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No Longer Last nor Least ... The Elderly and the Disabled

Introduction

In India in general, in both economic policy and social policy, two groups receive very little attention. Yet both encompass many millions of people and comprise a growing proportion of the population. Estimates of the number of people with disabilities vary very widely, from an unbelievable low of just over 2 per cent revealed by the Census of 2002 to about 16 per cent of the total population. Some have claimed it is higher.

The World Bank has guesstimated that there may be up to 90 million people with one or more disabilities (O'Keefe, 2009; Shenoy, 2011), and the WHO (2011) has estimated that the average percentage of a population having disabilities is 15.6 per cent, which would put the Indian number much higher. Yet, whatever their number, their needs tend to be neglected in public discussion of social policy.

Most of us have disabilities of one sort or another, latent or visible. Some face chronic disability and can barely function. Some face a life of episodic disability, that is, they have conditions, such as diabetes, which afflict them from time to time, incapacitating them temporarily. They are difficult to categorize, making it hard to design social policy oriented to helping those classified as 'disabled'.

Meanwhile, the elderly are a growing proportion of the total population. As mortality rates drop, and as morbidity among older people declines, this growing group is not just a dependent one requiring some formal or informal pension, but is also a substantial group of productive people, giving a new meaning to the idea of the 'elderly'.

The disabled and the elderly share some deeply ingrained problems linked to cultural and social prejudices. Typically, they are regarded as involving families and communities in additional social and economic costs. Almost by definition,

they have a higher probability of experiencing a shock in the form of a medical crisis that precipitates a financial crisis, simply because dealing with a medical crisis tends to be very costly.

Those with visible disabilities also tend to be regarded as having a lower expected income, in the short term and in the longer term. If they also require attention and care from others in their households, they also tend to lower the potential income of the household and, in particular, that of those who provide the care, typically a woman or adolescent.

A village community typically responds to these realities by supporting moral codes of behaviour and by various sharing practices. But households struggling to survive tend to behave, to a greater or lesser extent, in ways that maximize the probability that they will be able to maintain themselves.

That is likely to mean that priorities will usually be decided within families, explicitly by decisions made by the nominal household head or implicitly, over time, by rationalization of little acts of preference, such as giving larger portions of food to those seen as offering the highest probability of producing more or bringing the most income into the family. This is all understandable, and is what happens the world over.

Add cultural prejudices and there are the ingredients for a pattern of discriminatory decisions that inevitably affect the welfare and development of individuals. In this cruel dilemma, it is surely common for those with disabilities, and those aged and frail, to be the least favoured. This will not be the case all the time, because sympathy, pity and empathy play a part, leading to moral pressure on family members to compensate for their relative's disability or past contributions. But the sheer survival instinct must be strong in such circumstances.

Bearing these behavioural and attitudinal concerns in mind, it is important to consider how individualized basic incomes affected them, and affected the welfare of those with disabilities and the elderly. We will do this briefly in this chapter, hoping that the tentative findings prompt more detailed analysis.

The disabled enabled?

Examining the data from the evaluation surveys and relevant case studies, there was reason for thinking that those with disabilities would tend to gain nutritionally more than others, mainly because the basic income represented a higher proportion of their previous living standard, which would have been below that of other members of the household.

So, as the disabled tended to be disproportionately concentrated in lower-income households, receipt of their Rs.200 or Rs.300 basic income would have raised their relative as well as absolute standard of nutrition. It is also notable that scheduled caste households had a higher incidence of disabled members than others.

The basic income also had a particular emancipatory value for the disabled, because in gaining access to more food, the individualized basic income gave the person more bargaining strength within the household. It was their money.

The same reasoning is applicable to access to schooling. In a cash-scarce community, in which certain costs associated with schooling act as barriers to regular attendance in school, such as the cost of transport and clothes, the tendency will be for families to give priority to paying for those costs for children who have what they perceive as the greatest probability of turning schooling into income-earning activity.

Those with what families will tend to see as having a low probability of bringing income into the family are more likely to face discriminatory treatment by their own families. Again, this is not heartlessness but cruel pressure. In addition, the actual costs of ensuring school attendance would tend to be higher for children with disabilities.

Laws and regulations cannot fully overcome these self-discriminatory tendencies. A basic income could not be expected to do so either. However, the very existence – and the community's knowledge of its existence – of the individualized basic income would surely help improve the bargaining position of the disabled and induce moral pressure from others to ensure they have equal treatment.

Nanuram, a Bhil tribal agricultural labourer in one of the pilot villages, had a physically disabled son due to polio. Aged 20, he was studying in 10th grade at a private school and taking private tuition at a local town. Talking about the basic income, Nanuram said:

I don't take his money at all, Sir! He studies, so he needs that money for his books and transport. He takes from the bank whenever he needs money for his studies. So far he has done so twice – 600 and 500 Rupees. With the 600 he had his tricycle repaired. It has been lying broken because we did not have money. With his second withdrawal, he bought clothes and paid for his tuition fees.

Beyond nutrition and schooling there are, of course, the several effects on health and healthcare. Cruel decisions have always had to be made in cash-scarce situations. And the individualized basic income must have unambiguously positive

effects, even if they are modest. Happily, there is evidence from the evaluation surveys that this was indeed the case.

The health impact was strong. Households with disabled members were just as likely to report a lower incidence of ill-health as other households compared with those without the basic income. Thus, whereas 68 per cent of households without it and with disabled members reported some illness in the past three months at the time of the FES, only 56 per cent of equivalent households with the basic income had an illness.

Among households receiving the basic income, those with disabled members were more likely to have increased spending on medicine (68 per cent versus 56 per cent) and more likely to have done so than households with disabled members without the basic income. And among those with the basic income that increased such spending, those with disabled members were more likely to attribute that directly to the basic income.

Among the basic income households, those with disabled members were relatively more likely to have shifted to private treatment, 37 per cent of them having done so, compared with 26 per cent of other households.

And among the basic income households, those with disabled members were more likely to report having taken medicine more regularly in the period (24 per cent versus 14 per cent). This was more than double the share of households with disabled members that did not receive the basic income.

However, the biggest impact was in inducing more of the disabled to go for hospital treatment. Although the range of disabilities was broadly similar across all the 20 general villages, it was remarkable that in the year covered by the retrospective data collected for the FES, 48 physically disabled persons in the basic income villages had hospital treatment, whereas only two did so in the control villages. It is extremely unlikely that this difference came about by chance.

Moreover, when hospital treatment was needed, the average number of days between the need arising and going to hospital was much lower in the basic income villages. In short, the disabled and chronically ill were not only more likely to go for the treatment but were more likely to go in a timely way.

Kamlabai, a 70-year old disabled woman in Datoda village, was one of many disabled persons to have benefited from the basic income payment. Recounting how the money had helped her, she said:

All my basic income money was spent on my treatment itself, because I have such physical weakness that every month I have to spend up to 500 Rupees. We

go to Ghata-Billod for medical treatment because it is nearer. We go to a private doctor. He takes 200 Rupees.

Like Kamlabai, a majority of the disabled within basic income households perceived their situation to have improved. At the time of the Post-Final Evaluation Survey, a census in two of the basic income villages, 120 individuals said they had a disability or chronic illness that affected their ability to work or study, of whom 95 per cent said they needed regular treatment, medicine, aids or prosthetics for their condition.

Among the 120, 87 per cent believed the basic income had improved their personal living conditions, 80 per cent believed that it had helped them take medicines more regularly, 73 per cent said it had helped them to go to a doctor or clinic more regularly, 81 per cent said it had given them a sense of independence, and 76 per cent said that it had helped them pay attention to their health problems more than a year ago. Remarkably, it had an even bigger positive effect for women with disabilities (Table 10.1).

Similar findings emerged in the tribal villages, where nearly two-thirds of those receiving the basic income mostly went to hospital within two days of falling ill or needing treatment, compared with just over a quarter of those in the control group. The duration of stay in hospital was also less, suggesting that they went at an earlier stage.

Households with disabled members tended to experience more financial crises than others. There is nothing surprising in that. They were also more likely to have experienced a rising level of debt and were slightly less likely to have had any savings. But as with so many aspects of their lives, they reported that the basic income had lightened the load.

Table 10.1 General villages: Percentage of disabled and chronically ill persons reporting improvement due to basic income, by main reason and gender

	Disability		Chronic illness	
	Male	Female	Male	Female
Improved personal living conditions	91	100	86	88
Helped taking medicines more regularly	73	100	69	86
Helped visiting doctor/clinic more regularly	73	85	69	78

Source: MPUCT PFES, 2012; n=120

Debt, saving and financial crises

The effect of the basic income on the financial situation of households with disabled members was a mixed one. A majority of such households (58.5 per cent) reported an increase in debt over the year covered by the FES, compared with 45 per cent of other basic income households. But they were less likely to have experienced increased indebtedness than households with disabled members that had not received the basic income (64 per cent).

A similar pattern emerged with saving. For those receiving a basic income, households with disabled members were less likely to have saved in the past year (16 per cent versus 21 per cent). But nevertheless, they were more likely to have saved something than equivalent households that had not received the basic income (10 per cent).

The impact on work among the disabled

The disabled tend to be grossly neglected in analyses of labour and work, and much else. As emphasized earlier, they make up a significant proportion of village populations, and deserve far more analytical and policy attention than they receive.

It is difficult to isolate the effects of a basic income on work activity. Clearly, it was likely to help those capable of working to do so, enabling them to buy more raw materials or small tools or instruments, and so doing activities that they might have wished to do but lacked the resources. Thus, several people opened a little shop. Again, this is an emancipatory effect.

A poignant case was that of Saloni, pictured on the front cover of this book, a disabled 30-year-old landless woman from a backward caste, whose husband, Devnarayan, was also physically disabled, and who lived in the village of Malibadodia. She told the case study enumeration team that her disability meant she could not work outside the home, but added:

From the basic income money we saved and bought a hand-operated sewing machine. With the help of that, we started sewing work for the villagers. This has added to our income. In the past year [when receiving the basic income], we have increased the intake of vegetables, as compared to the year before. With the help of the cash, I also bought bangles, clothes, *chappals* and household utensils, and we paid the school fee for our daughter. For health expenses, we started taking our medicine regularly. The main benefit from the basic income

has been that of buying the sewing machine, which has increased our income, and as a result we are able to fulfil our family needs.

In effect, the basic income had released a constraint on her capacity to work and on her capacity to be a productive member of the community. It is this sort of small but vital liquidity effect that comes across in so many respects.

In terms of the statistics from the evaluation surveys, the FES revealed that households containing one or more disabled people were more likely to have increased their income-earning activity in the past year than similar households not receiving the basic income. The impact on households with disabled persons in them was remarkably similar to the impact on households without disabled members. In effect, such households were also able to take advantage of the opportunities afforded by the basic income.

Perhaps what was most striking was that households with disabled members who did not receive the basic incomes were the most likely to have experienced declines in income-earning – 27 per cent, compared with 12 per cent that had received the basic income.

A related finding from the FES is that the basic incomes appeared to have the same positive effect on the number of days of farm work done by households with or without disabled members, 14 per cent compared with 13 per cent for basic income households that did not have disabled members.

So, in net terms the change was actually bigger for those containing disabled members (i.e. comparing those with and without basic incomes). This latter finding was a reflection of a decline in own-account farm work by households with disabled members that were not receiving basic incomes.

In sum, one may conclude that at least some of the disabled, presumably those with least impediments, had been able to participate in the local economy and had thus become contributors to its growth and development.

The subsidy and labour lines

How did the disabled fare with respect to the two major welfare policies pursued over recent years? The subsidy line should be of concern. Households with disabled members were slightly more likely to have a BPL card, but still only a minority of those had one. They were less likely to have an APL card or to have an AAY card.

There was no difference between households in their use of the PDS ration shop. Over the past year covered by the FES, among those receiving the basic

income, more of each type of household reported using the PDS less. Thus, 10 per cent of households with somebody disabled in them used it less, compared with 5 per cent using it more. But more of the control households with disabled reported using it less, 11 per cent, compared with 2 per cent using it more.

In sharp contrast, 47 per cent of basic income households with somebody disabled reported using the market more, precisely the same as among other households receiving the basic income. That was significantly more than for equivalent control households. In sum, over half (52 per cent) of disabled basic income households reported shifting more to the market.

If the disabled were just as likely to be moving away from the subsidy line, their experience of the labour line was predictably dispiriting. A smaller proportion of households with disabled members were aware of the MGNREGS. And of those who were aware, only a minority had registered with the scheme, and of those only a very small minority had actually had any labour on it. Evidently, the scheme was effectively discriminating against those with disabled members.

The elderly

The elderly also tend to be neglected in discussions of social policy. That cannot continue with any credibility, because their numbers are growing. And in that regard it is welcome that a big enquiry was conducted in 2014 on the status of the elderly across India (NCAER, 2014). They presently comprise just over one in every 12 rural inhabitants in Madhya Pradesh, roughly the national average. Only about 16 per cent were receiving any money from government benefits.

In terms of assessing the impact of the basic income, there are two ways of looking at older people in the villages. One can look at them as individuals and one can compare households made up of elderly persons with those made up entirely or predominantly of younger people.

In dividing households into types, we may define an 'elderly' household as one consisting solely of persons aged over, say, 55, or as one consisting of a majority of persons over that age, or as one in which the average age is 55 or over. We have done all three. There is a rather extraordinary effect that emerges from examining the impact of basic income. In some crucial respects, the basic income had a bigger relative effect on outcomes in elderly households than in 'younger' households, whichever way one measured the difference.

Because the basic income was paid individually, its impact could have been high for similar reasons as for the disabled, by strengthening their voice in

decision-making and because the cash probably accounted for a larger-than-average share of their total income. But neither could be taken for granted, simply because the elderly tend to be frail and dependent on younger relatives.

According to the FES data, and using the first definition of an older household (all members aged 55 or over), more of the older households preferred the basic income to rations of equivalent value, although the difference was greater for young households. Of those older households that had received the basic income, 43 per cent preferred the basic income in cash and 39 per cent preferred rations.

The experience of basic incomes and the attitudes to them were quite similar to those of younger households. More preferred family accounts to individual accounts than was the case among the younger households. But most of both the old and younger households reported having no difficulty with operating bank accounts, while the take-up rate of the basic income was actually slightly higher for the older households.

In the year leading up to the FES, more elderly households that had received the basic income made at least some improvement to their dwelling or living conditions than their equivalent households that had not received the basic income. They were less likely to have done so than the younger households that had received it, but more likely than younger households that had not received the basic income. A similar pattern emerged with changes in energy and lighting.

It was a similar story for nutrition. The share of old-age households that received the basic income which reported having too little income for their food needs was just 16 per cent, which was higher than for the younger households that had received the basic income (12 per cent) but much lower than for old-age households without a basic income (31 per cent) and also lower than for younger households without a basic income (25 per cent). This is surely a striking finding. Very similar findings emerged using the other two definitions of old-age households.

The old-agers were most inclined to use their basic incomes for food and to try to save something for emergencies. Recall Surjibai, a 70-year-old woman whose plight was seen in the previous chapter. Her experience was typical in that respect if not in others:

Then the basic income started, with cash. I used this money for the treatment of my illness and for regular household things like tea, sugar, oil, salt, chilli, turmeric, etc. I smoke one bundle of *biri* every day, so I used to get that also. I glean the leftover wheat from the fields during the harvest season in order to eat.

First, I went to Borsi village for treatment of my eczema and then I went to the private doctor at Jambudi village. Later I also went to Indore for treatment but still there is no relief from the condition. Because of this illness I now have 1,000 Rupees of debt. But I have no other outstanding loan to repay. I borrow groceries from the shop when I need. I am not charged any interest. I repay the debt by working at houses, but I am not a servant. I don't save anything and I am not associated with any unit. I live by myself, and I take all decisions by myself.

I eat twice a day. For my last meal I had *kheer-puri* from the *anganwadi*. I eat three *rotis* at a time. I do get enough food. I don't drink milk. I am vegetarian and eat vegetables occasionally, when I can afford it. Otherwise, I eat only *dal-roti*. The food I get from the *anganwadi* is good enough. It is better than nothing. I get food to eat, but I can't say it is nutritious food. I don't have money for nutrition. I go to the market [which is 10 kms away] once or twice a month. I don't buy anything from the ration shop.

I was helped by this cash transfer money immeasurably. I could buy food from the village shop and use some for my treatment. I have relatives who come to help me when my sickness becomes severe. But otherwise nobody cares. I only cook food for myself. I don't get any other help from my relatives. Since the coming of the money, women of our village have started saving through small units. The villagers have also decided to build the roof of the temple from the last instalment of the cash transfer money. I feel SEWA is doing good work by trying to make women self-reliant.

Clearly, this is a tough survival existence. But the little more had enabled her to gain a modicum of control over her life, and buy extra food from the local shop. It was notable too that she did not use the ration shop.

Indeed, among those receiving the basic income, more old-age households reported buying less from the ration shops (13 per cent) than young-age households (10 per cent), whereas hardly any reported buying more in these shops (3 per cent compared with 5 per cent). In this respect, there was little difference between old-age households by whether or not they were receiving the basic income.

However, the real differences came out in the shift to use of the open market. Significantly more old-age households with basic incomes increased their purchases in the market compared with older equivalents without the basic income. In neither case was the shift as great as for younger households. All groups had shifted from the ration shops to the market.

Health and access to healthcare are the most crucial issues for the elderly. Here again the results were encouraging and similar. So, the share of old-age basic income households having had at least one illness in the past three months

was much lower than in equivalent households that had not received the basic income (52 per cent compared to 67 per cent) and also lower than in non-old households without the basic income.

And fewer had been hospitalized than their equivalent old-age households without the basic income. Meanwhile, old-age households with the basic income were the most likely to have increased spending on medicines. And as the control households were also more likely to report having spent less, the net difference was even greater.

Anandibai, a scheduled caste wage labourer, described how her mother-in-law, an asthma patient, was able to use her basic income to pay for injections and medicines, which cost her Rs.150–200 every month. Another old person, when asked what he did with the basic income, had this to say:

On account of my old age the money was utilized for my injections. Twenty Rupees would be spent just on transport. The rest of the money was given to the doctor.

Similarly, more old-age households with the basic income reported increased spending on doctors' fees, and the difference was greater for the old-age households than for younger ones. There was no significant difference between the aged and other households in terms of spending on private treatment. But the spending increase due to basic income was greater for old-age households.

Households with elderly persons were actually not more likely to have substantial debts than other households. The fact was that debt was pervasive, although the share of old-age households with substantial debt was lower than average. Some 58 per cent of old-age basic income households had debts, compared with 72 per cent of other basic income households. What was also striking, however, was that very few old-age households that did have debts were able to reduce them. And fewer old-age households managed any saving, whether or not they had received the basic income.

Many old-age households regarded the basic income money as a source of increased security. Consider another fairly typical account, by a 73-year-old man, Mohanlal, from the Teli-Rathor community (a designated backward caste), who lived with his 70-year-old wife, Parvatibai:

We have three children, all of whom are married. They all live separately from us. I have three acres of unirrigated land. We rent out this land on a yearly rent, for which we take 15,000–20,000 Rupees a year. We distribute this money among the three children. I do the work of herding the cattle of my three children. In return, they give us stuff required for the running of our household,

for example milk and groceries, etc. They don't give us cash. My wife goes to do wage labour in the fields of the village farmers. She goes for 8–10 days in a month, which provides us for the month.

Only my wife and I stay in our house; the children live nearby. I only do the herding of the children's cattle. We have an APL ration card, on which we buy wheat and kerosene. We both eat twice a day. We ate *sabji-roti* at our last meal. We both eat 2–3 *rotis* at a time. Food is sufficient and we don't face problems regarding food. The market is four kilometres away. We don't buy stuff in bulk; we go and buy things that are required at home. We buy vegetables from the vendors who come to sell in the village.

Both of us are in good physical health except for the usual seasonal illnesses. We go to Ghata-Billod for medical treatment. Our government hospital is at Betma, and it costs 20 Rupees to go there as it is far away. This is why we go and get the treatment in Ghata-Billod, which is nearby.

We sieve the water before drinking. We sometimes use soap for bathing and washing, but it is not obligatory. In order to repel mosquitoes we smoke the house; nothing other than that. We have a toilet in the house, which is shared by our children as well. The roads in the village are not at all good and there are no drains. All this causes a lot of dirt and filth in the village.

We have a bank loan to be repaid. We had taken this loan on land, from the Bank Society for Fertilizers and Seeds. I used that to go for a pilgrimage. We will pay it back by taking loans from here and there, and then we will take it out again after repayment.¹ It works like this only. At present we don't have savings of any kind. We have saved only the cash transfer money that has been coming. We have saved this so that we can use it in case of emergency. It will be useful if either of us falls sick. Fortunately our bodies are still in working condition, but as old age advances, this money will be useful to us. For this reason, we have not taken out any of the money.

Intriguingly, old-age households were significantly less likely to have experienced a financial crisis in the past year. They were just as likely to have had to borrow to meet a crisis if it arose, but at least among those receiving the basic income they were the least likely to have had to sell or mortgage any assets to deal with it.

Regarding access to selective and targeted social policies, the old typically have certain disadvantages. Old-age households were more likely than their younger counterparts to have a BPL or AAY card, and correspondingly less likely to have an APL card. But they were slightly more likely to have no card at all, presumably reflecting their difficulty of obtaining or re-obtaining one. Unsurprisingly, they were less likely to be aware of MGNREGS and, if aware,

much less likely to have had any labour on it. As with the disabled, that labour-based scheme of social security has been a discriminatory policy against older people.

Finally, there is the impact on the work and labour of the elderly. Here there is a very mixed picture. The problem is that with this age group, there is an income effect and a substitution effect. The increased income represented by the basic income should have enabled some to reduce their labour, particularly bearing in mind that among the elderly the productivity of manual labour would presumably be low. At the same time, the influx of the cash may have enabled them, like younger villagers, to obtain more seeds or small-scale equipment to enable them to conduct an income-earning activity.

In general, the data pointed to a slight drop in labour force participation among the elderly who received the basic income, although in the overall multivariate analysis the coefficients were not statistically significant. Taking the age group 55–59, the male economic activity rate as conventionally measured remained the same over the period of the pilot, whereas it dropped by about seven percentage points for women in the same age bracket.

This should not be interpreted as women doing less work per se, since they reported doing more housework and care work. Men reported doing less of such work. The changes in all these respects were greater than observed in the control groups.

As with all age groups, among those aged 55–59, those receiving basic incomes tended to shift from casual labour and construction labour to own-account work, and this was greater than in the control villages. For both men and women, there was a greater amount of animal husbandry. And for both, there was an increase in the number reporting that they were working what might be described as full-time, more than 20 days in the past month, whereas for the same age group there were declines in the control villages.

For those aged 60 or more, there were no discernible changes that could be linked to the basic income. But it seems as if for the age group 55–59, the basic income had a small positive effect on work activity, not the negative effect that one might have envisaged.

Concluding reflections

At the end of the pilot, in the PFES, a set of questions was asked about which person in the household had benefited most. The disabled were often mentioned.

Respondents who had some disability were just as likely as others to report that the basic income had made a difference – more reporting a big difference – to their influence on decision-making within the household. However modest it might have been, it was empowering for them.

In spite of the encouraging outcomes, it must be emphasized that the disabled continued to experience the greatest hardships, being in general the least likely to have increased their earned income, less likely to have saved and less likely to have reduced their debt, and more likely than average to have experienced a financial crisis. But in all those respects, the disabled with basic income did better than those without it. Even for them, it had proved emancipatory and had helped improve their general welfare.

Note

- 1 It is a reference to the bank loan given by the government to landowning farmers. The bank loan is 'renewed' every year after the repayment. Usually this happens during the harvest season. However, in the case of Mohanlal, who used this money for his pilgrimage instead of farming, he had to take other loans in order to repay the bank loan.