicine, food, and living spaces. The poorest and the poor elderly are the special concern in terms of their needs. Almost half of the elderly, (21.5 per cent poorest and 27.5 per cent poor), come under these groups have all sorts of problems- economic, physical and psychological. In one study it was seen that all the elderly (100 per cent) of the poorest and nearly 86.5 per cent from the poor had 'some problems' and 'lots of problems' [Ansari, 2000:207]. But among the well off this was only 66.66 per cent of the elderly. Nearly 82 per cent of the poorest elderly showed severe worry and 18.18 per cent mild feeling of worry. However among the better off and well off, severe worry was among 33.33 per cent and mild worry for 22.22 per cent among the better off, 41.66 per cent severe and 41.66 per cent had mild worry among the well off [Ansari, 2000: 208]. No elderly from the poorest section said that they had no problems but among the well off this percentage was 33.33, who reported that they did not have any problems. Likewise, no poorest elderly showed that they had no worry in their old age. On the contrary, 44.44 per cent of the better off and 16.66 per cent among the well off elderly had reported that they did not have any substantial worry about any thing in their old age.

**Policy Issues**

Policy makers, planners, social scientists and social workers attempt to assess the needs of the elderly. Some needs of the older people are general for all sections of the society while some others are specific for a particular group. The Alath anxiety has significant influence on the lives of the adults and elderly. All attempts are made to ensure that there should be someone who will take care of them in their old age particularly when they become weak and infirm. For that, they save some money, keep some land intact, ensure that they have sons and socialise their sons in a way that they feel their responsibility towards their fathers and mothers. This is the security need of the elderly where the poorest, poor, issueless and widows worry much. Life is harder for elderly women compared to elderly men. Rural and even urban areas show the greater intensity of the problem of living alone on the part of the women [Bose, 1982].

Older persons also suffer very heavily with non-communicable diseases and they need special attention [Alam and Agarwal, 1999; Mishra, 1999]. Alath elderly need nursing, cleaning their body, clothes, beds, feeding, medicine, and special space of living from where they can defecate easily.

There are elderly persons among all economic groups who have special needs. They are the widows; issue less, alone and disabled elderly. The widow and issueless have certain problems even among the better off and well off categories. These are nearly 29 per cent widow elderly and only 10.5 per cent widower, 0.43 per cent divorced and in same proportion (0.43 per cent) unmarried elderly. So this 40.36 per cent elderly are a matter of concern.

There are 8 per cent elderly who are issue less or alone. So these groups of the elderly are really a matter of concern. They have needs like- food, shelter, medicine, care, etc. However the rural and urban elderly have different needs. In rural areas they have less psychological and social needs. They have strong neighbourhood and affinity which is not commonly so in the urban areas [Shah, 1999].

**Policy Directions**

The focus on needs of the elderly, the most vulnerable sub-groups identified by one study [Ansari, 2002] and the modes of life of the elderly suggest some concrete direction for public policy for the elderly. The types of disability, illness/ diseases/ complications, their treatment, source of treatment, causes of not taking treatment on their socio-economic dimensions, have been found to be important. Poor economic condition is the main cause of not taking treatment for majority of the elderly. The elderly asked for free medicine in case of illness, and employment of their sons. Because they are not excluded from their sons' family, if sons will have money they can also avail the facility.

We should deal with other concerns of elderly health like the toilet facility particularly for immobile and disabled. Almost all elderly have to go to open field for defecation in the rural areas. In villages, unavailability of toilets is not considered as a problem but in case of disabled elderly, particularly for the Alath, a toilet at the doorstep is necessary for men as well as for women.

For housing facility, majority of the lower castes demanded that their houses should be constructed under Indira Aavas Yojana where the elderly could also reside with their family members. Policy makers should ensure one extra room for those households in

which one of the two elderly live instead of providing house at urban centres in old age homes. They opined that whatever services the old age homes may give that could not match for what they receive from their own people (offspring).

There will be a greater role of *Bathan* (A traditional institution away from main home in villages which is called *Bathan* or *Chaupal* where generally cattle are kept for agricultural purposes and elderly male members and unmarried adults stay. This is also used as a guest house and a place of social interactions). It can be developed and promoted in a way where the elderly and young can participate in their social and economic activity in an intergenerational manner within the community.

*Bathan* can be used as a substitute place of medical care facility for the elderly. The government health worker should come there at least once a week and provide medical aid to the elderly of the village as well to other age groups. This will be different from the old age homes. In old age homes the elderly would be totally alienated from their family and community.

At *Bathan* during daytime they can stay and relax from the daily routine work. In villages, males use rooms or inner house during the night only for sleeping but at daytime they need some open place to sit, gossip and chat. If some grant will be given to develop some extra spaces by erecting open shades so that in sun, rain the elderly can sit there, work there, can get medical treatment whenever the health worker visits. In case of illness, this institution may be used as wards where the other people of the village also can render their services.

In case if any one has no space they can come and sleep at night here. That can be used, as a community centre whenever there is a function like marriage, meeting, etc. In that way *Bathan* will be able to serve the elderly multi-purposely.

Moreover *Bathan* would be more useful for economic activity- some business and cottage industry should be promoted for those elderly who are able to do light physical work. Thread economy is the best for them. The *Khadi Gramodyog* was a good move on this regard, but now that is dead. These activities may be done at the *Bathan* along with the younger generations. They can spin the thread, fill the reels; can weave by sitting at *Bathan*. Other cottage industries that they can do is making paper bags, like making ropes, leaf plates (*pattal*), making baskets, making straw plates, baskets and dolls. They can get raw materials easily in the village itself. Moreover, it needs proper marketing of these goods through government channels. The involvement of the younger generation in these works will help the elderly. So *Bathan* may fulfil the social, economic and medical purposes.

**Existing Policies and Programmes**

***Old age pension: social security schemes***

For the pension of the elderly, who are in unorganised and agricultural sectors, the government has started projects (OASIS) through which every body has to deposit rupees 5 per day and if it will be sustained for whole working years (35years) then their would be large pool of money which could be given as pensions. But they failed to understand the daily cash income and household expenditure about the rural poor [Sujaya, 2000:19].

Pension is given to the elderly through out the country and the rate varies from rupees 32 to 250 per month. But this is only a token payment to ward off extreme destitution and cannot afford income or livelihood security and that is also not given timely. Though the policy speaks of revising the rate at intervals so that inflation does not deflate its real purchasing power, no details have been given to show whether a total review will be done on the basis of the need for economic sustenance [Sujaya 2000:15]. Only a fraction of the elderly population is covered by old age pension and other schemes.

***Policy for the sake of policy: implementation is crucial***

The other aspect of the policy part is the implementation. Whether the programmes for elderly are working properly or not? The Indian government has no proper and strong accountable monitoring system for any programme. So mechanism should be developed to monitor all the programmes and make authority/persons accountable and in case of any breach they should be punished.

The state did not view them as a resource or as active participants in planning their own development and welfare. On the other hand, the state governments found that there were severe financial constraints in expanding these social welfare schemes to cover larger numbers of older persons [Sujaya C. P. 2000:14].

***National Policy on Older Persons (NPOP)***

Though, the Indian government, in 1999 announced the National Policy on Older Persons on the eve of the United Nations International Year of Older Persons [Sujaya 2000:14-15] and declared the year 2000 as the National Year of Older Persons. But the problems of elderly people remained the same amid the seminars, symposia, and walk for all ages and so on.

National policy on older persons is based on the assumption that the proportion of the elderly is increasing in Indian population. The effect of the changes in the economy due to urbanization and industrialization and the introduction of new technology and new life styles and values on the structure and functioning of families and their capacity to care for the elderly [Sujaya 2000:15] which is not true. As, some studies contradict this notion [Desai, 1986; A. M. Shah, 1998; Ansari, 1997]. So the focus of the policy would also be not on the real problems.

However, this policy highlights 'the plight of the vulnerable older persons' category such as widow, women in general, the poor, rural residents, the disabled and chronically ill (including mentally ill) and others. But in the absence of adequate research on these groups, their conditions will not be clear, the prevalence, distribution, and severity can be understood through in-depth and holistic study.

As [Sujaya 2000:16] highlights that there are no available figures showing the number of older persons who are below the poverty line, the incidence of poverty can be assumed to be higher in the older age groups than in the general population. In the same way the disabled elderly and chronically ill elderly figures are not available.

The other facilities as the programmes show are that of strengthening the primary health services, providing geriatric care facilities at secondary and tertiary level, starting new specialized courses in geriatric medicine, starting mobile health services for the ailing old persons, meeting the education, training and information needs of the older persons and so on. But if we see these programmes then a major proportion of the elderly who are living remote villages having problem of basic needs: foods, shelter, clothes: hardly avail these facilities.

The other aspects of elderly needs are that when they fell ill permanently; a permanent caregiver is needed. So how to ensure the care at their illness particularly when they will become 'Alath' the mechanism should be developed by the government through the community, Panchayat and family.

For economic security, the government has some provision of loans for elderly but taking loans for elderly is very difficult. The provision should be in such a way that the care provider of the elderly should be given the loans, and other jobs that they will ensure the care of the elderly. It is found that majority of the elderly are taken care and reported by their family members. [Ansari 1997].

The workers of unorganized sector, particularly in rural areas should be given some economic security at their old age when they become unable to perform any economic security at their old age when they become unable to perform any task. The government has started a pension scheme for them but it is based on the assumption that the persons who at a minimum save Rs 5/- per day [Sujaya 2000:19]. But there are so many people who do not cash. To focus on poverty among older persons (not only older persons but households) without its political economy will not lead us to any substantial solution for continuing the problem of old age destitution.

**Conclusion**

In India, elderly among the marginal sections need special attention. The real cause of their problem is economic- poverty, landlessness, causal labour, poor health and lack of welfare services, poor transport and communication services etc. The living conditions of the elderly in India and other developing and under-developed countries are currently

characterized by extreme poverty in which they live and which is transmitted to subsequent generations. They are affected by situations of social exclusion, lack of opportunities to participate in development activities, extremely limited access to health care, non-existence or minimal development of pension systems, scarcity in the social service networks, housing, etc that fail to meet minimum conditions of dignity.

The emerging social and the public health consequences of ageing, especially in developing countries, need to be taken very seriously. In a majority of these countries, poverty and lack of social security schemes are the main reasons of the elderly disability (the world NGO forum on ageing meet, Madrid on April 5$^{th}$ - 9$^{th}$ 2002). In order to respond to public health challenges of population ageing, the World Health Organization (WHO) launched in April 1995 a new programme on ageing and health, which stems from and builds upon the achievements of its predecessor - the programme of health of the elderly.

The emphasis of the new programme is on healthy ageing rather than on "the elderly". Its key components include database strengthening, dissemination of information, advocacy, and community-based programmes, research, training and policy development. Living longer offers unprecedented opportunities that personally and socially fulfil lives, but it also presents individual and societal challenges related to quality of life in old age, including independence, social interaction, health care and community involvement. In order to respond to these challenges, countries have to develop sound and affordable policies that perceive ageing as a natural process, which continues throughout the life span. Effective community-based programmes need to form an integral part of such

healthy ageing policies. The creation and strengthening of a reliable database is a prerequisite for the development of national policies on healthy ageing.

It is also crucial for raising awareness among policy- and decision-makers about the population ageing and its public health consequences. This awareness is still low, particularly in developing countries. National policies on ageing should rely on the results of research aimed at cost-effective public health interventions to improve the quality of life in old age. Such results need to be widely shared among countries. WHO is particularly committed to improving knowledge and skills of primary health workers through training activities in a variety of countries to deal with ageing-related problems. Living longer is both an achievement and a perpetual challenge. Investing in health and promoting it throughout the life span is the only way to ensure that more people will reach old age in good health and capable of contributing to society intellectually, spiritually and physically.

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