CHAPTER 2

REVIEW OF LITERATURE

2.1 Introduction

Literature review for the proposed subject and area of research are based on books, unpublished thesis, articles in periodicals, online collections, presentations etc. The major sub-topics of the present study are (a) ageing in India: (i) state-wise and (ii) district wise within West Bengal, (b) socio-economic status and health condition of the elderly in West Bengal, (c) socio-economic status and economic activities of the elderly persons in West Bengal, (d) socio-economic status and involvement in decision making of the elderly persons in West Bengal, (d) Socio-economic status and household relative activities of the elderly persons in West Bengal, (e) support and care for the elderly persons in West Bengal, (f) socio-economic status and well-being of the elderly persons of West Bengal.

2.2 Theoretical/ Development Perceptive on the Research Problem

2.2.1 The Global Perspective

The First World Assembly on Ageing sponsored by the United Nations Organization(UNO) held at Vienna in 1982 realised population ageing as a global issue, not only concerned to developed countries but also to large part of the developing countries. Till the Vienna Assembly in 1982, the study on population ageing was exclusively based on the experiences of developed countries, since then various studies had been done on population ageing related to developed and developing countries by the agencies of UNO and at the country level. The plan adopted at the Vienna Assembly emphasized much on solidarity of the family, though the growing damages in the family system in the West were obvious to the delegates (Bose & Kapur Shankardass, 2004).

The official document presented by the Government of India (GOI) in Vienna expressed the view that in India, the elderly persons are well integrated with the society and the welfare of them was linked with the main stream of social and economic development of the country. The United Nations International Year of the Elderly Persons in 1999 emphasized for the marginalization of the elderly persons in the development process and for the need to develop ‘a society for all ages’. The Second World Assembly on Ageing was held in Madrid in 2002. The Madrid Plan of Action (2002) thought about

(a) a developmental approached for the elderly persons emphasizing in the mainstreaming of the population ageing and elderly persons into policies and planning, (b) changing demographic, economic and social systems requiring adjustments in macro level policies on social and economic securities like pension, healthcare, long term care and support systems, (c) to maintain economic growth and development by review process of existing policies to ensure and promote the idea of equity, mutual support, solidarity among the generations. The plan also emphasized poverty as the foremost structural damage to the traditional mutual support system in families (Saha, 2006).

2.2.2 Theories, approaches and implications of Ageing

There are various theories, approaches, interpretation and aspects of the process of population ageing and the elderly persons as a social category. These processes are biological, physiological, psychological, socio-economic, cultural, spiritual and political in nature. The physiological approach associates the elderly persons with the process of physical ageing and interprets their role performance with the deterioration of their physical health. The psychologists associate and interpret the problem from the view point of decline in their mental health and emotional status. The sociologists and the cultural approach associate and interpret population ageing with the social norms and cultural values. The politicians associate and interpret the elderly persons as their vote-bank and the elderly persons may utilize political advantages for social security and health measures for themselves. The economists associate and interpret the elderly persons in the view point of their possession and sources of economic resources which may be utilized for their livelihood in their rest of life (Paul Chowdhury, 1992).

The ageing in developing countries has been explained by ***modernization theory*** where the deteriorating conditions in the lives of the elderly persons are due to modernization. Modernization theory argues that industrialization and urbanization undermines the status of the elderly persons. It is also referred as '***golden age' theory of ageing***. Greater mobility of young and working people allows them to be free from the authority of the elderly persons in the family. ***Dependency theory*** relates the deteriorating conditions of the elderly persons compel the elders to be dependent on the existing social and economic structures (Saha, 2006).

Again there are two major known theories about the status of the elderly persons:

(i) Engagement versus disengagement theory– (a) Role theory, (b) Ashram theory.

(ii) Integration versus segregation theory– (a) Integration theory, (b) Social Adjustment.

In regard to the engagement versus disengagement theory, there are three major approaches for the elderly persons - (a) Activity approach, (b) Passive or disengagement approach, (c) Development approach.

In regard to activity approach, the elderly persons may be engaged to work which they postponed to the elderly age. In regard to passive approach, the elderly persons withdraw themselves from social activities; accept a secondary position transferring family responsibility to the younger generations and reduces social participation. The development approach is developmental, preventive and life-enhancing approach rather than curative. According to this approach, the necessary tasks for the rest of life may be done by the elderly persons - (a) redefinition of social identities with development of new social and economic goals, (b) linkage of past and present to the future for the betterment of family, associations, services and communities etc. (c) development of new self-image and sense of integrity etc. The elderly persons were the integral part of the family, but they are separated from their families and societies for various reasons which led to the loss of many roles of the elderly persons. Retirement is a context of role theory which may depend on how an elderly person is able to replace the work and activity roles by other roles (Activity approach). In ashram role, the elderly persons withdraw oneself from his/her work and devote time for the service of community. After some years, the elderly persons completely dis-engage from all affairs and devote oneself for self-expression (Passive approach). Integration theory for the elderly persons is the integration of role theory and ashram theory which leads to integration of these two roles, integration of old values and new values, engaging oneself in house-keeping, child-care, shopping etc. Social adjustment role is an adjustment by the elderly persons with the family and the community where the elderly lives (Paul Chowdhury, 1992).

Active ageing, a new concept deployed by the European Commission, the World Health Organization (WHO), used in Human Resource Management (HRM), evokes the idea of longer activity, with a higher retirement age and working practices adapted to the later age of the employee. It also extends to the social engagement of the elderly persons, according to which elderly person’s well-being relies on them staying active in their elderly age, again staying active is key to successfully ageing (visit https://www.revolvy.com/main/index.php?s=Active%20ageing). The Active Ageing Index (AAI) score for individual countries shows the extent to which their elderly

persons' potential is used, the extent to which elderly persons are enabled and encouraged to participate in the economy and society and to live independently. Active ageing index is highly positively correlated with (a) life satisfaction (well-being) of elderly persons and (b) gross domestic product (GDP) of the country. The determinants of active ageing are participation, health and security of the elderly persons. Active ageing applies to both individuals and population groups.

2.3 Measurements of population ageing

There are different indicators for measuring population ageing, these are:

(a) Proportion of aged 60 and above (Percent of elderly): This is the most frequently used measure of population ageing which is the per cent of persons aged 60 and above in the total population. Population would be considered to be young, youthful, mature and old according as population having less than 4 per cent, 4 to 6.9 per cent, 7 to 9.9 per cent and 10 or more per cent of people aged 60 and above in the total population. The UNO suggests that a 7 per cent number is enough to say the population as aged (Dhar Chakraborty, 2004 and Saha, 2006).

(b) Median Age: It may be defined as the exact age that divides the age distribution into two equal halves. Population would be considered to be young, in intermediate stage of the ageing process, aged according as population having median age below 20 years, between 20 and 29 years and 30 years and above.

(c) Proportion of Children under 15 years of age: It is the per cent of children under 15 years of age to the total population. Population with a value below 30 is considered as old.

(d) Aged-Child Ratio (or Ageing Index): It is the per cent of the number of elderly persons to the number of children. A population having a value of over 30 is considered as aged.

(e) Expectation of life at birth (or life expectancy at birth): It is an indication of population ageing. e_x^0 is the expectation of life at age x. e_0^0 is the expectation of life at birth. Similarly e_{60}^0, e_{70}^0 and e_{80}^0 are expectation of life at age 60, 70 and 80 years respectively. If the life expectancy at birth increases, the number of elderly also increases, as a result, different measures of population ageing also increase.

Generally female life expectancy at birth is found to be higher than that of males in many countries.

(f) Dependency Measures of Population Ageing: These measures are not utilized for measuring the population ageing, but for the social and economic dependency created by the population ageing. Some of these measures are:

(i) Old Age Dependency Ratio (per cent): It is the ratio of those 60 years and above to the persons of aged between 15 and 60 years of age.

(ii) Potential Support Ratio (PSR): It is the number of persons aged 15 to 64 years per every person aged 65 years and above.

(iii) Parent Support Ratio (PaSR): It is the number of persons aged 85 years and above per 100 persons in the age group 50 to 64 years.

(iv) Youth Dependency Ratio: It is the number of persons aged up to 14 years per 100 persons in the age group 15 to 64 years.

(v) Total Dependency Ratio: It is the number of persons under age 15 plus persons aged 65 and above per 100 persons aged 15 to 64 (Dhar Chakraborti, 2004).

2.4 Different Securities in Old Age

Security for the elderly persons is of different types and dimensions. A person has security from (1) his/her physical environments, (2) physical fitness and absence of disease, (3) economic or financial status, (4) social status and authority, (5) sense of belonging and being wanted and utilized, (6) purposeful life having regular work and a sense of achievement and (7) human contacts etc (Paul Chowdhury, 1992).

Social Security for the Elderly

Question of social security remains in human life from his/her early life to death and even after death. It measures the opportunities to prevent poverty, dependency and family disintegration. Its foundations are liberty and dignity of personality of the human being. Social welfare programmes would be inefficient without a system of social measures. Its measures will be incomplete without supplementary social welfare services. There are three methods of social securities (a) social assistance, (b) social insurance, (c) gratuity, pension, provident fund and other retirement benefits. A social assistance

provides benefits to persons of small means sufficient to meet the minimum standard of needs, financed from tax-funds. Social insurance provides benefits to persons of small earnings out of funds collected from the insured as his/her contributions and the subsidies from the employer and the state. Social assistance for the elderly persons may include health care services, financial assistances for food, cloth, living arrangements, daughter's marriage etc. Government and some private sector employees are entitled to avail the gratuity, pension, provident fund and other retirement benefits after their retirements. Gratuity, provident fund, leave encashment, commutated pension are provided to the retired person one time just after his/her retirement and pensions are provided to the retired persons monthly. Even after the death of the retired person, some fraction of pension earned monthly by him/her are provided monthly to his/her nominee(s) up to the death of the nominee(s) (Paul Chowdhury, 1992; Brown, 1997). There are various other measures of social securities for the elderly persons like (a) reverse mortgage loan, (b) micro-financing, micro-credit, micro-insurance etc. (Chatterjee, 2005; Ahuja, 2005 & Federal Ministry for Economic Corporation and Development, 2006). There are provisions for life insurance for elderly persons, even up to the age of 95 as well as plans that cover the elderly persons the rest of life and beyond the life. Such insurances for the elderly persons are for (a) burial life insurance, (b) term life insurance etc.

Poverty for the elderly persons has a strong gender dimension. Life expectancy for women is higher than for men, therefore elderly women may be in poverty for a longer period of their lives. Chance of losing life partner for a woman is higher, and women are less likely to remarry than men. In some societies, they have to deal with exclusion due to the stigma of widowhood. The worldwide pension coverage pattern also has a strong gender dimension. In most countries, the women are less represented in the formal economy than men are, and are therefore contributing relatively less to social insurance pensions. There is a gender bias that women are often employed in jobs with lower pay than that of men. Women may have fewer years of services – either because of they interrupt their careers to look after their children and other family members or for other care responsibilities, or because of women are encouraged to leave their labour market earlier than men. If the pension scheme is based on individual savings, women may have comparatively lower pensions than men. Generally, the husband contributes to a social security pension scheme, while his wife is dependent on his pensions. This is the classic model of the male breadwinner. In this case, women are entitled to derive pension rights

which are typically lower than for men. In case of a marriage break-up, there is generally no splitting of pension claims between husband and wife. In the best of cases, wives will then be eligible for lower-level tax-financed pension assistance benefits. In most cases, neither husband nor wife is entitled to social security pension, since they have worked in the informal economy. In that case, income security in elderly age depends on accumulated assets over life, such as savings, housing, livestock and land etc. Levels of benefits received from the social security pension system are of course dependent on resources invested. High-income countries spend on average 6.9 per cent of their Gross Domestic Product (GDP) on social security old-age pensions (slightly more than the average they spend on social health protection); middle-income countries only 2.1 per cent of their GDP; and low-income countries 0.6 per cent. Pension spending per person after retirement age in a country, expressed as a per cent of its GDP per capita, is an average of 56 per cent in high-income countries, 33.2 per cent in middle-income countries and 17.8 per cent in low-income countries. Share of population after legal retirement age in receipt of a pension and active contribution to a pension scheme in the working-age population in the world are 40.2 and 26.4 per cent respectively (these are high in high-income countries and low in low-income countries, these figures in India are 24.0 and 6.4 per cent respectively). The International Labour Organization (ILO) believes that a guaranteed basic pension for all the elderly persons should be one of the components of the set of social security guarantees referred to as the social protection floor (ILO, 2010).

Health care is certainly the most complex of social security branches. Social health protection is defined by ILO as a series of public or publicly organized and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earning, or the cost of necessary treatment that can result from ill health (ILO, 2010). Health care in India is generally, financed through out-of-packet (OOP) payments of individuals, central and state government tax revenues, payments from employers, external aid, private sector profits and other sources. Indian national health accounts reveal that the government sector (central, state and local) together account for around 25 per cent of the total health expenditures (representing around 3.6 per cent of GDP – among the lowest in the world), external aid via voluntary sector for 1 per cent and 91.4 per cent take the form of out-of-pocket payments – one of the highest percentages of the world (WHO, 2006). Since the availabilities of funds with the governments for the support services for health cares,

insurances for the elderly persons and others also and pensions are very limited, there are Public-Private Partnership (PPP) models to provide such support services by the private sectors efficiently and effectively to public including the elderly persons' saving the costs of the governments (Valsangkar, 2000). Globally in 2006 (according to WHO), expenditure on health was about 8.7 per cent of GDP, with the highest level in the America at 12.8 per cent and the lowest in the South-East Asia Region at 3.4 per cent. The share of government in health spending varies from 76 per cent in Europe to 34 per cent in South-East Asia. Where government expenditure in health is low, the shortage is made up of low-income countries by private spending, about 85 per cent of which is out of pocket. External resources are becoming a major source of health funding in low-income countries. From a share of 12 per cent of total health expenditure in 2000, external resources represented 17 per cent of low-income country health expenditure in 2006. Governments face increasing pressure on public finances for the provision of public services, particularly healthcare expenditures. Many low-income countries lack the facilities necessary to provide basic healthcare services and products. Most countries also face shortage of trained medical personnel (Nayak et al, 2011).

2.5 Well-being and the Determinants of Quality of Life (QOL) of the Elderly

Well-being and quality of life are subjective matters mostly depend upon personal perceptions and adjustment in stages of life. Elderly persons have significantly poor subjective well-being than middle aged persons. Most rural elderly persons exhibit negative self-perception, especially those belonged to better off classes. The elderly persons in non-institutionalized settings are better on psychological well-being and less depressed than those in institutionalized settings. Ill health and disability are the most important factors affecting in becoming well-being of the elderly persons. Besides this, financial position (financial self-sufficiency) and support, living arrangements, family environment, mobility, belongingness, social integration, care arrangements, emotional support, marital status, educational attainment, orientation, physical independence, occupation etc are the components for becoming well-being of the elderly persons. Well-being and quality of life are very much associated with each other. Determinants of quality of life are physical and mental health, mobility, social functions, physical and emotional roles, housing satisfaction, perceptions of neighbourhood condition, current health, safety, support from friends, access to basic services, financial condition and

support, achievements, stress and strain etc (Panda, 2005). It may be mentioned that living within a family does not guarantee positive physical and mental health and living alone need not imply social isolation.

2.6 Economics of Population Ageing

The economic aspect of an economy affected by population ageing has two sides (a) increase in the number of the elderly persons and decline in rate of population growth resulting in reduced growth rate in both aggregate demand and investment meaning lower capital formation (macroeconomic phenomenon) and (b) the impact of ageing upon autonomous individuals in the form of economic behaviour over the lifecycle (microeconomic phenomenon). Life Cycle Hypothesis (LCH) provides how individuals' savings depend not only on their current income but also on their anticipated future situations in the elderly age when their earnings reduce sharply, people save earnings at their younger ages for their use in their old age transferring resources to their elderly age through savings. Dis-saving (spending more than one has earned in a given period) occurs in the elderly age of the elderly persons. As the number of elderly persons increases, reduction of aggregate savings is predicted due to dis-savings. The elderly person not only dis-saves, but also spends less on consumption goods and services. This microeconomic behaviour of the elderly persons affects national production, consumption and capital formation (macroeconomic effect of the ageing) (Saha, 2006).

2.7 Directly Related Studies in the Literature

Our research study is 'Population Ageing in West Bengal with special reference to Social Security'. This study also includes (a) nature and pattern of population ageing among Muslim and Non-Muslim population in West Bengal with special reference to Malda district, (b) nature and pattern of population ageing among Scheduled Tribes (ST) and non-Scheduled Tribes population in West Bengal with reference to Jalpaiguri district, (c) population ageing among Scheduled Castes (SC) population and (d) policies and programmes for social security and Indian Constitutional Provisions for maintenance of elderly persons in India and West Bengal. Very few literatures have been noticed which are exclusively on West Bengal. Several literatures have been noticed studying the following topics related to population ageing of different countries in different periods.

Ali et al. (2001) conducted a study on displaced (due to land acquisition) elderly persons in the rural areas: Kolaghat (East Midnapore) and Kharagpur (West Midnapore),

West Bengal. Tribals, Hindu and Muslim elderly people made up the sample population. Age sex composition of the elderly persons, perception about elderly age by respondents, type of tasks performed by elderly persons, perception of the necessity of the elderly persons in family and society were reported. According to the study, 68.18 per cent of the elderly persons reported that their ability to work decreased, 43.18 per cent and 45.45 per cent of the elderly persons were involved in looking after small children and in household work respectively. Regarding perception of the necessity of the elderly persons in family and in society, 47.73 per cent, 38.64 per cent, 36.36 per cent, 27.27 per cent, 25 per cent, 27.27 per cent, 13.64 per cent of the elderly persons reported about their needs because of looking after the house, looking after children, guard the house, providing useful advice, knowing a lot, helping in religious rituals, helping settlement of disputes. Some elderly persons reported that there was a break up of family after being displaced; quality of their food in the family had been worsened. Many elderly persons reported that their health deteriorated after displacement.

Chakraborty (2005), based on 1991 census, reported different socio-economic characteristics of the elderly persons like literacy, marital status, living arrangement, economic conditions, morbidity, health seeking behaviour in India. He conducted a sample survey (using cluster sampling method) to study health seeking behavior of elderly population of a rural block of North 24 Parganas in West Bengal. Chronic and acute diseases that elderly persons perceived to be suffering from at the time of interview were recorded. Several conditions affect health-seeking behaviours. They may be at individual, households and community level. Treatment of chronic condition (dependent variable: binary) was enquired and grouped as (a) regular, (b) irregular. Age, education, occupation, sympathetic, care, distance, long waiting time at hospitals were considered as independent variables. Based on sample survey data, distribution of the elderly persons by age and sex for socio-economic and health, treatment characteristics etc were presented. Chi-square tests were employed to study the associations between socio-economic status and treatment regularity. Step-wise binary logistic regression was employed to study the treatment and socio-economic factors contributing to the irregular treatment. Monetary constraint was a single dominant (75.3 per cent) factor contributing to irregular treatment. Distance (51 per cent) and lack of support to accompany elderly were other reasons for their irregular treatment. Over 50 per cent of elderly (65.4 per cent men and 46.4 per cent women) used some form of tobacco. Over 70 per cent of the

elderly persons had chronic diseases and 54.4 per cent of them more than one disease. Mental and vision ailments got the maximum attention from the elderly persons. Over 60 per cent of elderly persons had mental problems where it was 53.8 per cent for vision problems.

Roy (2010) conducted a study on status of elderly persons in the tribal society (Lepcha) of Darjeeling district of West Bengal. The elderly persons are treated differently in different societies and the complexities of them vary over times and societies. Tribal societies are simple, easy and straight forwards even today and are free from most of the complexities and complications of modern civilized societies. Primary data was collected from the elderly persons from four Lepcha dominated villages (two villages were very near to town and other two were far off town). Some tables on family size, age and sex distribution of populations, engagement of elderly persons in earnings (direct, indirect) were created. In case of Lepchas, the elderly persons are never considered as burden, but they are respected and are considered as assets of the community. Elderly persons in Lepcha community play indispensable role in preserving Letcha culture, custom, language, religion in their society.

Mallick (2011) pointed out that tribal development in West Bengal is directed towards ensuring an immediate boost to agricultural production in tribal areas, improve economic conditions of the landless among the tribals, recognise the co-operative and marketing structures, and to provide employment and increased income to the tribals. Family-based economic programmes include land reclamation, land development, supply of agricultural inputs and the like. The area-based economic programmes include construction of roads, execution of minor irrigation and lift irrigation schemes and so on. Although, the tribals are in the process of transition from a traditional society to a modern society, they are going through the process of institutionalised exploitation and socio-political marginalisation. They are not health conscious and yet practice traditional methods of medicine.

The study of Kejriwal (2011) on socio-economic condition of elderly people in Siliguri (West Bengal) and its adjoining rural areas tried to (a) observe and identify socio-economic aspect, (b) occupational structure, (c) living conditions of the senior citizens and (d) analyse the implementations and enforcement of government schemes and policies among them.

Nayak, Bagchi and Nayak (2011) presented in the Indian scenario, population ageing, health problems for the elderly persons, provisions for social security, privileges and benefits; human rights and provisions for healthcare etc for the elderly persons, mental health, health care law etc.

Maulik et al. (2012) has explained that background of ongoing economic development and consequent change in family structure, made the rising elderly population lose their relevance in their own house and they started feeling lonely and depressed. They conducted a study on the elderly population in Singur Block of Hooghly district of West Bengal to assess the psychological status of a population aged 60 years and above.

Islam and Nath (2012) pointed out in Bangladesh, the future journey of the elderly persons support capacity with economic and caring aspects. The society changing along with the economic hardship would be serious threat to the elderly persons support system in Bangladesh. It was the high time to think about the problems of elderly persons and to take long-term sustainable aging policies to face the future problem.

Roy (2013) in his paper aimed to present an emerging scenario of population ageing in West Bengal on the basis of past trends. It was found that the elderly population in West Bengal has been growing in a faster rate than all India average. The current trend of population ageing also reveals the fact that, in future, there will be larger proportion of elderly population in the state, with higher age and majority of them would be women for whom better social security measures would be needed. It is the need of the hour to study the ageing processes in West Bengal, so that, its implication for the elderly population in particular and society at large could be judged.

Alam et al. (2014) has delineated the status of elderly persons in West Bengal-income and asset holding among elderly persons, living arrangement and family relations, health status including mental health, morbidity, hospitalization, access to health care and financing, social security in elderly age etc.

Sharma (2014) has discussed about government policies and programmes for the elderly persons in India. He has mentioned that the goals of the policies are the well-being of elderly persons aiming to help elderly persons to live the last phase of their life with purpose, dignity, good health and peace etc. The nation would extend support for financial, health care, shelter, welfare, protection against abuse, provide available

opportunities for their potential development, seek their participation, provide them services so that they can improve the quality of their lives and other requirements. The paper also mentioned Indian Constitutional provisions, legal measures and different services being provided to elderly persons.

Mane (2016) mentioned that population ageing in India is exponentially increasing due to impressive gains in increased life expectancy. An ageing population puts an increased burden on the resources of a country creasing both medical and sociological problems. Elderly persons suffer high rates of morbidity and mortality due to infectious diseases. Ageing problems attribute to the different levels of socio-economic development, cultural norms and political contexts. Hence it would be a herculean task for policy makers to address the geriatric care that would take into account all these determinants. Care for the elderly persons is fast emerging as a critical element of both the public and private concern. Elderly persons require lifelong drug therapy, physical therapy and life-long rehabilitation. They tend to be cared for a variety of setting: home, nursing home, day-care centre, geriatric out-patient department, medical unit of intensive care centre unit.

National Institute of Rural Development & Panchayati Raj, Hyderabad (2016) in Policy for the Aged: Opportunities and Challenges highlighted different policies for social securities for the senior citizens in India and recommended for their welfare. It also mentioned the initiatives taken by different Indian states and union territories including West Bengal.

Rahman (2017) mentioned that elder abuse and neglect was a burning issue in Bangladesh. Bangladesh government had taken policy, namely, national policy on ageing in 2007 to ensure the dignity, social security, health care etc; allocated some fund for the nongovernment institute named ‘Bangladesh Association for the Aged and Institute for Geriatric Medicine’ (BAAIGM), had taken old age allowance program, national health policy for the elderly persons in the society. Many non-government organizations were continuing programs related to elderly persons. But these were limited and insufficient for huge number of elderly persons.

2.8 Spatially and Contextually Relevant Empirical Research

Paul Chowdhury (1992) presented the per cent of population aged 65 and above, related data in selected countries, 1850-1970 and its projections up to 2025. He also presented

some data on population 60+ in India, 1981. His findings indicate that the number of aged 60+ in India increased by 22.40 per cent during 1951-61. The increase in 1971 rose to around 32.32 per cent but fell to around 32.02 per cent in 1981. India is around 40 years behind the West in life expectancy. India would be expected to reach the level of life expectancy of the West only by the year 1921.

Dandekar (1996) provided international (UNO, 1988) and national (state-wise) (NSSO 42nd Round) demographic and socio-economic data compared aspects of ageing in Maharashtra with India. The profile of the elderly of Maharashtra was not very different from other states of India. There are many old age homes (OAH) in Maharashtra. No body likes to leave home and live in OAH. Sometimes circumstances compel them to go to OAH. The OAHs in Maharashtra present a picture of useful institutions badly needed for homeless, helpless or childless. The situation of elderly persons in rural areas of Maharashtra were studied through field survey, sample of villagers from eight villages in four subdivisions of Maharashtra was taken to study the elderly-age problems in rural areas. Socio-economic, workforce, activity, social security etc of the elderly persons in rural Maharashtra obtained from field survey were presented. In the absence of modernization, the elderly persons in the villages did not seem too worried about their problem of elderly age, they often depend on their neighbours when needed. Most of them depend on agriculture and they did not have any retirement. Poverty is the part and parcel of their entire life.

In the thesis 'Economic Security for an Aging Canadian Population', Brown (1997) reported for Canada, the demographic, economic and political background; sources of retirement income security; health care and economic security; recent amendments to Canada's retirement income security system; social security reform; a wealth transfer model to assure total security funding stability. While presenting about Canadian demographic, economic and political background; economic security; social security reforms etc, data on same for different countries had been present for comparisons. Early retirement is more common for the economically and socially advantaged, while the converse is not true for late retirement. Many who retire early are capable of further contributions to the production of goods and services. For males, most important factors for early retirement are (a) having job-related pension; (b) personal income; (c) early retirement incentives and (d) home ownership. For females, the reasons

for the same are (a) for care giving; (b) spouse's desire for retirement etc. The Canadian social security system is worth saving.

Rajan et al. (1999) have presented socio-economic, ageing data of India along with states and territories for 1961-1991 and projections for 2011-2021. They have suggested different policies and programmes for social security implemented in India with special reference of Kerala.

Rao (2000) conducted a study on the socio-psychological problems of the elderly persons residing in old age homes (OAH) in Karnataka selecting four OAHs (two are paid OAHs, others non-paid OAHs) and concluded that in general socio-economic and demographic factors do have substantial influence on elderly persons in making decision to stay in OAH, but the main reason seems to be the differences in the value system of the elderly persons and younger generations. The number of OAHs is increasing day-by-day, Kerala is having maximum number of OAHs.

Rajan (2000) stated that Kerala is ahead by 25 years from the rest of the country and in the final stage of the demographic transition. He provided ageing scenario including work participation and non-workers for Kerala district wise and sex wise from 1991 and different social security scenario of Kerala from 1983-84 to 1993-94. He assessed that if the government could implement all the schemes very seriously and provide assistance to the real needy elderly persons, Kerala can continue to run the social assistance schemes without much financial constraints.

Rani (2000) studied tribal elderly population in Kerala and reported that they have longer life span and good health because of pollution-free atmosphere. They work in fields and are not idle at homes. The elderly age problem is not serious among the tribals.

Sivamurthy et al. (2001) discussed about the care and support for the elderly persons in India based on a survey of the elderly persons in four villages of rural North Karnataka (India). The Governments in India both central and state and some NGOs have been providing care of the elderly persons. However, family still plays the most important role in India in providing the same. Surveyed data was collected from the elderly persons in four villages of North Karnataka. Surveyed results are: 58.9 per cent, 88.2 per cent, 28.4 per cent, 28.0 per cent, 59.7 per cent of respondents expressed for elderly persons are respected by the family members, are better taken care of before, have health problem as main problem, have health and economic problem as main problem, may consider son

as of best help in very elderly age respectively. Discriminant analysis for headship status was done and it is inferred that contribution to family be the most powerful variable for headship. It was observed that the proportion of the elderly persons being head of the households is higher among lower economic status households than among higher economic status households.

Bose and Kapur Shankardass (2004) presented figures on population ageing and related data of the different states of India consisting (a) growth of 60+ populations, 1951-2016, (b) characteristics of 60+ population, 60+ workers, economic security, living arrangements, disability and chronic illness, 60+ widow and widowers: district wise for states, 1991, (h) micro survey of 60+ persons in a middle class locality in New Delhi, (i) international comparisons: elderly in Canada, (j) global perspectives: UNO projections. Per cent of 60+ population in 1991 in Kerala and West Bengal were 8.8 and 6.1 respectively.

Paul Singh (2002) stated that the percentages of elderly population in India were 5.63 in 1961, 5.96 in 1971, 6.49 in 1981, 6.58 in 1991 and 7.45 in 2001(Census of India). India is an agriculture dominated economy where 70 per cent population lives in rural areas and is dependant on agriculture and allied occupations. The persons aged 60 years and above represent about seven to eight per cent of the population, most of them are living below poverty line. The elderly persons in the unorganized sector are economically in desperate position. Economic hardship, health problems etc are the major problems faced by the elderly persons. A field work undertaken by the researchers in the rural areas of Haryana to study the social position, adjustment problems, physical status and health problems of the landless elderly persons in Haryana. Demographic, socio-economic, health status of the respondents has been provided. The major finding are: (a) Majority of them were in the age group 60 to 70 years and there was a sharp decline in their population after 70, (b) health problems increased with advancing age, (c) the government run hospitals/PHC etc did not have proper facilities for the elderly persons, (d) majority of landless rural elderly persons depended on quack/untrained medical practitioners, (e) they did not have secure source of livelihood, (f) they were dependent on daily labour, in spite of their poor health, disabilities etc.

Rajan (2002) studied ‘Oldage Allowance Program (OAP) in Nepal’. Demographic, social and economic indicators for Nepal, 2001 were provided. Data on old age allowance program beneficiaries, trends in expenditure of OAP, elderly persons 75

and above etc in Nepal are also provided. In Nepal, one out of every 100 persons is an elderly 75 and above and 8 out 10 of them are enjoying old age allowance. Sample data was collected on 197 elderly persons from villages and municipalities in Nepal and corresponding results have been reported. It is reported that the family mostly care of the elderly persons in Nepal. Nine out of ten elderly persons received pensions regularly (three times annually).

Rajan et al. (2003) studied 'Economics of Pension and Social Security in South Asia: Special Focus on India, Sri Lanka and Bangladesh'. Demographic, socio-economic, ageing data for these countries were provided. Besides the economic, social, health data from official publications, other secondary sources, a sample survey was conducted on these three countries to obtain field data on these issues. Demographic, socio-economic, ageing, sources of care and securities data based on surveyed data for these countries were provided. All governments in South Asia slowly shift from defined benefit pension scheme to defined contributory scheme. Contributory provident funds suffer from several limitations; two of them are frequent withdrawal from the fund and one time payment at the time of retirement. Countries in South Asia should increase their retirement age in view of increase in life expectancy. Collective care arrangement in elderly age is a concept practiced in Kerala. The Welfare Fund Model of social security for unorganized sectors may be initiated in other states in India and in other countries in South Asia.

Dhar Chakraborti (2004) discussed population ageing in the context of Asia. Based on UNO data and Indian census data, indices of demographic and ageing, socio-economic characteristics and workforce participation of elderly persons, health conditions, national health expenditures and related figures for 1950-2050 for different world regions particularly Asia including India have been provided. Ageing of the population of low developed countries (LDC) is more than fifty years behind as compared to the situation in more developed countries (MDC). Labour force participation rate (LFPR) of the elderly for 1950-2050 for world, MDC and LDC have been presented. There is a decline in LFPR of the elderly persons throughout the world. Correlation coefficients, regression equations between proportion of elderly and total fertility rates (TFRs) for different regions of the World have been presented. Population ageing has been increasing unevenly throughout the world and has many serious developmental linkages in economic and planning in developed and developing countries. According to

Dhar Chakraborty, a detailed and careful economic analysis on population ageing is a burning need of the present days.

Panda (2005) conducted a study on 'Elderly Women in Megapolis Status and Adjustment'. The study has urged both secondary and primary data. Primary data covering family background, economic condition (past and present), economic security, feeling of security-insecurity and loneliness, involvement in decision-making, willingness-unwillingness in doing household work, health and well-being, social acceptance and social adjustment, life-satisfaction etc of the elderly women were collected from the elderly women in Pushp Vihar Colony and Saket in South Delhi. A number of cross-tables were created and inter-linkages between variables were studied. A number of tables of averages were also created. Some of the major conclusions about the elderly women derived from the study are: Deterioration in health, strength, and impairment, certain ailments are common. These accompany reduced autonomy in activities of daily-life, (b) they are frail, especially those in old-old age-group, need more care and attention, (c) many of them faced adjustment problems, (d) there is a shift in the role of elderly women from a 'provider' to a 'dependent', (e) many children are less mindful about elderly women in the household, (f) they sometimes feel lonely, alienated, insecured and neglected, (g) a large proportion of them do not have acute or visible economic problems etc.

Research study in Population Ageing in Tripura by Saha (2006) was mainly based on sample survey data. Based on Indian census data for elderly persons : 1901-2001, she presented the figures on (a) demographic characteristics, different indices of ageing, burden of population ageing, work participation rate and elderly workers for Tripura, (b) number and proportion of elderly persons, annual average growth rate of elderly in north-eastern states of India. She presented expenditure on pension payments: 1999-2003 to the elderly, beneficiaries of NOAP in Tripura by Government of Tripura. Based on field data, she presented the figures for elderly persons: Age distribution, socio-economic profiles, sources of basic facilities, living arrangement, household income, educational level, health conditions, work participation, economic security, sources of subsistence, care givers, reasons for moving to OAHs, data on surveyed OAHs. She employed Z (standard normal) test for comparing proportions. Major findings made by her are (a) having a regular income raises the elderly persons being the head of the family, to live with dignity

and (b) most of the elderly persons co-reside and care and support for them are provided mostly by the female members of the family.

Rajan (2006) based censuses (1971-2001) and NSSO (52nd round) presented demographic, ageing, socio-economic figures and some projections of India up to 2051. Health, health services data including morbidity for elderly persons in India have been presented. Most of the elderly persons in India being economically dependent, the cost of treatment is often a burden on their households. Appropriate insurance schemes are necessary for them to meet such expenses. Rajan (2007) again discussed about population aging, health and social security in India. In addition to the earlier discussion (2006), social assistance programmes for elderly persons have been discussed. He has added that the unorganized poor workers should organize themselves to be able to plan for their old age security.

With regard to population ageing in the world, Devi et al. (2008) pointed out almost the same thing as Dhar Chakraborti (2004). It is presented that there is an increasing trend in relative change in the economically active elderly persons in India from 1961-2020. Based on Indian census data, different indices of population ageing state wise have been presented (Kerala is having highest and Assam is having lowest per cent of elderly). The study made by Devi et al. (2008) was on Kerala mainly based on sample survey data. For the elderly persons in Kerala, based on census, per cent distribution of age and sex composition, work participation, non-workers by activity status, literacy rate, education level, main workers, economic characteristics (based on NSSO, 52nd round), and the number of beneficiaries of various pension schemes (Economic Review, 2004, Kerala) have been presented. Based on sample survey data on elderly persons in Kerala, per cent distribution of different characteristics of the elderly persons has been presented. In the study, logistic regression were employed to study influences of determinants (sex wise) of (a) health, (b) involvement in decision making, (c) involvement in household work. The main conclusion of the study is that possessing some asset, especially liquid asset, increases the chances of the elderly persons being made a part of household creating a feeling of belonging which is of greatest importance of the elderly persons.

Malakar et al. (2010) studied 'Evolving Marketing Strategies for Over Aged Persons'. Financial capacity of an individual influences own purchasing decision. Some qualitative parameters like tastes, preferences, culture etc formulate marketing strategies. Age composition of the customers is a significant parameter in marketing. In the process

of growing elderly, individuals undergo various changes; reduce variety roles which affect their lifestyle and consumption behaviors. Economic and demographic factors mainly focus on capital formation. Until 1980, companies focused on younger consumers, ignoring the elderly persons. Perception of elderly consumer market began around 1980. There was less reliable data for effective decision making in the present scenario, marketing decisions were made based on unreliable data and it was marked as 'trial-and-error-marketing'. Then in 1990 onwards, marketing provide special attention of elderly people. But the elderly persons are of heterogeneous groups, there are consumptions and preferences are heterogeneous. Again elderly persons buy generally for others. According to Malakar, all these are to be incorporated in marketing and production strategies.

Kabir et al. (2008) in their paper tried to identify problems facing by elderly people in Bangladesh from a micro study and suggested means through which elderly persons can continue to make active contribution to the economic, social and cultural life of their families and communities. Although ageing was not a major problem in Bangladesh, they expected that information on ageing in Bangladesh might provide a useful tool for formulating effective long term policy strategy to face the problem in the near future. They collected some suggestions and opinions for the welfare of the elderly populations which included financial benefits; recreational facilities; nursing home; health care facilities; nursing, social and community support.

Subba et al. (2010) assessed (a) the labour participation rates of the elderly workers and presented a diverse occupational pattern of the ageing workforce in India, with special reference to the informal/unorganized sector, (b) the dependency status of the elderly as well as the various social security policies meant for the elderly workers engaged in informal sector. According to an estimate made by NSSO in 61st round (2004-2005), 93.4 per cent of the total Indian workers are employed in the unorganized sector. A greater concentration of elderly workers is found in the informal sector. They presented some data from various secondary sources on (a) Indian and international labour force participation rates for elderly persons, (b) employment status, occupational structures, economically dependence and basic needs unmet of Indian elderly persons etc.

Misra (2010) in his paper compared ageing and social security measures in India and Japan. From secondary data for India, age structure of population: 1901-2020, trends in old age dependency by sex: 1901-2011, dependency burden on labour force: 1971-1991 have been provided. In Japan, social security systems are planned to guarantee a

minimum standard of living and to protect citizens from certain types of social and economic risk, expanded from occupation-based insurance to universal system to cover all citizens. The social security system in India is complex. The key problem with social security system in India are that budgetary support are not commensurate with the needs most come under welfare programmes, targeted, selective and conditional bereft of inefficiencies, biases discrimination, miss-targeting, adverse selection etc. According to Misra, the social security systems are to be universal to reduce the cost of administration and eliminate adverse selection.

Central Statistical Organization (CSO, 2011) mentioned that India, a developing country might pose mounting pressures on various socio-economic fronts including pension outlays, health care expenditures, fiscal discipline, savings levels etc. The elderly population faces multiple medical and psychological problems. There is an emerging need to pay greater attention to ageing-related issues and to promote holistic policies and programmes for dealing with the ageing society.

Prasad (2011) in his study has mentioned different aspects of human deprivation in the elderly age other than the measurement of income poverty, health and social aspects of deprivation and how it varied across space (sector and state) and gender. He has looked up on correlates and determinants of old age deprivation in India.

Bookman et al. (2011) has observed that present demographic shifts - delayed marriage and childbearing for young adults, decreased family size, and changes in family composition and structure - are complicating challenges to the family members and society. Increased longevity among elderly persons not only extends the years of care giving by their adult children but may require their grandchildren to become care givers as well. Married couples may have as many four elderly parents living; in fact, they may have more parents or relatives in need of care than they have living at home or on their own.

Khan (2011) has reviewed the policy interventions addressing the emerging ageing issues in the population and development dynamics context of a developing country in Bangladesh, a Muslim country. Although the per cent of elderly persons seemed not that high (6.6 per cent in 2007) and the number of the elderly persons are continuously increasing, some policy interventions from different levels are being executed and these are not adequate enough to address the issues. That review suggested

to take this population dynamics positively and initiate appropriate policies and its implementation for the betterment of this population as well as to integrate the issues in the mainstream development activities for a sustainable future of Bangladesh.

Kabir et al (2013) reported that in Bangladesh as in other regions of the world, the population aged 60 years and above was growing faster than the total population. Growth in the elderly population relative to other age groups challenged existing health services, family relationships and social security. According to Kabir, with continued population ageing, the loss of cognitive function would potentially cause enormous social and economic burden on families, communities and, to the country. The paper investigated that increasing longevity and declining fertility were combining to convert the population age structure from young to old. That combination was resulting implications on the family health care and unmet need of health care services in the public sector. The support index shown that there would be fewer persons to support elderly population in future with implications in traditional family care. The care index shown the cost of burden for long term care associated with the shift in the population age structure. As a consequence Bangladeshi societies would confront population aging without traditional kin support.

Dhar (2014) pointed out a decline in the workforce participation rate among the elderly persons, particularly among the urban and rural males. The decline in the workforce participation rate appears more as a deliberate withdrawal from the labour force, caused by rural prosperity and the expansion of employment opportunities in the manufacturing sector between 2004 and 2009, rather than due to forced unemployment. An examination of the occupational profile shows that in rural areas, the elderly workers are concentrated in the primary sector, whereas in urban areas, on the other hand, they are mainly engaged in services. An analysis of the occupational structure and earnings, however, reveals that the elderly persons who continue to work are generally employed in the low-wage sectors. Further, their own wages are lower than the (low) average earnings in these occupational categories. This remains an area of concern that needs to be addressed by policy-makers.

2.9 Identification of Research Gap

The shortcomings of the previous studies are (a) comparisons and conclusions were done through numbers and percentages, but not applying any statistical and econometric tools, (b) some of them are based on secondary data only; (c) again, most of them were covering only limited problem areas related to population ageing, covered only a limited section of the population. New form of research studies are needed which would (a) be based on primary data collected through field survey on sample population (elderly persons in West Bengal) and secondary data, (b) consider a considerable problem areas like ageing and its related problems, health and health care, social security and (c) apply various statistical and econometric tools for comparisons and conclusions etc.

The present study is unique because of the following reasons:

(e) India's Muslims have the lowest living standard in the country on a per capita (NSSO Report No. 468 (55/10/6) (July 1999 – June 2000) Employment and Unemployment Situation Among Major Religious Groups in India). Very few studies have been done on population ageing of Muslim population in India, West Bengal and Malda district. Again, no study on comparison of population ageing between Muslims and non-Muslims has been done.

(f) Scheduled Tribes (ST) and Scheduled Castes (SC) are weaker/backward section of society in India. Very few studies have been done on population ageing of ST population in India, West Bengal and Jalpaiguri district. Again, no study on comparison of population ageing between ST and non-ST populations has been done.

(g) No study on population ageing among SC population has been done.

(h) Very few studies have been done on Indian Constitutional provisions and legal protection, government programmes and policies for the welfare of elderly persons in India and West Bengal.

Knowledge gathered from the present study on this topic will be helpful for policy making. Considering the uniqueness of the study, our study will certainly contribute additional knowledge in the present topic.