

MA SOCIOLOGY

Paper-18

SOCIOLOGY OF AGEING

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In this unit we will analyze the various concepts and aspects of ageing. How old age is defined and how the treatment towards elderly is a product of social and cultural context. There is a need to examine ageing as a social process and the development of social gerontology as a sub discipline. Though various studies have been conducted in India on ageing but still many new emerging areas are needed to be explored.

1.0 Objectives:

After studying this unit, students will be able to gain knowledge and can develop an idea about:

- Old age, ageing and various concepts associated with ageing like ageism, definitional dilemmas of old age, life course perspective, dimensions of ageing etc.
- A new sub discipline of sociology i.e. sociology of ageing, also known as Social Gerontology, its scope and the relevance of studying it. Its emergence and growth in both world and Indian scenario.
- Trends and patterns of ageing in Global as well as Indian context.
- International conferences held on ageing.
- Scope and significance of Sociology of ageing.

Ageing is a universal phenomenon and every object in the earth undergoes the process of ageing. In the human society, ageing is considered as a social phenomenon rather than physiological, as ageing is always understood in the background of social milieu. A deeper understanding of ageing in the present day society needs the review of ageing as a process at the individual level and at the societal level.

1.1 Ageing – A New Concept:

Ageing is not an event but a process. For the development theorists and practitioners ageing is one of the most neglected issues mainly because aged people are considered as disempowered and non-resourceful persons. They are not considered as a class category or status group neither by economists nor by sociologists. Though ageing is universal, till a decade back ageing is considered as natural and evolutionary process and hence it is not taken seriously. Till 1980s the problems of the old were not known to the state in the developing countries and therefore they were not attended. There are many ways to reduce the child population whereas the old population cannot be stopped as the developing countries like Asian countries methodically ignored the structure of the population.

Ageing can generally be described as the process of growing old and is an intricate part of the life cycle. Basically it is a multi-dimensional process and affects almost every aspect of human life. Introduction to the study of human ageing have typically emphasized changes in demography focusing on the 'ageing of population'- a trend, which has characterized industrial societies throughout the twentieth century but in recent decades, has become a worldwide phenomenon.

Population ageing is the most significant result of the process known as demographic transition. Two dimensions of demographic transition are:

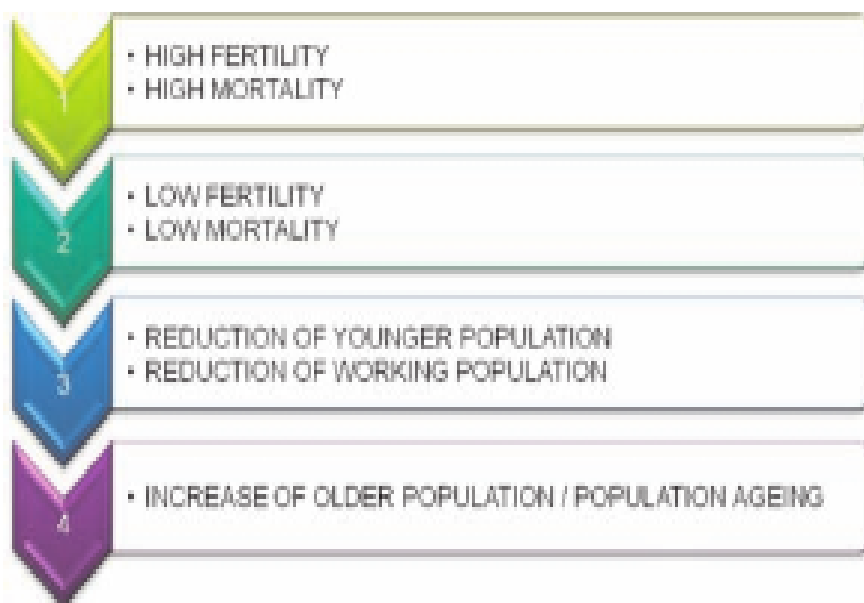
- a) Reduction of fertility that leads to a decline in the proportion of the young in the population.
- b) Reduction of mortality which means a longer life span for individuals.

Jean Bourgeois Pichat (1979) has called attention to two process in ageing which reflects the two dimension of demographic transition.

- a) Ageing at the base
- b) Ageing at the apex.

Ageing at the base occurs when fertility falls, thus decreasing the proportion of children and ageing at the apex occurs when the proportion of aged persons increases presumably due to declining mortality at older ages.

Population ageing involves a shift from high mortality / high fertility to low mortality / low fertility and consequently an increased proportion of older people in the total population (Prakash, 1999).



This is a dynamic process was first observed in post-industrial European societies in the nineteenth century.

The United Nations Conference of Ageing Populations in the context of the family held in Japan in 1994 observed that for all developed countries has at least one demographic issue in common: population aging which was the inevitable consequence of fertility decline. But although fertility decline is usually considered the driving force behind changing population age structures, changes in mortality assume greater importance as countries reach lower levels of fertility.

Ageing of the population is a major phenomenon in the present day world as a result of the changing demographic transition. Though the phenomenon has a universal character, it occurs in various countries at different point of time. The ageing is a phenomenon already occurred in the developed countries in the latter half of the twentieth century. The similar situation is emerging in the developing countries in the recent periods. Although the proportion of elderly in the years 60 and above is considered to be relatively low in the case of the developing countries such as India and China, they have a larger population base. Developed countries have aged with high social and economic development, the socio and economic condition of the elderly in the developing world is a cause for concern as most of them end up in living below poverty line in old age due to inefficient social security (Rajan, 2004). The poverty and deprivation are very common among the aged in the country because there is no proper safety nets provided by state. Though pension schemes are available but they are meagre. The state only focusses on economic dimensions of ageing and neglects the social and psychological aspects of it.

1.1.1 Dimensions and definition of Ageing

Ageing has been defined in various ways by different scholars and it is measured in many ways according to the academic background of the person who study them. Some have regarded ageing as period of physiological deterioration, others regard it as simply the advancement of years and still others have emphasized that ageing involves a restriction on cultural roles.

According to Bhatia (1983) the term 'ageing' is a broad one and can be studied under three types – Biological, Psychological, and Socio-cultural.

In the broadest sense, Charles S Becker (1959) defines ageing 'as those changes occurring in an individual, which are the result of the passage of time'. These may be, according to him, anatomical, physiological, psychological and even social and economic. He further adds: Ageing consists of two simultaneous components – anabolic building up and catabolic breaking down. In the middle years there is an essential balance between expansion and decay, while growth predominates in youth;

degenerative changes which start occurring very clearly in life pre-dominate in the late life span.

Edward J. Stieglitz (1960) defines ageing as 'the element of time in living'. According to him, 'ageing is a part of living. Ageing begins with conception and terminates with death. It cannot be arrested unless we arrest life.

According to Tibbitts (1960) ageing may be best defined as the survival of a growing number of people who have completed the traditional roles of making a living and child rearing and years following the completion of these tasks represent an extension of life." He also says, ageing is an inevitable and irreversible biological process.

According to Hooyman and Kiyak (1994), the gerontologist view ageing in terms of the following four distinct process or dimensions:

Four dimensions of ageing are commonly identified: chronological, biological, psychological and social ageing.

Chronological ageing refers to the number of years since someone was born. Chronological age also provides individuals with a means of distinguishing roles and relationships in terms of the behaviour and expectations that are linked to different chronological groupings. But it is generally not recognised as an adequate measure of the extent of ageing because, as a process, it is thought to vary between individuals.

Biological ageing, often known as senescence (declines of a cell or organism due to ageing) and sometimes functional ageing, refers to biological events occurring across time which progressively impair the physiological system so that the organism becomes less able to withstand disease, ultimately increasing its susceptibility to death. From this perspective, the ageing process stems from several physiological factors, and is modified throughout the life course by environmental factors (such as nutrition), experiences of disease, genetic factors and life stage. This is usually associated with decline in the regulation and proper functioning of the vital organs of the body. However, not all people experience decreased organ function in the same proportion. Some individuals have healthier hearts at age 80 than others do at age 60.

Psychological ageing focuses upon changes that occur during adulthood to an individual's personality, mental functioning (e.g. memory, learning and intelligence) and sensory and perceptual processes. Jegede (2003) stated that the indices of psychological ageing include feelings, motivation, memory, emotions, and experience and self-identify. For instance, people who had intention of traveling abroad may decide to drop the idea and contribute to the growth of their own economy. Psychological ageing is heterogeneous and continuous as an individual passes through life.

Social ageing refers to the changing experiences that individuals will encounter in their roles and relationships with other people and as members of broader social structures (such as a religious group) as they pass through different phases of their life course. In sociological ageing, personal or attitude and interaction within the community are used to assess a person's maturation and ageing. As a person ages socially, he/she calculates his/her utterances, limits the use of vulgar language, prunes relationship to mature friends, changes his/her mode of dressing, reduces nocturnal clubs. As a person ages socially, he/she tends to be guided by the norms of the society to which the person belongs. As an individual experience, social ageing affects perceptions of who we are, but can also be shaped or 'constructed' by social and cultural contexts which dictate the normative expectations about the roles, positions and behaviour of older people in society. While all three dimensions of biological, social and psychological ageing generally interact, the pace at which each dimension is experienced may be different for the same individual. This is usually how a person relates with others in the society.

Strehler (1962) has proposed four criteria for ageing, reported in Tyagi (1999). They are:

- Ageing is universal, which means it occurs in all members of population.
- Ageing is progressive, a continuous process.
- Ageing is intrinsic to the organism
- Ageing is degenerative

Thus, ageing is an inevitable, ubiquitous and universal phenomena of human life because it is a natural process.

Finally, population ageing, sometimes referred to as societal ageing, is a process whereby a group (such as a country or an ethnic group) experiences the progressive increase in the actual numbers and proportion of older people within its total population. This change, brought about largely by socio-economic improvements in health and living standards, progressively reduces mortality and fertility, resulting in increased life expectancy and fewer births, and ultimately, an increase in the older population in relation to younger age groups. Population ageing has long-term implications for governments in terms, for example, of the cost of health and social care for an increasingly important number of older people.

Cavanaugh (1993) in Osunde and Obiunu (2005) divided ageing into three types, the primary ageing, the secondary ageing and the tertiary ageing.

The Primary Ageing: Primary ageing is considered as the normal process which has nothing to do with illness. It simply involves changes in the biological, social and psychological domains. These occur due to tear and wear of vital organs of the body.

The Secondary Ageing: This process is associated with different kinds of terminal illness which prevent normal functioning of the individual.

The Tertiary Ageing: This occurs when there are losses brought about by death or disasters like war(s) on a family member or close friends that could lead to a gradual decline in the proper functioning of the individual.

1.2 Definitional problems of Old Age

When is a person old? When does one categorize a person as elderly?

From time to time scholars have employed different definitions of 'aged', 'elderly', 'old', and no one can claim to have a patent over the definition. The variety of definitions offered in gerontological literature is almost as diverse as the number of writers. Thus, adding confusion to an already difficult nomenclature. "Adults delude that old age can be put off until an indeterminate moment, and for young people, this does not exist at all on their horizon" (Elorea, 1980:234). Simply stated, 'aged' means the state of being elderly and it cannot be defined properly. Whether a person is perceived to be elderly or not depends upon the observer's eye. There exist no clear-cut demarcation of age upon the attainment of which a person can be called 'old,' 'elderly,' or 'aged'. Nor is there a biologically determined age limit that classifies a person as elderly.

The definition of the term 'elderly' or 'aged' varies from society to society. Ancient Chinese scholars delineated seven phases in a man's life and Pythagoras in the sixth century B.C. compared human life to the seasons. In both cases, old age was deemed to be beyond 60 years (Stub, 1982). Some societies still treat 40 or 50 years as marking the transition into old age. "In Thai society, old age begins at 60 years. After reaching this age, a person is addressed by younger persons with special terms of respect, the equivalent of kinship terms grandfather or grandmother, even though the speaker may not be related to the older person in any way of kinship" (Wongsith and Saengtienchai, 1994:430).

Guha Roy (1991) observes, "The definition of old age is very much dependent on its use in particular context. Way of fixing the entry into old age based on retirement, however, ignores the large number of women who have not been in gainful occupation and that the age of retirement varies not only between countries but also between public and private sectors within a country."

A survey of some studies conducted by some scholars in India also highlights the fact that it is really difficult to draw a dividing line uniformly to categorize the 'elderly'. The range of variation extends from 39 years to 51 years and above; for Jatana et al. (1991) it is 51 years; Prakash (1987, 1991) puts it as 50 years for women and 60 for men; Sen (1991) uses 39 years as the dividing line; for Easwaramoorthy (1991) it varies between

58 and 70. Barai (1991) and Patil et al. (1991) treat 60 Years as the limit for an individual to be treated as 'elderly' or 'old'. The census of India uses 60 years as a cut-off point to classify people as old. For purposes of being eligible for old age pension (OAP) most of the states in India have laid down 65 years as the minimum age, while in a few states the age limit is fixed at 60 years (Arora, 1993). Scholars such as Gokhale (1994:78) point out, for statistical analysis 60 is convenient age. But old age is a very relative concept. The process of continuing physiological, psychological and social change throughout the life span with great variations, occurs among individuals."

What is considered old age varies between countries because of different social, economic, and historical situations and conditions. Each society divides the life span into a definite number of stages embedded in the culture. It assigns a meaning to these stages and defines, for individuals, the conditions of transition from one stage to another during the life course, that is, the socially organized life-span. Old age designates the last stage and thus has to be understood as a continually renegotiated social construction.

Old age itself, has become clearly distinguished as a specific stage of life, and delimited chronologically, with the result of a sharp tripartite division of the life cycle into a phase of preparation, followed by the one productive activity in economic/income generating terms, and finally, the stage of retirement. In many countries the definition of elderly persons is closely related to their position in the labor market; thus persons on their retirement are regarded as elderly. Official definitions of elderly refer to the people of post productive age that is of retirement age.

The collective definition of elderly is based on three criteria:

- a) Retired from work and drawing a pension,
- b) Looking old and
- c) Having some limitation in activities of daily living.

The chronological criterion for classifying an individual or a collectively as 'aged' or "elderly" is the operational means generally employed for administrative purposes – pensions, insurance, and the like. For administrative purposes each country tends to fix an age limit for working life of a person to suit its own interests. But the phrase 'old age' is socially defined by the transition from salaried work to retirement. This definition does not cover the fact that a large number of men and women who have been or are generally outside the ambit of gainful employment, and do not retire at a formal age. This also applies to those engaged in the unorganized sector. It is interesting to note that the age of retirement even in the formal sector shows considerable variation.

This categorization is difficult to apply in the Indian context, because the majority of the elderly, especially elderly women have not gone to school and often do not know their chronological age. Second, the concept applies mainly to people employed in the formal sector in India, a very few elderly people – more so elderly women are employed in the formal sector. For majority of a population whose activities are confined to the urban informal sector or to the rural agricultural sector, work activity continues until extremely advanced ages when they are disabled and can no longer work. It is, therefore, necessary to develop realistic and meaningful measures that accurately describe the elderly in India. The categorization of the ageing population should reflect the local communities' perception of the ageing process.

The 'old' or 'aged' is relative term and generally used in relation to young. It is really difficult to draw a dividing line uniformly for all communities. The classification of a person or a group of persons as elderly by reasons of age and the extent of ability is determined by such factors as level of socio-economic development, living conditions, nutrition, health services, cultural factors and the nature of work.

In non-literate societies there is hardly any conceptualization of absolute age calculated by time elapsed from a fixed position such as date of birth. Members of primitive tribes often do not know how old they are. Old age is, generally determined by physical and mental conditions rather than chronological age. Indeed the idea of keeping a precise account of age is a relatively recent one. In rural India, people are not classified as 'aged' by an absolute biological or chronological criterion --- as most do not know how old they are. They are, however, generally aware of their relative age and the category and activities appropriate to their contemporaries and the progress made through the life cycle of their kin in adjacent generations.

The definition of aged officially accepted in India was 55 years – the age of superannuation, when the employees retire from service. Subsequently it was raised to 58 years and then to 60 years.

1.2.1 Heterogeneity in aged group: Aged are not a cohesive group. They may be composed of several generations, each of them having its own history, different standards of living throughout the life-course and different values giving rise to different behaviors. In developed countries the elderly persons are divided into three or more categories, viz.

i) 'The young-old'-- The 'young-old' category comprises of persons in the age group 60-69, who maintain working capability after their retirement. As of 1990, India had 38-39 million in this category.

ii) The 'middle-old'-- The 'middle-old' consists of persons aged between 70 and 75.

iii) The 'old-old'-- The 'old-old' category comprises of individuals aged over 75, who are likely to be frail, and possibly be a victim of physical disabilities and mental illness associated with old age.

iv) The 'very old'--And finally, the 'very-old' category constituted by individuals who are 80 years and above.

The disadvantage of using chronological age a guide, however, is that the problems associated with all people at some predetermined age (De Loach et al., 1983). It may be that a person who is 55 years of age is not able to work because of health conditions arising out of old age, at the same time a person of 75 age is still fit enough to carry all activities.

In an attempt to decide who is elderly it is important to focus upon functional capability rather than chronological age. For the purpose, at least two factors can be mentioned: One, the elderly constitute that age group for which disability is most common. Old age is often viewed as a gradual loss of physical and mental abilities with an increasing difficulty to maintain mobility and independence.

WHO (1967) defined old age as, "The period of life when impairment of mental and physical function becomes increasingly manifest by comparison with previous periods of life." It is considered an assortment of diseases and disabilities leading to dependency in later life. The majority of disorders occurring in the elderly people are not solely due to ageing process which would minimize the pathogenicity and incidence of ailments (Fried and Bush, 1988). Second, "older people face the same stigma, prejudice, and stereotyping that people who are disabled encounter" (Benedict and Gankos, 1981).

Social class aspect in aged

Social class is a critical factor influencing how people experience old age and, in particular, the quality of the lives they lead. In general, social class is an important indicator of a person's position in the social stratification system in any society and their access to material resources (Gjonca and Calderwood, 2003). Occupational status along with educational attainment have a direct impact after retirement in the form of non-wage benefits such as access to private healthcare etc. Social class is directly associated with the material, financial and cultural resources which are necessary to enable an older person to remain independent and live a life of dignity. Those who lack resources, including access to care, are most likely to enter residential care which is marked by reduction in older person's autonomy and independence (Arber and Ginn, 1993; Townsend, 1981; Walker, 1982). Financial resources may be used to adapt or purchase appropriate housing or aids to promote independent living. Experience of ageing for rich is different from that of poor.

Pension: Pensions are the main source of income after retirement. Retirement is not a homogenizing experience because most of the people come under informal sector where such services are excluded. Occupational pensions provided an excellent source of income in old age for middle and high earners and government employees, but, the poor employees of informal sector suffered.

Gender:

Women are the majority of the older population in virtually all nations and face different circumstances and challenges than men as they age. Older women are more likely to be widowed, to live alone, and to live in poverty. Older women tend to have lower educational attainment, less formal labor force experience, and more family caregiving responsibilities than do older men. In this brief, we will examine the demographics that underlie the socioeconomic differences of gender and aging.

Women constitute 55 percent of all persons aged 60 and over, and the majority (58 percent) of the world's 310 million older women live in developing countries. In all regions and practically all countries of the world, women account for the majority of the older population, and the proportion female increases with age. On the global level, women make up just over half of the age group 60-69, but they account for 65 percent of the oldest old (80 years and older). The term the feminization of later life has been used to describe how women predominate at older ages and how the proportions increase with advancing age (Arber and Ginn, 1994).

Throughout much of the world, women tend to marry men older than themselves. This, combined with higher female life expectancy, increases the chances that a woman will outlive her spouse and spend a portion of her older years living on her own or with adult children. In most countries, older women are much more likely to be widowed than are older men

1.3 Some Other Concepts:

1.3.1 Ageism

Ageism is increasingly an issue that older adults face (Butler, 1990; Palmore, 2001). Ageism is discrimination against individuals or groups on the basis of their age. This may be casual or systematic. The term was coined in 1971 by Robert Neil Butler to describe discrimination against seniors, and patterned on sexism and racism.

Butler defined "ageism" as a combination of three connected elements. Among them were

- i) Prejudicial attitudes towards older people, old age, and the aging process;

- ii) Discriminatory practices against older people; and
- iii) Institutional practices and policies that perpetuate stereotypes about elderly people.

Often compared to the other 'isms' that exist, including racism and sexism, ageism is unique because, as Palmore (2001) rightly points out, every individual has the potential to experience discrimination or prejudice based on their age if they live long enough.

The origins of ageism are discussed in both psychological and social terms. Martens, Goldenberg and Greenberg (2005) suggest that the unconscious concern with death and frailty motivates individuals to use cultural systems of beliefs to maintain a positive sense of self. As a result, individuals devalue old age as a means to cope with the threat of death. Others highlight the social origins of ageism, emphasizing the importance of social roles (Cuddy et al., 2005; Hagestad and Uhlenburg, 2005; Kite et al., 2005). According to the interactional theory of ageism, including research that suggests that the more individuals watch television, the more likely they are to perceive elders in negative terms (Donlon et al., 2005).

1.3.2 Assisted Living

A living arrangement where older people can benefit from different levels and types of support to assist them in retaining independence. A single consensual definition of 'assisted living' does not exist and many definitions lack a clear focus on the services to be provided and the needs to be met by assisted living. Several features, however, such as 'flexible care, self-contained dwellings and a homely feel to the building' are essential in a definition (Hanson et al., 2006: 1). Few examples of it are:

Designated housing: general stock for rent, usually bungalows, designated for independent older people.

Extra-care in sheltered housing: a form of sheltered housing with additional care facilities to cater for a population with mixed dependencies, usually with other services and activities provided. 'Extra care housing is a development of sheltered housing that aims to meet the housing, care and support needs of older people, while helping them to maintain their independence in their own private accommodation' (Darton et al., 2008: iv). In the UK, extra-care models of housing are primarily from the public and registered social landlord sector.

High dependency extra-care housing: a form of extra-care housing where the majority of residents, older than in other settings, have moderate to high levels of care needs.

Registered care homes: accommodation and staffing that meets care standards to house a population with care needs short of nursing homes.

Nursing homes: licensed facilities that provide nursing or personal care services to people who are infirm or chronically ill, though not necessarily an older population, again meeting care standards.

Assisted living can range from small three-resident properties to retirement communities.

1.3.3 Cohort

A group of individuals or couples who share a common event, such as birth or marriage, during a particular period of time, usually a year.

Cohorts normally experience the same demographic event (birth, divorce, marriage, education, for example), so we therefore talk of birth cohorts – individuals born in the same year – and marriage cohorts – those who married in the same year, and so on. Cohorts are said to ‘age’ as they advance continuously from one age group to another across their life span.

Cohort analysis, sometimes referred to as longitudinal analysis, uses data to track cohorts of individuals across time. For example, a marriage cohort can be followed from the time they marry through successive periods to assess how many couples divorce, or to establish the risk of them divorcing after a certain period of time. Some studies adopt an inter-cohort approach because they aim to compare differences between two or more cohorts, while others will focus on intra-cohort variations, those within a given cohort. One of the main methodological challenges of cohort analysis is to be able to distinguish whether observed trends reflect cohort differences (whether cohort effects have an impact on one age group in a population), changes in age-specific behaviour (where age effects refer to an individual’s experience of the passing of time) or the influence of particular historical circumstances or events (known as period effects, which have an impact on everyone at a particular point in time) as these three variables are not independent of each other (Hardy and Waite, 1997).

Jamieson (2002) argues that, as a multidisciplinary field, social gerontology focuses on understanding changes to individual lives in the context of changing social structures, and that central to these processes is the passing of both individual and historical time. It is when individual and historical time are studied together that it becomes important to distinguish cohort, period and age effects. Several macro-level factors contribute to cohort changes and differences, including: the composition of each cohort (e.g. their size or distribution by gender); changes to the ways in which a society and its institutions are organised, such as changes to the allocation of financial resources at retirement; technological changes such as the availability of new drugs; and, finally, how the links with other surviving cohorts who are in different phases of the life course are structured (e.g. increasing employment among women may affect the type and

frequency of support that older cohorts can expect from their offspring) (Uhlenberg and Miner, 1995).

The sociologist and demographer Norman Ryder (1965), interested in cohort change or succession and how it was linked to social change, argued that people belonging to a certain age group at a given point in time were also members of a specific birth cohort which had a particular or unique location in history. He argued that new cohorts, as they progressively replaced members in the age categories of preceding cohorts (part of the process of cohort succession), could potentially provide the opportunity for social change to occur because they would bring with them characteristics (e.g. an unusually large cohort) that were different from those of preceding cohorts. For Ryder, comparing different cohorts would provide a strategy for studying and understanding social change. Later on, the concepts of cohort and age strata became central to Riley's (1971) work on age stratification, a macro-social level of theory, reflecting the idea that age is a factor which influences how societies structure themselves and how individuals are organised into groups or strata based on age, moving from one age stratum to another during a lifetime (Hammarstrom, 2004).

Riley uses the concept of cohorts to identify individuals who age together, through biographical time (their own personal ageing history) and historical time (the unique historical background they share as they age). This perspective links the life course of individuals and the historical background within which ageing occurs. As cohorts age, moving through specific historical periods, they will pass through age structures which reflect expectations and experiences about the roles and behaviour people are expected to abide by and adopt. Cohort members therefore influence these structures but are also influenced by them. Riley and colleagues' later work in 1999, known as 'the ageing and society paradigm', explains variations between age groups and birth cohorts as the interplay between cohort flow (the movement through time of individuals born in the same year), the individual ageing experience and historical change. In sum, the age stratification perspective aims to understand the inter-linkages and interdependencies between the individual ageing process, age cohorts and social structures by considering individuals as members of age strata, cohorts and the historical periods in which they live (Hardy and Willson, 2002).

1.3.4 Filial Responsibility

<p>The expectation that adult children will provide assistance to older parents in times of need, giving priority to their parents' needs over their own.</p>

One of the closest kinship ties across the life course involves the relationship between a parent and child. The birth of a child signifies a new era in the life of their parent, igniting

a period of unyielding responsibility to ensure that the infant develops into, at the very least, a healthy adult. Once an adult, their parents have grown older, and the nature of the parent–child relationship may shift. Where once the child was dependent on their parent(s) for well-being, the parent may begin an era of dependence on their child for well-being. The character of this transition is often gradual, involving both the emotional and instrumental components.

Relying on a child in times of need, particularly related to finances, living arrangements and personal care, is particularly salient as one grows older (Finch and Mason, 1991). The impact is perhaps felt greatest when a health crisis occurs, such as if a parent suffers a stroke, or requires major surgery, and the older parent suddenly is no longer able to live independently. A major issue arises in such cases as to the responsibility that a child has to care for the parent, and the extent to which the child will sacrifice their needs to ensure the well-being of the parent. The significance of filial responsibility has attracted wide attention in social gerontology due to enormous economic and demographic transitions happening globally. Increased wealth and larger proportions of older adults within a society signify concerns that value shifts to individualism, accompanied by the sheer practical realities of living in a changing world, preclude an adult child's ability or commitment to care for an older parent in need. The accumulating research, however, suggests that filial responsibility is a dynamic occurrence, often context-specific and depends on a number of situational factors (Finch and Mason, 1991; Gans and Silverstein, 2006; Lee et al., 1998). Norms of filial responsibility continue to guide the relationship between older parents and their adult children, though explanations for why and how it persists vary.

1.3.5 Life-course Perspective

A dynamic and process-based approach to understanding ageing by examining how human lives are socially organised and evolve over time. The life-course perspective emerged during the 1960s in response to limitations identified in existing theories about human development, particularly the conceptual and methodological issues associated with ageing. The noteworthy aspect of a life-course perspective involves highlighting the significance of context to human ageing. The personal and biographical level of human experience is examined with simultaneous consideration of timing, social institutions/policies and structural position (i.e. race, class, gender) within a historical time period. The hallmark study that initiated a life-course perspective was carried out by Glen Elder (1974/1999), who demonstrated in his book, *Children of the Great Depression*, that socio-historical events have lasting effects on individuals, their relationships and their well-being over time.

Elder outlined five key principles:

- i) The principle that human development and ageing are lifelong processes;
- ii) The principle of timing which asserts that the developmental antecedents and consequences of life transitions, events and behaviour patterns vary according to their timing in a person's life;
- iii) The principle of linked lives which states that lives are lived interdependently i.e. we all are dependent on each other and all the experiences that we have gained through social-historical influences are expressed through this network of shared relationships;
- iv) The principle of historical time and place, which states that the life-course of individuals is embedded in and shaped by the historical times and places experienced over their lifetime; and
- v) The principle of human agency, stating that individuals construct their own life course through the choices and actions they take within the opportunities and constraints of history and social circumstances.

The concept of the life course is differentiated from that of the lifespan. Such distinctions are discussed at some length by Settersten (1999). Life course connotes an approach to understanding and studying human development within socio-cultural and historical contexts. Social institutions and policies shape life experiences over time, influencing social roles, positions and statuses as well as providing meaning to such experiences. Moreover, attention to general patterns between and within birth cohorts is key to applying a life-course perspective. Life-span approaches, on the other hand, assume that human development is lifelong, but occurs in stages, and is unidirectional. Life-span psychology takes as the unit of analysis individual behaviour, emphasizing plasticity and malleability over and above social structural factors that impinge on human experience. A political-economic perspective of the life course points to the development by which chronological age became meaningful (Dewilde, 2003). Government-defined roles and statuses have shaped life-course experiences by dictating the ages at which it may be acceptable to engage in activities such as education, marriage, work and retirement.

According to the life-course perspective, life events (e.g. marriage) and life phases (e.g. old age) must be studied in tandem, at multiple levels of analysis, and within the context of previous life experiences.

1.3.6 Retirement

Retirement is a difficult concept to define because its boundaries are fluid. It may represent a transition or process which has no single cut-off point – shifting from full-time to part-time, and then to a complete withdrawal from paid activity. Conversely, it

may be marked by a specific event – stopping paid work at a precise and given age and receiving some form of retirement income for the first time. Although, for purposes of measurement, it may be important to establish retirement status in terms of its objective elements (receipt of a pension and reduced activity in the labour force at an older age, for example), it then becomes problematic to know how to apply these parameters if individuals have not been involved in paid work during their lives.

Defining the concept of retirement, then, is challenging as it represents a variety of experiences which do not lend themselves to simple classification. As an individual experience, however, it can be conceptualized as a process involving different pathways and outcomes, defined with reference to a cut-off point or an event occurring at a given age. Alternatively, if retirement forms part of a broader inquiry about how people's social, psychological and economic well-being evolve in later life, then its meaning and definitional boundaries will relate to a broader spectrum of events and transitions occurring across the life course (Künemund and Kolland, 2007).

In some senses then, retirement is more a construct than a clearly defined concept and can be used interchangeably to represent different things – a specific ceremony marking the end of a working life, a period of a person's work life history during which they prepare for this departure, a change of social role from worker to retiree. As such, its meaning will be fluid, depending not only upon individual trajectories but also on macro-level influences such as labour market fluctuations or socially prescribed, normative expectations about the life course.

The notion of retirement is a relatively recent social phenomenon, coming into its own as a singular phase or transition in the life course during the mid-twentieth century with the establishment of organized social security systems which provided some form of income security in old age. Prior to this, and with the exception of some military, church or benevolent pension provisions, people did not generally have the opportunity or expectation of withdrawing from the workforce but worked until they were no longer able to do so. One explanation for the emergence of retirement as a social institution is that certain conditions need to be present, such as a system of economic production which is so efficient that it can make a surplus; institutional structures which enable this profit to be redistributed to people who are not economically active; a society which will accept the idea that part of the life course does not have to be dedicated to paid work; and, finally, the possibility of living long enough to be able to take advantage of a period of life without work (Hill, 2007; Midwinter, 1997).

Some gerontologists offer what can be considered as a functionalist explanation for the historical emergence of retirement. As such, retirement is understood as a mechanism which regulates the flow of workers into and out of the labour market, reduces unemployment or creates places in the labour market so that younger people can

replace a more costly, older work force. Victor (1994) suggests, for example, that the emergence of retirement at a fixed age in twentieth-century Britain was due not only to the development of pension provisions, but also to demands for labour market changes: an economic recession, reduced demand for certain skills, and pressure for older workers to retire and make way for younger cohorts. Linked to this explanation is the idea that retirement marks a broader process of 'institutionalisation' of the life course. Despite individualised experiences of the retirement process, these nonetheless occur in sequences shaped by the needs of the broader economic and labour force environments of industrialised societies.

Retirement thus becomes an anticipated and socially normal phase of the life course, representing a form of social organisation based on age (Kohli, 1986). In the contemporary period, and particularly since the 1970s, an increasing trend towards early exit and early retirement from the labour force, coupled with increasing life expectancy, have consolidated retirement even more as a distinct phase of the life course, although it still remains as a mechanism through which to pursue broader economic objectives. Extending rather than reducing the age of retirement, for example, has now become a prime policy focus in several industrialised countries as one means of meeting the costs of pension provisions in a context of population ageing.

In the field of social gerontology, the phenomenon of retirement has become an area of multidisciplinary interest. Post-war gerontological research frequently portrayed retirement as an inevitably difficult and problematic transition, detrimental to social relations and with negative psychological and health implications, brought about through a loss of status and self-esteem and an increased risk of poverty. This perspective was evidenced through the work of prominent gerontologists, geriatricians and sociologists of the time, notably Sheldon (1948) and Townsend (1957), particularly in their work on older people's lives in the UK communities of Wolverhampton and Bethnal Green. As a challenge to this position, other studies emerged which portrayed a more complex picture of the motives for leaving paid work and the outcomes of the transition to retirement. For example, it was found that ill health could be a cause rather than a consequence of retirement, and motivations to retire could also be linked to poor working conditions.

1.4 Gerontology

Gerontology is derived from two Greek words "geron" which means "old man" and "logos" which means "discourse" or "study". Gerontology is the study of the phenomenon of old age. It is the study of the social psychological and biological aspects of ageing in an adult person.

Gerontology is distinguished from geriatrics which is the branch of medicine that studies the diseases and care of the elderly person. The elderly adult deserves intensive medical attention as he continues to grow old.

The Oxford Minireference Dictionary defined gerontology as the study of ageing. The new Webster's Dictionary of English Language (1994) edition, defines gerontology as a study of the phenomenon of old age. Also, the encyclopedia on ageing (volume 2, 297-298) defined gerontology as the scientific study of ageing and older population. As the adult advances in age, the need for gerontology becomes necessary. Contemporary gerontology concerns itself with the ageing population.

Considering the above definitions and explanations, gerontology encompasses the following:

- i) Studying the physical, mental and social changes in people (adults) as they age.
- ii) Investigating the ageing process itself (biogerontology).
- iii) Investigating the interface of normal ageing and age related diseases (geroscience).
- iv) Investigating the effects of our ageing population on our society; including the fiscal effects of pensions, entitlements, life and health insurance and retirement planning.
- v) Applying knowledge to policies and programmes; including a macroscopic perspective i.e. (running a nursing home).

These five scopes of gerontology can simply be referred to as multidisciplinary. This is so because there are a number of sub-fields in it, as well as psychology and sociology.

The field of gerontology is relatively a late developed field of study. This simply means it is a recent field of study. This made it possible for it to lack structural and institutional support required. However, the huge increase in the elderly population in the post-industrial western nations made gerontology to become most rapidly growing field of study.

1.4.1 Branches of Gerontology

The following are the branches of gerontology which are embedded in its scope discussed above.

Biogerontology: This is a sub-field of gerontology that studies the biological process of ageing. It is composed of the interdisciplinary research on biological ageing, causes, effects and mechanisms in order to better understand human senescence. Some biogerontologists like Leonard Hayflick, have worked to show that aging is a biological

process which we are far from controlling. They are also known as conservative bio gerontologists.

Biomedical gerontology: This is also known as experimental gerontology or life extension. Life extension is a sub discipline of biogerontology that endeavors to slow, prevent and even reverse ageing in both humans and animals by curing age-related diseases and showing the underlying processes of ageing. Some bio gerontologists are at intermediate position, emphasizing the studying of the ageing process as a means of mitigating ageing – associated diseases. They claim that maximum life cannot be altered.

Medical gerontology: This branch of gerontology studies the biological causes and effects of ageing, medical and biogerontology are considered by many scientists to be the most important frontier in ageing research (Gracia 2010).

Social gerontology: This is a multidisciplinary sub-field of gerontology that specializes on studying and working with older adults. Social gerontologists are responsible for educating, researching and advancing the broader causes of ageing in older adults by giving informative presentations, publishing books and articles that concerns the ageing population, producing relevant films and television programmes and producing new graduates in colleges and universities.

Tibbits (1960:3) coined the term "social gerontology," referring to the fact that aspects of gerontology have a major component of social factors and forces. Included in these social forces are roles and status of the old, how the old are viewed by society, and the degree to which normative aspects of aging determine the behavior of older persons. While the subject of aging is of interest to a number of scientific disciplines, the focus of this paper will be on sociology's contribution to the field of social gerontology.

1.4.2 The Uniqueness of Social Gerontology

A number of social gerontologists have delineated the focus of the social scientist studying aging into the category of studies of situational changes in later life. These changes involve the older individuals' adjustments to a changing role in the family, the community and the society. These are at various times defined as socioeconomic, sociological, or situational changes in old age.

Tibbits (1960), Cox (1988), and others have identified a number of situational changes to which an older person must adjust:

1. The completion of the parenting role;
2. Changing attitudes (often negative stereotypes) toward the aging individual by significant others;

3. Loss of the work role and acceptance of the retirement role (with the concomitant loss of income, status, privilege, and power associated with one's position in the occupational hierarchy);
4. A major reorganization of one's life and time following retirement;
5. A new definition of self which is not tied to career and parenting responsibilities;
6. The search for a new identity, meaning, and value in one's life;
7. The loss of health and restricted mobility;
8. A need for special living arrangements;
9. The death of a spouse;
10. Disability and the recognition of one's own impending death.

Any of these changes can result in a loss of self-confidence on the part of the individual and considerable effort must be utilized to maintain ego balance when confronted by the inevitable stresses of old age. Changing economic, social, and political roles in old age have provided fertile ground for a multitude of studies of behavioral changes in later life.

Economists have carefully highlighted the economic needs and resources of older persons. On the one hand, they observe that the elderly, while living on a lower income, generally have no children living at home, are retired, own their homes, and have expenses that are likely to be lower than the middle years—except for medical expenses which are likely to be higher and to climb steadily as one ages. On the other hand, the economists point out that the elderly are confronted with the problem of maintaining an adequate standard of living on a fixed income where inflation and rising prices are constant and inevitable. Moreover, there is little or no opportunity for the elderly to increase their income at this stage of life.

Political scientists are quick to note the increasing impact that the elderly have on the federal government as a result of the fact that they represent an ever increasing number and percentage of the total population. Moreover, political scientists observe, older persons are more likely to vote than younger persons and through organized groups who lobby for their interests, they have considerably improved the share of the nation's resources directed to their needs in the last 20 years. The growing influence of the nation's elderly on the political system will provide fertile grounds for study for political scientists for some time to come.

Sociologists have long focused on the socialization of individuals for the changing roles and statuses that accompany different stages of the life cycle. When older people plan for the next phase of their lives, not all of the roles they will be assuming are positive

and desired. Retirement after 40 years of striving to succeed in a career may be desirable. Being a widow or widower, being sick, or being disabled, however, are roles that usually are not desired. For most, this is the first time in their lives that the future is not viewed positively and anticipated with high expectations. Adjustment to changing roles and status and the inevitable losses of old age have provided, and will continue to provide, fruitful research endeavors for sociologists.

1.5 Emergence of the Discipline

Interest in understanding the processes of ageing, the decline of the ageing body and the quest to prolong life has been a source of inquiry for thousands of years, and has been represented in various civilizations. The search for the causes of ageing in western culture appear as early as the Greco-Roman period, with Hippocrates' theory of ageing, which was based on the idea that an innate heat was essential to life, and that as people aged, it would diminish as part of the natural course of life. Later, Aristotle carried this theory further by comparing the innate heat to a fire, and hence to something that could be extinguished or exhausted.

1.5.1 Research and Studies of Ageing in the World

➤ Before Nineteenth Century

Although the scientific study of social gerontology is relatively new, but it has its roots in biological studies of ageing process and in psychology of human development. Several key publications and research studies can be identified as milestones in history of this field, for example, Roger Bacon's quest to identify the laws governing the ageing process during the 1600s and later during the 1700s with Benjamin Franklin's interest in rejuvenation. Bacon suggested that life expectancy could be extended if health practices, such as, personal and public hygiene, were improved.

According to Thane, 2005, the first signs of interest in age as a category to be studied can be dated back to the seventeenth century when the first collection of statistics on mortality and morbidity was recorded.

Galton's data, collected during the 1800s, demonstrated that many human attributes varied depending upon age, and during the 1900s, biologists such as Pearl contributed to an investigation of the hereditary nature of longevity (Birren and Clayton, 1975). The first scientist to explain ageing as a developmental process, rather than as stagnation or deterioration, was a nineteenth century Belgian mathematician, named, Adolph Quetelet. During the first part of the twentieth century, large-scale studies of the ageing process were largely of medical orientation, but its social dimensions were also beginning to draw interest; in the UK, for example, in 1947 the Rowntree Committee's

study on the Problems of Ageing and the Care of Older People was published (The Nuffield Foundation, 1947).

These developments formed the basis of what was to become the scientific study of ageing during the 1970s, which has subsequently emerged as a multidisciplinary field.

➤ **Early Twentieth Century**

In 1903, a Russian-born biologist named Elie Metchnikoff first proposed and named gerontology as a new field of study. Gerontology is a multidisciplinary subject. Since its conception in 1903, its definition has expanded to include different perspectives on and approaches to ageing, such as critical gerontology, techno gerontology and environmental gerontology (Johnson, 2005). The term is also associated with geriatric medicine, which in the UK is a hospital-based specialty concerned with mental and physical disorders which also includes prevention, diagnosis, care and treatment of older persons through medicine, nursing and the allied health professionals.

Social gerontology concentrates on the study of the social, economic and demographic characteristics of older people and an ageing population. Increasingly, the focus has been on the life-course approach to ageing rather than the study of old age per se in gerontology (Johnson, 2005).

Two important forces led to the expansion of research of the aged problems in social gerontology, in the late nineteenth and early twentieth centuries. First, the growth of population over age 65 years because of increase in life expectancy. Second, emergence of retirement policies in industrial settings. For the first time the idea of the 'old' as a separate group emerged, becoming particularly identified in the UK with the first pensions on a large scale in 1909. The prevailing belief was that families should be responsible for their ageing members, however, the great depression brought to policy makers the stark realization that families struck by unemployment and homelessness could not be responsible for their elderlies.

Whereas before the Second World War there was a concentration on paediatric care, by the end of the war there had been a greater recognition of the social and medical implications of an ageing population as well as an awareness of the low level of care for older people. Thus, early work in social gerontology dealt largely with social and economic problems of ageing. For example, E.V. Crowdy's Problems of Ageing, published in 1939, focused on society's treatment of older people and on their particular needs (Reported in Hooyman and Kiyak, 1994).

➤ **The period of 1940s**

In 1945, the 'Gerontological Society' in America was founded, bringing together small group of researchers and practitioners, who were interested in gerontology and

geriatrics and 'The Journal of Gerontology' which began publishing in 1946, served the first vehicle for transmitting new knowledge in the growing field. The creation of the National Health Service in 1948 in the UK also provided financial and administrative support for geriatric medicine. Thus, as society grew more aware of issues facing the older population, the formal study of ageing emerged in the 1940s.

➤ **The period of 1950s**

According to Hooyman and Kiyak (1994), the indicator of the knowledge explosion in the field of social gerontology is that the literature on ageing, published between 1950 and 1960, equaled that of the previous 115 years. The various aspects of aged life pattern were focused by scholars in various fields, such as,

Psychological: (Havighurst and Albercht, 1953; Friedmann&Havighurst; 1954; Pollak, 1957; and Swenson, 1959);

Social: (Devis and Coombs, 1950; Hauser, 1954; Pitkin, 1956; Townsend, 1957; Backer, 1959; and Parsons, 1959)

Economic: (Burns, 1954; Carson and Mc Connel, 1956)

The study of ageing was advanced through a number of classic texts, such as Howell's Our Advancing Years (1953), Exton-Smith's Medical Problems of Old Age (1955) and Peter Townsend's Family Life of Older People (1957) and The Last Refuge (1962). The latter sociological studies showed the problems older people faced in the community as well as in institutional care. All raised the implications of a growing older population posing problems for society, family and individuals. Policy considerations driven by these studies viewed the elderly population as a 'burden' and ageist assumptions dominated gerontology (Johnson, 2005).

➤ **The Period of 1960s and 1970s**

Now the trend started of exploring different aspects of social life of the aged, such as, the studies of the problems, needs and adjustments of aged people. Some studies of 1960s were Burgess (1960), Tibbits (1960), Cowgill and Holmes (1972), Sussman (1976) and Fischer (1978) etc.

In 1970s, two new phenomena had come in focus, first, the mistreatment or elder abuse (Lau and Kosberg, 1979; and O'Malley, et. al., 1979) and second, the critical examination of social policies and services for the welfare of the aged (Estes, 1979).

➤ **Last three decades**

The United Nations declared 1982 the 'International year of the Aged' and this meeting brought about a revolution in the field gerontology. Therefore, in 1980s, several

encyclopedias, handbooks and sourcebooks were written to provide more information about ageing. And many Government and Non-Government Organizations (NGOs) had started working in the field of welfare of the aged.

In the last three decades, the issue of population ageing has received renewed attention in the field of social gerontology because population ageing is an obvious consequence of the process of demographic transition. The developed regions of the world have already faced its consequences and are also facing it whereas, the developing regions will sooner or later face the similar situation.

1.5.2 Development of Gerontological Theories:

Gerontological theory also mirrored the research on ageing and started with the development of 'disengagement' theory and 'activity' theory. The expansion of gerontology came with the establishment of the associated groups of the British Geriatrics Society, the British Society of Gerontology and the British Society for Research on Ageing in 1945; and journals such as *Ageing in Society* and *Age and Ageing*. In 1948 the International Association of Gerontology held its first meeting when researchers, teachers and practitioners who worked with, or studied, older people and old age were brought together. In Britain, the establishment of the National Old People's Welfare Organisation (now Age Concern) in 1940, the National Corporation for the Care of Old People (now the Centre for Policy on Ageing) in 1947 and, in 1961, Help the Aged were all influential in furthering the study of ageing. This was followed by the growth of gerontology in university settings, for example, university courses in gerontology at King's College, London and Keele. Courses in gerontology expanded along with increasing study on the processes of ageing funded by the major research councils (e.g. the Economic and Social Research Council (ESRC) through the Growing Older and New Dynamics of Ageing programmes).

Among the numerous advances in the biology of ageing, there has been attempts to distinguish physiological from pathological ageing and the development of 'biomarkers' as a means of measuring the rate of ageing. Several theories, notably theories of the evolution of ageing, seek to explain the effects of senescence on the body, why ageing occurs, what genes contribute to the process and how the human genome is affected by natural selection. It is now established that manipulating both the environment and the genetic make-up of human beings can alter life expectancy and the maximum duration of the life span, innovations which raise the question of whether the process of biological ageing itself can be delayed or even reversed. Studying how genetics may influence the ageing process and longevity raises several questions, notably why the human organism should need to age once it has fulfilled its functions of reproduction (an evolutionary perspective) and whether it will be possible or desirable to intervene and change the rate of ageing and its causes (Moody, 2006).

Within social aspects of gerontology, there have been numerous contributions that include a critical gerontological perspective, life course perspective, rational choice perspective, cumulative advantage/disadvantage theory, and exchange theories.

The late 1980s saw the development of critical perspectives (Estes, 1979; Phillipson, 1982) which recognised that the experience of old age is determined as much by economic and social factors as by biological or individual characteristics. The development of critical approaches (e.g. biographical approaches) which contextualise the ageing process on life histories has subsequently grown, firmly identifying gerontology with a life-course approach. Consequently, there has been a redefinition of the subject's core issues and greater attention on the process of ageing as experienced by individuals. Other trends within gerontology today include the recognition of diversity within the ageing population, particularly around gender, class and race; a focus on 'non-pathological' ageing; and the expansion in the field of study to encompass the life-course perspective. Ray (1996: 675) defines critical gerontology as: 'a critique of the social influences, philosophical foundations and empirical methodologies on which gerontology as a field has been historically constructed'. Phillipson and Walker (1986: 280) defined critical gerontology as 'a more value-committed approach to social gerontology – a commitment not just to understand the social construction of ageing but to change it'. The emphasis in both of these definitions is on values, change and action.

In the 1990s, the sociology of ageing focused on change and stability across the life course and with this started the era of Life course perspectives.

Life course perspectives have enriched ageing research in several ways (Elder 1995; George 1993).

First, a life-course approach is attractive because it recognizes that the past predicts the future. That is, status and personal well-being in late life depend in large part on events and achievements experienced earlier in the life course.

Second, life course perspectives emphasize relationships across life domains, recognizing that, for example, family events affect and are affected by work and health. Traditionally, sociological research has focused on specific life domains (e.g., the sociology of work, the sociology of the family); life-course perspectives, in contrast, are person-centered rather than domain-centered.

Third, life-course perspectives focus on the intersection of history and personal biography. Although the macro-micro schism remains difficult to bridge, life-course research has documented some of the complex ways that historical conditions affect personal lives both contemporaneously and over subsequent decades.

1.5.3 Role of Critical Gerontology in theory building:

Bernard et al. (2000) suggest that the study of social ageing has recently benefited from the work of critical gerontologists who have raised awareness of the role that the welfare state may play in increasing economic dependency and social marginalisation in later life, and there are also postmodern theorists who have challenged the conception of the ageing experience as one characterised by a progressive loss of meaning to life, also highlighting how the ageist attitudes and expectations prevails. Bernard et al. suggest that along with biographical perspectives, which have helped to demonstrate how diverse the ageing experience is and how it mirrors a lifetime of other experiences, there are also different perspectives that have highlighted many implications of the ageing experience, particularly for women, in areas such as employment, income, wellbeing, and the various dimensions of caring.

A more recent focus on ageing has been to view it as a dynamic rather than a static process, as people move through different stages and transitions of the life course. This has led to a growing diversity of methodological approaches in the field, including longitudinal and event history analyses which track the paths or transitions that individuals and groups follow as part of the ageing process, and help distinguish age, period or cohort effects. The increased availability of large, often cross-nationally comparable data sets has also meant that significant developments have been made in distinguishing both culturally specific and historically determined aspects of the ageing process (Morgan and Kunkel, 1998). In the field of biological ageing, for example, the development of longitudinal studies has been used to identify physiological functions or 'biomarkers', biological indicators which help identify the key features of the basic ageing process, such as a person's ability to hear.

In relation to older people, critical gerontology has focused on how marginalised and pathologised older people have been in society and how we need to view older people and later life in a different and more positive way, challenging traditional theories in gerontology and the methods by which we study ageing, and giving voice to those people who are often unheard (Hols tein and Minkler, 2007). In the UK, the emphasis has been on a critique of the state as the dominant provider of welfare (Phillipson, 1982). There has been considerable development in relation to the application of critical gerontology. Political economists drew attention to the ways in which our welfare system was effectively transforming ageing into a dependent status (Townsend, 2007) with long-term and community care systems perpetuating the power inequities between experts (such as social workers) and lay people, and were creating what Carol Estes (1979) called 'The Ageing Enterprise'. These systems and structures were essentially about controlling and managing people, rather than enabling older people to engage in a full life.

Whereas the tradition to critical gerontology has come from an emphasis on the political economy of ageing, Minkler (1996) argued that the other strand of development in critical gerontology stems from more humanistic approaches, stressing a focus on the 'meaning' of old age and growing old, with a greater emphasis (although not exclusively) on individual aspects of ageing. Biographical and narrative perspectives also provide another basis for exploring the social constructions of ageing. Taken together, all three perspectives are seen as empowering older people. The challenge for gerontology is how to bring the different strands together. The application of the different influences on gerontology for the study of ageing is also a test – how we research and what methods we use will be influenced by our gerontological understanding. Whereas biographical approaches have been favoured under the critical perspective approach, there is a need for a methodological bricolage (Holstein and Minkler, 2007: 22):

Methodological bricolage means not ruling out knowledge that is gained from personal narratives, fiction, poetry, film, qualitative investigations, philosophical inquiries, participatory action research and any other method of inquiry we may discover that yields insights into fundamental questions about how, and why, we experience old age in very particular ways. Ray et al. (2008: 29) also highlight the challenge of applying this to the ways in which professionals work with older people. Taking the example from social work, they argue that 'a Critical gerontology perspective with human rights, empowerment and methodological bricolage at its center, means that instead of "doing to" older people we need to look at ways of "working with" them, in partnership'. The history of the concept has illustrated the shift in the 'problematization' of age to one where solutions across the life course and the positive aspects of ageing are reinforced. Developments in theory and methods have followed with feminist gerontology, critical perspectives and a greater acceptance of qualitative methods in the study of ageing. Older people's voices are increasingly central to understanding the experiences of ageing. Alongside this has been the expansion in the field of gerontology to include ecological and technological aspects of ageing under gerontechnology and environmental gerontology.

In addition to theory and method, ageing has been the object of interventions in various fields. Health interventions, such as exercise programmes for example, have been designed to address the physiological declines resulting from disuse of the body; and from psychology, intervention strategies are now available to help older people learn and remember better. Research on the brain, behaviour and ageing has highlighted the importance of interventions which facilitate environmental stimulation for older people, in the case of stroke victims for example, and the use of environmental prosthetics now provides a means of adapting the physical environment to fit the needs of older people who experience sensory deficits. From a social policy perspective, the engagement of

policy makers, planners and legislators has enabled the development and implementation of strategies to address, in particular, issues of ageism and age discrimination which intensify with the ageing process.

1.5.4 Indian Context:

Although in India, the interest in the prevention of ageing is ancient, its scientific study is of recent origin. Ayurveda, 'The Science of Life', is an example of it. On the psychological aspects, there are prescriptions of Sage Manu, in his Dharmashastra, with regard to the do's and don'ts in old age. Many ancient writers and poets have discussed, at length, the problems of old age, but scientific interest in ageing is a 20th century phenomena.

While in Europe and North America gerontology has seen an explosive growth since the last half century and more, but in India the discipline came in prominence only in the last two decades of the 20th century, even though, it emerged as a branch of study since India gained independence.

In one of the articles in 1993 Ramamurti and Jamuna also observe that systematised research on ageing is of recent origin. According to Bali (2001), most of the studies carried out by psychologists, social workers, anthropologists, demographers, sociologists and biologists have dealt with problems of the aged and the processes of ageing, with the research being influenced to a large extent by western theoretical perspectives, methodologies and paradigms.

As Shankardass in 2004 in review of the study of ageing in India also commented that from the 1980s there has been a steady growth in publication of research studies on ageing issues, however their contribution to increments in scientific knowledge is limited. As she points out "the field of studies on ageing reflects many inter disciplinary amalgams but we still need to negotiate differences in individual scholar's interests and concerns with data incommensurability, notwithstanding multiplying disciplinary traditions and loyalties", which need to be urgently dealt with.

The Period of 1950s, 1960s and 1970s

It was in the 1950s, for the first time that a few articles on ageing appeared in journals (e.g., Ramamurti, 1956 and Amesur, 1959) followed by a few scientific studies in the early 1960s. Efforts started with the establishment of the Indian Gerontological Association in the late 1960s by bringing together a group of experts from different disciplinary backgrounds. However, Kumar, Dey & Nagarker pointed out in early 1990, "Ageing in India is not an established field. Scattered experimental observations have been provided by a handful of Indian workers since last few years".

➤ **The period of 1980s**

The United Nation's 'Vienna Declaration' of the international year of the elderly, in 1982, spurred research activity in ageing in India. The founding of the Association of Gerontology (India) in 1982 and the Geriatric Society of India, already established in 1979 brought gerontologist in India together. A center for research on ageing started at the Sri Venkateswara University in 1983. Soon a string of conferences, seminars and research projects were organized that heralded a general awareness in ageing that gradually built up research interest country wide.

The Ministry of Social Justice and Empowerment (earlier called Ministry of Welfare and later as Ministry of Social Welfare) of the Government of India took initiative for sponsoring studies in the field of gerontology such as surveys on the older people, evaluation studies of public assistance schemes, etc.

The Information Exchange System on Ageing was established in 1978 by the Social Development Branch, Centre for Social Development and Humanitarian Affairs and Department of Economic and Social Affairs of the United Nations. Its purpose was to monitor the present and prospective changes in number and proportions of the aged and the underlying demographic factors, to maintain a system of collection and dissemination of information on ageing and to promote research at the international and national levels in the field of gerontology.

As a first step, the department prepared a bibliography of the books and articles on ageing, which had appeared in the various professional journals since 1950 to 1979. This annotated bibliography was named as "Ageing in India". This bibliography had papers under five broad categories relating to demographics, economics, and health, social and psychological aspects. The purpose of this bibliography was to "acquire potential users with the type of information that was available in the field of ageing in India". It was also hoped that this would be of use to policy makers, planners, researchers, and social workers in the field of ageing and will help them obtain relevant information for improving the planning, delivery, and integration and evaluation services as well as for developing new and improved methods to meet the human and environment needs of ageing.

➤ **Last Three Decades**

During the last three decades there have been numerous studies accumulating vast data from micro and macro perspectives; but, nonetheless development of theory and contribution to critical development of the field of studies on ageing in India has not made a mark worldwide, though we take a lead in the SAARC region and influence much of research and academic work in other South Asian countries. The technical complexity achieved by researchers in gerontology is recognised even though there are

certain doubts about theoretical insights. Nevertheless, debates over theory and praxis have been part of development of the field also in developed countries, where gerontology has a long history, and yet, has only modest scientific sophistication (Achenbaum, 1995). We need research data that is scientifically collected and driven by appropriately defined questions covering basic assumptions and larger theoretical issues. Our questions must be informed by critical understanding of the processes and not merely by assumptions which can create fallacies of the analysis, missing an opportunity of establishing gerontology as a professional discipline.

Various Indian scholars and experts from various parts of the country affiliated to different universities, research organisations, to a range of government and private institutions have contributed to research and theoretical expositions in gerontology. Most social scientists have kept their focus on studies of ageing as a social process or on studies that depict social conditions of life of older people. Such work together provides interesting insights into ageing, life course and social structures which orients us to focus on issues related to longevity, health, work, retirement, family life, intergenerational relationships, social care and diverse related concerns.

Many studies draw on ethnographic accounts of the old and theorise on social conceptions of ageing and old age. There is of course growing awareness about the gap between public images of ageing and personal perceptions of older people necessitating the requirement to recognize in research, the emphasis on documenting the needs of older people, as indicated by them. Use of ethnographic approaches and qualitative data can be made part of 'critical gerontology' as indicated by Lubinsky and Sarkar (1993) and in the works of Gubrium (1992, 1993) and in India too Shankardass and Kumar (1996 [a] & [b]) challenging much of the fields epistemological girding drew attention to thinking of gerontology 'critically' by bringing in humanistic elements in theory for discourses in gerontology. But, we need to bring in better assimilation of the diversity of experience and the contingency and uncertainty of meaning — an analysis and understanding of phenomena linked with social change as integral part of theory (Baars, et al, 2006) as is happening in new developments in gerontology in countries where ageing is a bigger concern, but will soon impact India too.

The above mentioned stance gives weight to methodologies which incorporate older persons' voices and examine the social, cultural representations to grasp the gap between societal conceptions and experiences of older people. Work over the years also indicates a gradual shift in focus not only on individual representations of ageing but understanding derived from social, economic and demographic changes that impact on ageing societies. Certainly, we need to press on understanding heterogeneity among the ageing population and recognising not only cohort differences in ageing, but, also related to gender and marital status. We do need better understanding of ageing through cohort analysis as well as from insights derived by understanding the interplay

of social forces, including demographic, economic, structural, historical and social changes.

By now we know that processes affecting ageing are very complex and we need different disciplinary perspectives to throw light on ageing features of societies. Of course, there is need for continuing greater inter disciplinary studies which cut across sociology, anthropology, psychology, economics, social work, medicine, psychiatry, architecture and gender and development studies. Encouragingly, there is notable increase in state, regional, national and international networks that cut across disciplinary and professional boundaries which are promising developments in gerontology and probably an indication of being able to face the challenges in the field of ageing.

According to Ramamurti (2005), 'the function of ageing research in India would be three fold. First, research is expected to provide basic normative data on the overall status and need of elderly. This could form basis of policy and planning. Second, research is aimed at understanding the ingredients of a good quality of life for the elderly. Third, research is to be directed towards the formulation, execution and evaluation of appropriate intervention to improve the lot of the elderly.

In recent times emphasis on ageing and social policy has gained momentum. This provides platform also for studying roles of older people in society and bringing attention to their contribution to economy, society and focus on opportunities and constraints from both welfare and development perspectives. There is emerging awareness on rights of older people and promotion of policies and programs to enhance the potential of older people in society. Clearly, studies on ageing have to develop major gerontological paradigms and provide insightful research for theoretical development. We have to continue to develop traditions that influence both theoretical and methodological questions and bring attention to the actual experience of ageing, not just at the individual level; but, through the complexity of social consciousness and action through the conjoin of the micro and the macro.

Studies on Urban Elderly

Raghani and Singhi (1970) surveyed the adjustment problems of 50 Gazetted and 50 Non- Gazetted retired persons aged 55 years and over. About 63% of them reported that although kinship ties still persists in the realm of family relations, they had a feeling of being dethroned and devalued.

Desai and Naik (1972) studied 600 pensioners in the city of Bombay on three important aspects viz., health, finances and social psychology.

Delhi School of Social Work (1977) took up a social survey of older persons in Delhi covering 200 persons aged 60 and above. The sample comprised of 55 % men and 45 % women. The study revealed that three-fourth of the elderly were living with children and most of the elderly persons living alone were widowed and half of them had no sons. Nearly half of the elderly persons had no income at all and the proportions of persons without any income is found to increase as there is an increase in age.

D'Souza (1982) focused on the problems of the poor urban elderly in eight resettlement colonies of Delhi. The study was conducted on 304 elderly people and most of the respondents belonged to scheduled caste and were employed in low status occupations in unorganized sector. The outcome reflected that a majority of the older persons were either totally (58%) or partially (12%) dependent on others for their living. Among women 72% and among men 42% were totally dependent. The level of economic and physical dependency, which in case of women was accentuated by widowhood, determined the status of elderly within the family. There was differential erosion in status of elderly men and women in the family and it was visible in the relatively low participation of elderly women in decision making in the family. Even in case of roles, there was a certain blurring of roles traditionally specified for men and women. Older men were found to be engaged in household chores such as cooking and activities related to child care, which traditionally in India come under the domain of females.

Mahajan (1987) for his study of the recipients of old age pension in Haryana state took a sample of 369 men aged 60 years and above, and 380 women aged 55 years and above. About 97% of the sample were illiterate and were earlier employed in unorganized sector, where there was no provision of retirement benefits. A majority (79%) of the women elderly were widows, whereas only half of the elderly were never married. More than half (53%) were living alone and they suffered from a feeling of being rejected by relatives and of becoming social outcasts. Another 11% were living with their spouses as their only companion. About 82% of the old age pensioners were of the opinion that the younger generation did not show due respect to the elderly. Most of them felt that their lives had become meaningless.

A study on "Impact of out migration of the young and older people" was conducted by Indira Jai Prakash (2003) on 75 urban elderly (35 men and 40 women), educated, salaried, all belonging to an association of parents of non-resident Indians in Bangalore city. All the respondents were living either alone or with spouse, but without any children at home. Male children had gone abroad for studies or for work and had settled there. Female children had migrated after marriage and settled/employed abroad. Most of the people felt they would not like to live with their married children and grandchildren. The reasons stated by them include fear of becoming a burden on children, lack of opportunities to socialize, difficulty in adjusting to non-Indian ways of children, the alien culture, difference in life style, loss of independence, clash of ideas with children and

grandchildren, unpleasant weather, isolation from family and friends, feel imprisoned in the house, health problems prevent travelling, not welcomed by children, unwilling to accept other culture and preference to live in familiar home town. Most expressed the feeling that their age and lack of mobility in a foreign country made them totally dependent on children, both physically and economically.

SushmaBatra's (2004) study on social components of active ageing of engaged and disengaged women after retirement found that the living arrangement of the retired women was not dependent on whether they are engaged/disengaged. The engaged women did not take up activity because of economic necessity.

Studies on Rural Elderly

Marulasiddaiah (1969) studied the declining authority of old people in Karnataka and it was found that elderly respondents aged 70 years were found to have been ignored by the younger generation, even in village administration, although they were still doing some functions such as performing white magic and other rituals. They preferred to live alone as long as they have enough support from property.

Kanta et al (1987) study comprised of 100 females over 60 years of age in a village of Haryana. It was found that three fourths of the aged women were enjoying a position of importance compared to other females in their families, whereas one fourth did not report any such privilege. Major problems faced by the respondents were economic (25%), followed by psychological (24%), social (22%) and health problems (22%). Of the respondents with economic problems, 58% belonged to schedule castes, followed by backward castes (29%) and upper castes (7%). Of the respondents who experienced psychological problems, 27% belonged to upper castes, whereas only 16% belonged to scheduled castes and 14% belonged to backward classes. This reflects that where upper castes elderly women had psychological issues, lower castes elderly women had to deal with economic problems.

Studies on attitudes towards the elderly

One of the earlier studies (Tuckman and Lorge, 1952) reported that one-third of the respondents perceived elderly as stubborn, touchy, and being engaged in frequent quarrels with their children. Another study (Golde and Kegan, 1959) also indicated negative attitudes of youth toward old people.

A study comprising of 69 children belonging to three different cultural groups indicated that culture and affluence has a strong influence on children's attitude towards elderly (Seefeldt and Ahn, 1990). The study sample consisted of children from Korea, of Korean heritage children and Anglo children living in U.S. It has been found that as compared to children from Seoul (Korea), Anglo children and children from Korean

heritage in the United States of America rated the old people positively as healthier and cleaner.

Sharma (1971) in a study of student sample comprising of students from India, U.S.A., Japan, Sweden, Greece and England observed the impact of education and cultural differences and their attitudes towards elderly. The results indicated a negative attitude of all the students and Indian students held more negative attitudes towards elderly as compared to the students from U.S.A.

These studies have focused upon retired persons, old age pensioners, beneficiaries of community care programmes living in both urban and rural areas. However, the findings of these studies may not enable us to generalize because of the differences in definitions, sample size, foci, tools and nature of respondents studied. The cutoff point to define an older person in all studies ranged between 50 and 60 years.

Most of the elderly live with their children or relatives; co-residence with married children is still a predominant living arrangement. However, a smaller proportion of the elderly are living with their married daughters and many of them are widows. Most of the studies indicated that a majority of the elderly are not working and therefore, do not have income of their own, with the exception of those elderly who have retired from organized sector occupations. Lack of income of their own made them dependent on their children and other relatives which lead to unpleasant experiences for the elderly. Study reveals that the most vulnerable section among the elderly population are widows.

Advocacy, research, involvement of voluntary agencies, training different levels of gerontological workers, catalyzing the community, awareness building, organizing older persons themselves and networking with international agencies are all essential to empower older Indians. Good planning, policy making and action should be based on accurate information. Hence quality research in ageing issues is urgently needed. At present, nation-wide community-based studies that provide baseline data on health, morbidity, psychological status, socio-economic conditions and living arrangements of the total population are not available. In the early part of 1998, Help Age India took the initiative of conducting a series of seminars in the four regions – north south, east, west – of the country. From each region, existing regional data were compiled and eventually presented at a National Conference held in New Delhi. This was one of the most serious efforts to document and compile existing nation-wide data.

This Conference recommended that a National Institute on Ageing be established in order to:

- i) Undertake, promote and supervise cross regional multidisciplinary research on all basic issues related to ageing;

- ii) Issue guidelines for training different levels of gerontological workers;
- iii) Evaluate such training programmes;
- iv) Monitor the work of old age homes and NGOs involved in gerontological work;
- v) Initiate and maintain networking among institutions and individuals involved in gerontological work;
- vi) Act as a documentation and dissemination centre.

An examination of culturally relevant strategies for improving the wellbeing of elderly people is strongly recommended. Indian culture has inherently several elder friendly values and practices which need to be reinforced. Importing a western model of care for elderly people is likely to be costly in a country that can ill afford such initiatives. Working in close collaboration with international agencies is one way of learning from models that have been used in other countries and adapting those best suited to the socio-cultural milieu of India.

1.6 Scope and Significance:

Gerontology is not merely the study of aging or the study of the problems of the aged as understood by independent subject disciplines or the individuals writing proposals for research grants (Bass, 2009: 352–53).

Gerontologists deal with three general sets of themes as they attempt to analyze and understand phenomena of ageing (Bengtson, *etal.*, 2000).

The first set of issues concerns the aged as such: populations that can be categorized as elderly in terms of their length of life or expected lifespan as members of a society.

A second set of themes involve ageing as a developmental process occurring over time longitudinally. Here the focus is on how individuals of a species grow up and grow old—the processes of development, growth, and senescence over time—and the biological, psychological, and social aspects of that process, including its variable rates and consequences.

The third set of themes relates to the study of age as a dimension of structure and behavior within species. This is of obvious interest to sociologists and other social scientists examining human populations, and the social organization they create and modify, in response to the age-related patterns of birth, socialization, accession to adult status, and retirement or death within the human group. The phenomena to be explained here concern how age is taken into account by social institutions; examples include the labor market, retirement, pension systems, and health care organizations.

These three concerns are quite different in focus and inquiry; yet they are inextricably interrelated in gerontological research and practice.

Ferraro wrote about what he calls seven tenets of the gerontological imagination. According to Ferraro, they include concepts such as

(a) Ageing and causality—those things frequently associated to age may not be age-related phenomena and gerontologists always question what an age effect is;

(b) Ageing as multifaceted change—changes associated with growing older are not necessarily linearly associated with chronological age, with the process of ageing being multidimensional in nature and involving changes touching on biopsychosocial influences;

(c) Genetic influences on ageing—the individual genetic makeup has profound influences through the entire life course;

(d) Ageing and heterogeneity—the diversity of the population is positively associated with ageing;

(e) Ageing and life course analysis—ageing is not just for the old but occurs throughout the years, and this lifelong perspective helps understand later life;

(f) Ageing is cumulative—similar to item e, advantages and disadvantages for individuals and groups accumulate over many years; and

(g) Ageing and ageism—ageism remains a phenomenon that is part of modern society and may exist even among the aged themselves (Ferraro, 2006).

Alkema and Alley (2006) identify three unique gerontological theories and orienting frameworks:

(a) A life course perspective,

(b) Cumulative advantage and disadvantage theory, and

(c) Ecological theories in ageing.

Ageing thus may be constructed on the life experiences of an individual and how individuals view the age of an individual. While young one may claim old and while old one may claim young leaving scope for popular perceptions on such individual in question. Modi (2001) says 'more than any other social phenomenon, ageing, in its varied ramifications, particularly its socio-psychological dimensions, has acquired unprecedented significance both nationally and internationally'. It is here that one can look for social perspectives.

The study of the social dimensions of ageing, usually referred to as social gerontology, incorporates three distinct aspects (Ward, 1984).

The first approach examines ageing as an individual experience by investigating such topics as changes in perceived age identity as the individual progresses through the life course. However, few individuals grow older in isolation from the rest of society. Rather, ageing occurs within a social context ranging from the micro-scale of the family to the macro-scale of the whole society or culture.

The second approach to the study of ageing examines the social context which defines ageing and seeks to understand the position of elderly people within society.

The third dimension of social gerontology is the examination of the societal consequences of ageing. Demographic change in the composition of the population, such as the ageing of the population, raises a host of policy issues, especially in the economic field, which require investigation and discussion (Johnson and Falkingham, 1992).

Ageing is a sociologically interesting phenomenon because it takes place within a social context which exerts various constraints upon the individual. For example, society may encourage older adults to maintain patterns of behaviour typical of earlier stages in the lifecycle. Alternatively, older people may be encouraged to adopt patterns perceived as 'appropriate' to their age, such as playing bowls or giving up playing vigorous sports such as squash. The constraints operating upon the ageing adult are numerous and include the obvious biological changes which accompany old age as well as social factors such as employment policy, housing, social services, social attitudes and stereotypes of age-appropriate behaviour in later life. The meaning and impact of the constraints operating upon the older adult are highly dependent upon the social environment in which the individual encounters them. Ageing is not a homogeneous experience which affects every individual within the same society in exactly the same way. The experience of ageing amongst members of ethnic minority groups may differ markedly from that of the host population. Older adults from different social classes may experience ageing quite differently. We must recognize that ageing is interpreted differently in various societies and cultures and the experience of ageing has also varied historically.

We also need to remember in our study of ageing that the older adult is not simply a passive actor in the process of ageing. The interaction between society and the older person is not unidirectional. Rather, there is a continuous interaction between the older adult and society so that the ageing of individuals influences the context within which it occurs and vice versa. For example, older workers may possess unique skills and qualities that society may (or may not) use to advantage.

According to Johnson, five main areas of investigation that have dominated empirical work are:

1. Morbidity studies. These are usually epidemiologically based studies which seek to determine the incidence and prevalence of social, mental and physical disabilities amongst elderly people, in either community or institutional settings. Such studies have been conducted at national (Hunt, 1978) and local levels (e.g. Bond and Carstairs, 1982).

2. Quality of life. These are concerned with various aspects of old people's environment such as access to facilities, housing quality and related aspects. The bulk of these studies have concentrated upon housing either in the community, in sheltered housing, or residential homes (Willcocks, Peace and Kellaheer, 1987).

3 Personal relationships. This category includes the vast bulk of sociological studies of ageing. Empirical investigations of family relationships (Townsend, 1964), friendship patterns (Jerrome, 1990), social isolation, loneliness and social networks (Wenger, 1983) have received the most attention. Little attention has been given to the positive contribution made by the elderly either to their families or to the community.

4 Use of services. This type of investigation has pursued a narrow objective in that it seeks to describe old people's use of, and need for, specific social and medical support services such as home helps or meals on wheels (Bond and Carstairs, 1982). Also included are studies which have looked at the misallocation of elderly to institutional care (Townsend, 1964).

5. Retirement and employment. These surveys have looked at the creation and growth of retirement (Phillipson, 1982; Laczko and Phillipson, 1991) adjustment to retirement, early retirement and the contribution of older workers to the labour market (Parker, 1980). These have been based upon the premise that retirement is a male problem. There are still few studies of retirement as a female issue.

Scope of sociology of ageing is vast and takes into account large number of factors. However it is a relatively unexplored field which has not been given much importance.

Following are the points that highlight the scope and importance of sociology of ageing:

A central aim of social gerontology since its inception as a discipline, has been to understand and improve the lives of older adults, and to ameliorate the "problems" of aging (Achenbaum, 1995). Thus social gerontologists are interested in the impact of socioeconomic, political, and cultural forces and conditions on the processes of aging, and in the statuses and well-being of older people. Social gerontology

explorestheways in which the older population and the diversity of the aging experienceaffectand are affected by social structures (Hooyman and Kiyak, 2005).

The study of aging occurs at many different levels of analysis, from macro structures and systems, to the meso level of social institutions, the micro level of individual relationships and behaviors, and the even tighter focus at the level of physiology and biology. There is a need to highlight macro social or demographic trends operating at the societal level, for example, the characteristics of the ageing population at any given time, how those characteristics affect individuals and the society and their response towards it.

Macro demographic trends are the consequences of population aging and also influence the social experiences of aging. Some key demographic trends include the rapidly increasing number of the “oldest old,” a more racially and ethnically diverse older population, more immigrants and foreign-born citizens among the elderly, changing causes of death, and greater human capital (education and work experience) and labor force participation among older adults.

To deal effectively with the challenges created by population aging, it is vital to first understand the demographic, economic, and social changes that affects ageing and, to the extent possible, their causes, consequences, and implications for elderly. Sociology of ageing can offer a knowledge base, a number of useful analytic approaches and tools, and unique theoretical perspectives that can be useful to this task.

Research in social gerontology addresses many domains of social life and behavior, including family relationships, health and disability, and older adults’ social participation. Topics of attention for aged can include cognitive function of the aged, their health, disability, financial, and emotional wellbeing, labor force participation, living arrangements, social ties and transfers, perceptions of aging and older persons, and public resource allocation.

There is a need to study impact of ageing on individuals in various spheres like health, economic status, social status etc.

From health point of view, it is not merely the absence of diseases that marks good health, rather one should be both physically and mentally fit. In case of elderly, it is important to investigate:

- The diseases (physical and mental) most frequently observed among elderly
- The kind of health care system they avail
- Government interventions for fatal diseases.
- Care and support system available with the elderly, in case they suffer from fatal, contagious and incurable diseases.

- Practices that prevent unhealthy ageing

Economic aspect can reflect on

- Recent developments in government pension systems,
- The continued importance of earnings in old age,
- The relative financial position of older men, women, and couples,
- The problems of equity and economy for pension schemes, and
- Alternatives to government pension schemes.
- Participation in labor market
- Economic independence of elderly

Social and psychological can focus on

- The intergenerational relationship among family members and generation gap.
- Perception of elderly about their own identity
- Changing social roles and social positions of elderly
- Impact of modernization and globalization on status of elderly
- Social participation of elderly in family and community activities
- Various psychosocial problems faced by elderly

Sociology of Ageing can also focus on how factors in the social environment (such as socioeconomic position, income distribution, social networks, social support, social capital, community cohesion, work environment, neighborhood, and community) are related to a broad range of mental, physical, and behavioral health outcomes of elderly.

Elderly Abuses:

The latest available sources addressing elderly abuse have used the definition adopted by the World Health Organisation (WHO) in 2002: *a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person (WHO 2002: 3)*. The term 'abuse' comprises various dimensions such as, physical abuse, physical neglect, sexual abuse, verbal assault, material abuse and neglect of the environment and violation of rights. Elderly abuse has been described as intentional actions that cause harm or a risk of harm as a caregiver's failure to satisfy the basic needs and safe living conditions of elderly.

Recently from a survey conducted by Help Age India, it was found that half of the elderly (50%) reportedly experiencing abuse. 48% males and 53% females reported personal experience of abuse. In 2014 the % of elders abused went up drastically from 23% in the previous year to 50%.

Both researchers and policy makers need to focus on

- The detrimental effects of abusive behavior on elderly
- Legal safeguards for elders
- Various government schemes in domains of health, pensions, social security etc. in order to make them economically independent.
- Interventions of Non-Governmental Organizations (NGOs) in providing assistance, policy making etc.

One of the most important task of researchers is to give sociology of ageing a scientific base. Termssuch as 'the elderly' or 'older people' are often used, by bothprofessionals and the lay public, to describe people in the later phases of life. This does not imply that the identified group is homogeneous. Theterm 'elderly population' is often used to describe a group with an age range of 40 years or more i.e. (60 to 100 +). It is totally unrealistic to expect such a groupto be homogeneous in either character or attitudes.

Therefore, there is a need to

- Deconstruct the elderly population into component parts,and to
- Describe the diversity which characterizes old age and the ageing experience in modern society.
- There is a need to analysedifferent approaches which havebeen adopted for defining oldage and to examine the characteristics of these competing perspectives.
- This also provides a summary of some of the dominantvalues that characterize society which are of importance for understanding the experience of ageing and the position of the elderly inmodern society.

A better understanding of this can help researchers and policy makers in improving the lives of elderly.

Historical and cross cultural context of ageing:

The experience of aging is dramatically different from earlier historical periods. The social and economic roles of older persons, their interactions with families and the larger social system where they live are in many ways profoundly different today from previous generations. Until relatively recently, only a minority of people lived long enough to be considered old. As the number of older people has grown and as social values have changed, the authority and power of older adults in society have also shifted.The experiences of older adults differ cross culturally as well as historically.

That is, in addition to historical changes, significant cultural variations affect the social position of older persons. Perhaps the greatest differences in the status of older adults

are between traditional societies and those of the modernized world, with its rapidly changing values and norms.

There is a need to examine:

- The different ways that other societies, both historical and contemporary, have dealt with issues affecting their elders which can help to shed light on the process of aging in our society.
- How different cultures treated their elders
- Status of elderly at different points of time in history.

Senecide:

Even though positive attitudes toward the young-old were widespread, non-supportive or death-hastening behavior was shown toward those who survived beyond an “intact” stage of life. This stage of old-old age was often referred to as the “sleeping period.” No longer able to contribute to the common welfare and look after themselves, older people were then viewed as useless, “overaged,” or “already dead,” and were sometimes treated brutally. Those who outlived their usefulness were a heavy burden in societies that existed close to the edge of subsistence, particularly those in harsh climates with little agriculture (Barker, 1997; Glascock, 1997). The practice of **geronticide** or **senecide**—the deliberate destruction of older community members—was viewed as functional and, for many traditional societies, was often performed with great reverence or ceremony.

Thalaikkoothal is the traditional practice of senicide (killing of the elderly) or involuntary euthanasia, by their own family members, observed in some parts of southern districts of Tamil Nadu state of India. Although thalaikkoothal is illegal in India, the practice has long received covert social acceptance as a form of mercy killing, and people seldom complain to the police. In some cases the family informs their relatives before performing “thalikoothal”, and the victims sometimes even request it. However, social acceptance may lead to more egregious abuses.

Therefore, there is a need to document such practices, reason and culture associated with it, response of elderly, government response to it etc.

Anti-ageing industries:

Aging and anti-aging industries have become big business. Aging (and anxiety about aging) has demanded that new institutions be designed (e.g., residential settings to meet the full spectrum of needed care; educational settings to meet the need for “lifelong learning”) and that services and products be brought to market (e.g., aesthetic services, hormone treatments, vitamins and supplements, legal services). The marketing and consumption of these institutions, services, and products has also brought a wave of new legal and regulatory concerns.

Sociology of ageing needs to focus on all these emerging trends because anti-aging industries are blooming and they target the perception of people and build an atmosphere where ageing is considered as demeaning. Research should show why

embodiment and body image matter in our social practices and in the moral life more generally. There is also a need to understand the social impact of such products and how it changes and molds the perception of people towards ageing and elderly.

Sexuality in older persons:

Thomas Walz (2002) indicates, the more positive representations of embodiment and sexuality in older persons may open up the possibility for new self-understandings and identities. We recognize that men, too, increasingly experience social pressure to emulate the ideal male appearance. The marketing of treatments for hair loss and age-related erectile dysfunction are but two examples of how men are pressured to live up to youth-oriented societal standards. Perception of sexuality differs on basis of gender, for example, older men's bodies are still likely to be perceived as being "distinguished" or "full of character," while women's bodies tend to be negatively perceived as unattractive and even revolting (Sontag, 1972).

Elderly women have for years experienced the undoing that happens as they get older and have completed child-rearing tasks; with menopause, many women experience the diminished sense of being attractive, sexual persons. The change in their status is not a sudden event, but a continuous process that begins as many as 40 years earlier. Yet the pressure to stay attractive continues into old age for most women. This perception of old age leads to deterioration of self-image and loss of identity.

Researcher must focus on

- How self-perception of sexuality changes with age, especially among women
- How loss of sexuality accompanies loss of identity and self esteem
- Sexuality as a social construct
- How perception of sexuality differs on basis of gender

Successful ageing:

The emerging discourses, built upon several disparate parts—successful aging, productive aging, civic engagement, and post-traditional or postmodern aging—assume that one can and should maintain good health into advanced old age. These norms are meant to replace the stereotypical "decline and loss" paradigm that once served as the dominant motif in talking about old age.

They share several recognizable components: they see the world of old age from a privileged perspective; they aim to demonstrate that the old are not a burden on society but rather contributors as producers or consumers; they strive to open opportunities and change images of aging but do not consider the structural inequalities that shape what is possible and probable for individuals.

In a direct challenge to the view that old age burdens society, these views promote the reverse—older individuals ease the demands on social resources by engaging in socially valued activities. They work; they volunteer; they respond to communal needs; they are productive; they consume—all culturally resonant attributes. These discourses serve as

counterweights to long-held views that old age is primarily about individual decrements or losses to which elders and societies needed to adapt (Phillipson, 1998).

It will be important for both researchers and policy makers to focus on

- The positive side of ageing rather than thinking of elderly as problem and burden.
- What measures should be taken so that aged can have a healthy ageing experience.
- What factors (social, environmental) contribute to healthy ageing.

Care:

Older people who need assistance to remain at home can do so only by relying on others to compensate for what they can no longer do for themselves. Public policy, cultural norms, and the structure of the labor market dictate that these helpers are most often family members, and, more specifically, female family members. Although publicly-funded support is available to older people who have very low incomes, such care is rarely sufficient to meet needs; hence, families must retain their involvement in their loved-one's care.

However in the contemporary scenario, the traditional Indian extended and joint family system has undergone changes due to factors such as mobility from rural to urban centers and transnational flow. This trend has some economic benefits, but also some drawbacks such as contributing to the nuclearization of families, leaving behind the elderly parents, emotional insecurity among aged, physical threats etc. This has led to burgeoning of many institutions for taking care of elderly.

However, not much work has been done in this area. The caregiving research started from the late 1980s through the 1990s and an extensive research on "social support" grew with it. These values focus on the other side of home care.

There is a need to analyse

- The impact of modernization and globalization and the changes associated with care giving for elderly.
- Perception of aged towards home based care and institution based care.
- The more negative aspects of giving care – including "caregiver strain" and "caregiver burden especially for women.

Generational relations:

Longstanding interests in intergenerational relationships, especially between older people and middle aged children, and between older people and grandchildren, grew alongside the long era of caregiving research.

With it grew attention to the dimensions to characterize family relationships – for example, whether the relationship between that of parent and children is that of "solidarity" and "conflict" and, more recently, "ambivalence." Studies of intergenerational relations, traditionally framed within a "family studies" context, tend to examine how people of different generations perceive towards one another. In the functioning of

intergenerational families, grand parents have an important role and the positive role of grand parents have been emphasized (Miller and Sandberg, 1998). Grandparents as “family resource”, “family national guard” (Hagestad, 1985) and “family watchdog” (Troll, 1983) are described as important assets in multigenerational families across culturally. It has become important to examine

- The nature of intergenerational relations,
- To document the patterns of exchange, affectional ties, normative obligations and the nature of association and interaction among cross generational family members in such households, and
- The changes that have taken place due to modernization and other factors.
- To map out the gender gap that exists.

Health and disability:

Health also becomes a dominant point of focus over these years. Here, we see the emergence of notions of “health span,” “healthful aging,” and “healthy life expectancy”; attention to “activities of daily living,” “functional status,” and the “disability cascade”; concern about a wide variety of specific disability or illness conditions, some of which also mark the times (including HIV/AIDS, Alzheimer’s disease, cancer, osteoporosis, arthritis, and obesity); and language related to health care and institutions (including “independent living,” “assisted living,” “long-term care,” “home health care,” “rationing,” and “person-environment fit”). Alongside major attention to health grew significant attention to the connections between health, religiosity, and spirituality (and their measurement).

Sociology of ageing can focus on various aspects of “healthy ageing” and factors contributing and acting as obstacles for it.

Technology: With advances in technology, there came the scope for the “built environment” and the use of new technologies to help people “age in place” and monitor their health, as well as terms associated with advances in computing, the internet, and digital social networking. Special homes were built looking into the needs of elderly and internet bridged the gap of distances. Therefore, there is a need to explore the various dimensions of such built environment and internet on the lives of elderly, their interaction, solidarity and cohesion pattern etc.

Diversity:

Diversity became part of our scientific enquiry in the late 1980s and through the 1990s and many new terms appeared to reflect the reality such as “aged heterogeneity,” and regular references to Blacks, Scheduled castes, Scheduled Tribes and other special populations (e.g., the “differently abled,” “rural elderly,” and “gays and lesbians”). With this came sensitivity as well to the combined risks of being in multiple vulnerable statuses or positions – for example, the “double jeopardy” or “triple jeopardy” hypotheses. With this sensitivity grew towards the multiple vulnerability positions of the elderly, such as elderly belonging to schedule caste groups face “double jeopardy” i.e. first belonging to aged population and then to the scheduled caste groups.

It will be interesting to note how the gay and lesbian couples face the ageing and what sort of problems they will face. In case of India, we find there is difference in rural and urban set up in terms of sex ratio, economic dependence etc.

Gender:

With greater attention to diversity also came a stronger focus on women – the “feminization” of later life, the “sandwich generation” of “women in the middle” who are caregivers to both parents and children, and women as “kin-keepers” of family relationships and traditions because it is the women who have to take care of the elderly. Again, elderly women in comparison to their contemporary men, face age related problems like physical, social or psychological more. Sociology of ageing can through various qualitative methods take into account the narratives of old women and widows particularly because they have different life chances and experiences. There is a dearth of literature regarding female perspective of ageing, for example, working women after retirement will have different experiences than a housewife.

Sociology of ageing can take into account the female versions of ageing on topics like economic dependence of elderly women, plight of widowhood, derogatory behavior of children, menopause related health issues etc.

Women are also more likely to undertake unpaid labor, such as when caring for sick or elderly relatives and therefore are more reliant on state pensions (Ginn 2003). Women’s pay does not increase over time at the same rate as men’s, resulting in a gendered pay gap, which continues after retirement (McMullin 1995).

Inequality:

Social gerontologists are also interested in social inequality by age—the unequal treatment of older people and in the deleterious effects of ageism. The recognition of diversity and inequality has been crucial to the development of the field, and are incorporated in theory and practice. In Indian context, there is a need to compare and contrast the status of elderly in rural and urban scenario, rich and poor etc.

Taken together, the components like diversity, gender, and inequality, there is a need to have significant breakthroughs in understanding inter-individual variability in aging.

Impact of global process on ageing:

The advent of modernization, industrialization, urbanization, secularization, occupational differentiation, education and growth of individualism have changed the status of aged in numerous ways. The disintegration of joint family into nuclear family due to educational and occupational opportunities which are the result of industrialization and urbanization have brought tremendous changes. The traditional values that vested authority with the elderly have been eroded and this has led to defiance and decline of respect for elders among members of younger generations (Nayar, 1987).

According to U.N (1991), there are four ways in which industrialization and urbanization tend to make family care of the elderly more problematic.

- As economic production shifts from family to factory or workshop, the older generation tends to lose control over younger family members. This control was traditionally maintained through their control over productive resources such as land. The ability of the younger generation to earn a living no longer depends on access to land or other resources controlled by their parents.
- Globalization and Industrialization tends to increase the labor force participation of female members who are then less available to care for the aged family members.
- Declining fertility means that there are fewer adult children to share in the care of older family members.
- Increased rural to urban migration among the young tends to separate the two generations physically and spatially. Also, people can't afford to keep their old parents with them due to constraints of space, high rentals and high cost of living.

Presently, modern families are bestowing more attention and care in educating and bringing up their children and greater investment is made on this. Also it is generally felt that expenditure incurred on old people is unproductive.

Media's attitude towards older adults

The media regularly perpetuate the stereotypes of older adults through inaccurate and sometimes demeaning portrayals of older adults in print, advertising, and entertainment. Limited efforts have been made to alter how older adults are depicted in the media. Perhaps as more members of the baby boom generation age, positive changes will emerge.

Government Policies and Programmes: Sociology of ageing should also focus on

- Evaluation of various government schemes and programmes addressing aged.
- Allocation for elderly under different ministries
- Inter-country and Intra country analysis of various policies and programmes

Theory: Finally, in approaching the topic of sociology of aging, it is important to be aware that a persistent shortcoming, in the view of many sociologists, is a lack of theory to guide empirical research (Hirsch, Michaels, and Friedman, 1987). Indeed, some argue that theory development in the sociology of aging has been slow (Alley et al., 2010; Clark et al., 2011; Entwisle, 2007; Mayer, 2009; Yen, Michael, and Perdue, 2009), and the theories that have been postulated have not been sufficiently integrated into a larger explanatory framework (Bengtson, Burgess, and Parrott, 1997). Therefore, researchers should focus on creating more relevant theories which will act as a paradigm shift and not just extension of previous theories.

Environmental Gerontology

There has been a broadening of research under the badge of environmental gerontology to include: psychological aspects of the environment, such as identity and ageing and the meaning and attachment to a place; the physical and material environment through the study of housing in later life; retirement communities; rural ageing; urban ageing; ageing in disadvantaged areas; the social environment of ageing and older people's use of space. Much of this research has applicability in policy and practice development.

The broader focus on these areas is a response to the concern that there should be more attention paid to cultural aspects and the meaning of place, integrating social theory and cultural geography into the equation.

Trends within sociology have also influenced the development of gerontological approaches through the influence of health sociology and the application of the concept to the ageing body, the home and institutional settings. A focus on research of the living arrangements of older people initially concentrated on the design, architecture and structure of individual buildings, but later on it concentrated on residential segregation and long-term care settings. Much of this focused on specialist settings such as residential care (Willcocks et al., 1987) or assisted living.

1.7 International Declarations on Ageing:

Universal Declaration of Human Rights (December 10, 1948)

This fundamental text describes the values, rights and goals of the United Nations and specifically mentions the security of human beings in their old age.

United Nations call for the First World Assembly on Ageing.

In the mid-1970s United Nations called worldwide attention to ageing issues by viewing it as a serious problem besetting a growing proportion of the populations of the world. United Nations decided "to launch an international action programme aimed at guaranteeing economic and social security to older persons, as well as opportunities to contribute to national development." In 1978 the General Assembly of the United Nations decided, in resolution of 14 December, to convene a First World Assembly on Ageing in 1982. It was with these mandates in view that the Vienna International Plan of Action on Ageing was conceived, which is considered as an integral component of the major international, regional and national strategies and programs formulated in response to important needs and problems of aged.

Vienna International Plan of Action on Ageing (1982)

The Vienna International Plan of Action on Ageing is the first international instrument on ageing, guiding thinking and the formulation of policies and programmes on ageing. It

was endorsed by the United Nations General Assembly in 1982 (resolution 37/51), having been adopted earlier the same year at the World Assembly on Ageing at Vienna, Austria. It is sometimes known as the 'Vienna Plan' in honour of its city of origin. More frequently, however, it is referred to as the 'International Plan', underscoring its relevance for all world regions.

It aims to strengthen the capacities of Governments and civil society to deal effectively with the ageing of populations and to address the developmental potential and dependency needs of older persons. It promotes both regional and international cooperation. It includes 62 recommendations for action addressing research, data collection and analysis, training and education as well as the following sectoral areas:

- Health and nutrition
- Protection of elderly consumers
- Housing and environment
- Family
- Social welfare
- Income security and employment
- Education

The Plan is part of an international framework of standards and strategies developed by the international community in recent decades. It should, therefore, be considered in relation to agreed standards and strategies in the areas of human rights, advancement of women, families, population, youth, disabled persons, sustainable development, welfare, health, housing, income security and employment, and education.

Declaration of the Rights and Responsibilities of Older Persons (1990)

In 1990, the International Federation on Ageing (IFA) published its Declaration of the Rights and Responsibilities of Older Persons, a two-page document detailing the rights of older people regarding care, dignity, self-fulfillment, participation and independence. This document is the foundation of the UN principles of Older Persons, adopted in December 1991, aiming to be integrated in every program for older people.

United Nations Principles for Older Persons (December 16, 1991)

The General Assembly, in pursuance of the International Plan of Action on Ageing, adopted by the World Assembly on Ageing and aware that in all countries individuals are reaching an advanced age, encourages Governments to incorporate five main principles for older persons into their national programs whenever possible. The main points of the principles are independence, participation, care, self-fulfillment and dignity of older persons. They aim of the principles is to ensure that priority attention will be given to the situation of older persons.

International Conference on Population and Development Program of Action (1994)

At the 1994 International Conference on Population and Development in Cairo, 179 countries recognized the interdependence of population and development. The conference adopted a 20-year Programme of Action, which includes provisions to protect older persons, particularly with regard to establishing social security systems; eliminating all forms of violence and discrimination; increasing access to healthcare; and assisting those displaced during conflict. The subsequent Madrid International Plan of Action on Ageing incorporated these provisions six years later to the situation of older persons.

The Economic, Social and Cultural Rights of Older Persons (December 8, 1995)

The Committee on Social, Economic and Cultural Rights was created by the Member States parties to the 1995 Covenant on Economic, Social and Cultural Rights to improve its translation into acts by drawing governments' attention on the implementation's insufficiencies. This document demonstrates how the UN mainstreams older persons in its work. It contains Committee's recommendations on how to implement this comprehensive treaty on older person's economic, social and cultural rights.

Macau Declaration on Ageing for Asia and the Pacific 1998

A declaration of the United Nations Economic and Social Commission for Asia and the Pacific adopted the Plan of Action on Ageing for Asia and the Pacific convened at Macau from 28 September to 1 October 1998 for addressing ageing issues in the region. The major areas of concern outlined in the Macau Declaration and Plan of Action relate to ageing and older persons, including: the social position of older persons; older persons and the family; health and nutrition; housing; older persons and the market; income security; maintenance and employment; and social services and the community. The Plan of Action also discussed structures and processes for its implementation, including: the re-examination of the national infrastructure for ageing and older persons; inter-sectoral collaboration and support; coordination and monitoring; resource mobilization and allocation; and regional and international cooperation.

The Montreal Declaration on Rights of Older Persons (1999)

This document is the result of more than a year of deliberations and input from member groups of the International Federation on Ageing throughout the world. It was officially released and turned over to the United Nations Aging Unit at the closing plenary session of the IFA's Montreal International Conference in 1999. Its purpose was to guide UN policy on aging during the next decade.

Madrid International Plan of Action on Ageing (2002)

160 UN Member States adopted the Madrid Plan of Action on Ageing (MIPAA) in April 2002. Later, the General Assembly affirmed the Plan on December 2002 during its 57th session. The document addresses four major areas of concern:

- Older persons and development;
- Health and well-being into old age;
- Enabling and supportive environments for ageing; and
- Implementation and follow-up.

While MIPAA asks governments to integrate the rights and needs of older persons into national and international economic and social development policies, the plan is not legally binding. Therefore, MIPAA relies on each government's willingness and capacity for implementation.

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

Adopted in 1979 by the United Nations General Assembly, this is an international bill of rights for women. Currently in its 47th session in (2010) in article 21, Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), decided to adopt a general recommendation on older women and protection of their human rights.

The International Federation on Ageing (IFA) is an international non-governmental organization founded in 1973 and based in Toronto, Ontario (Canada) working in the field of ageing, older persons and ageing-related issues such as ageism. The intent of the organisation is for NGOs, the corporate sector, academia, government, and individuals working together to make, a "change for older people throughout the world by stimulating, collecting, analyzing, and disseminating information on rights, policies and practices that improve the quality of life of people as they age". The IFA has General Consultative Status at the United Nations Economic and Social Council (ECOSOC).

It organizes many international conferences on ageing where emerging issues affecting the elderly, strategies and execution plans are discussed.

Other International strategies and plans that addressed the issues of ageing are:

The World Population Plan of Action

The World Plan of Action for the Implementation of the Objectives of the International Women's Year

The Declaration of Alma-Ata (on primary health care)

Declaration of principles of the United Nations Conference on Human Settlements (HABITAT)

The Action Plan for Human Environment

International Labor Organization (ILO) Convention No 102 concerning minimum standards of social security.

ILO Convention No 128 and Recommendation 131 on invalidity, old age and survivors' benefits

ILO Convention No. 162 concerning old workers.

The Programme of Action of the World Conference on Agrarian Reform and Rural Development.

1.8 Global Scenario:

The age distribution of the world's population is undergoing a profound and unprecedented transformation. It has been shifting gradually to older ages and is marked by a process known as "population ageing". Population ageing means an increasing share of older persons in the population and it is a major global demographic trend which will intensify during the twenty-first century. Ageing results from the demographic transition, a process whereby there is reductions in mortality and it is followed by reductions in fertility. Together, these reductions eventually lead to rising median ages of population, smaller proportions of children and larger proportionate shares of older people in the population.

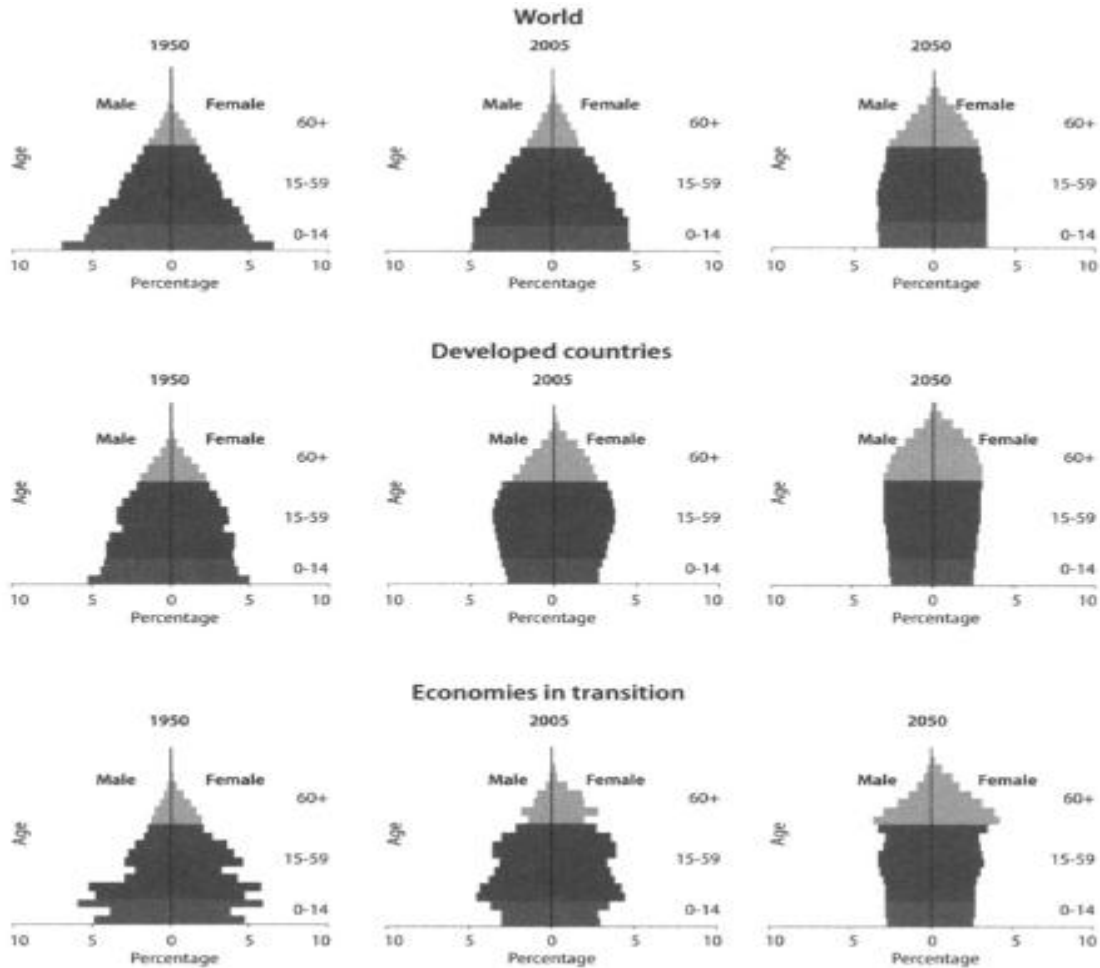
For statistical purposes, in The World Population Ageing report older persons are considered to be those aged 60 years or older. For understanding the global scenario, regions have been demarcated as more developed, less developed and least developed.

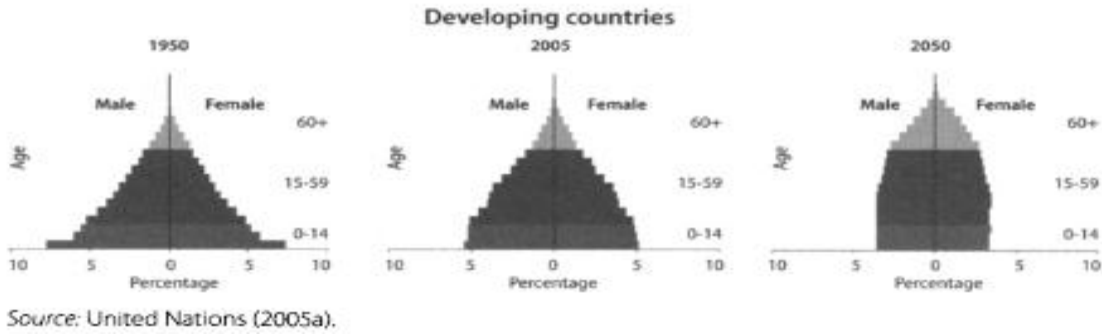
Regional differences in population ageing

Ageing is taking place almost everywhere, but its extent and speed vary. In most developed countries, the population has been ageing for many decades, while in developing countries, population ageing has taken place relatively recently, as their mortality and fertility levels have fallen. This reflects that the age structure of the developed countries is in general considerably older than that of the developing countries. In countries with economies in transition, the age structure is generally younger than that of the developed countries but still significantly older than that of the developing countries. It is expected that all groups of countries will undergo substantial ageing of their populations in the coming decades.

According to United Nations estimates, 21 per cent of the population in the developed countries was aged 60 years or over in 2005. This proportion is projected to rise to 28 per cent in 2025 and 32 per cent in 2050. In countries with economies in transition, the average proportion of the population aged 60 years or over is projected to increase from 16 per cent in 2005 to 22 per cent in 2025 and 29 per cent in 2050. In the developing countries, the proportion of the population aged 60 years or over was estimated at only 8 per cent in 2005 but is expected to reach 13 per cent by 2025 and nearly 20 per cent by 2050. Thus, the number of older persons in the developing countries will likely more than double between 2005 and 2025. This increase is much larger than in the developed countries and in the economies in transition, where the number of older persons will grow by about 44 per cent and 32 per cent respectively during the same period.

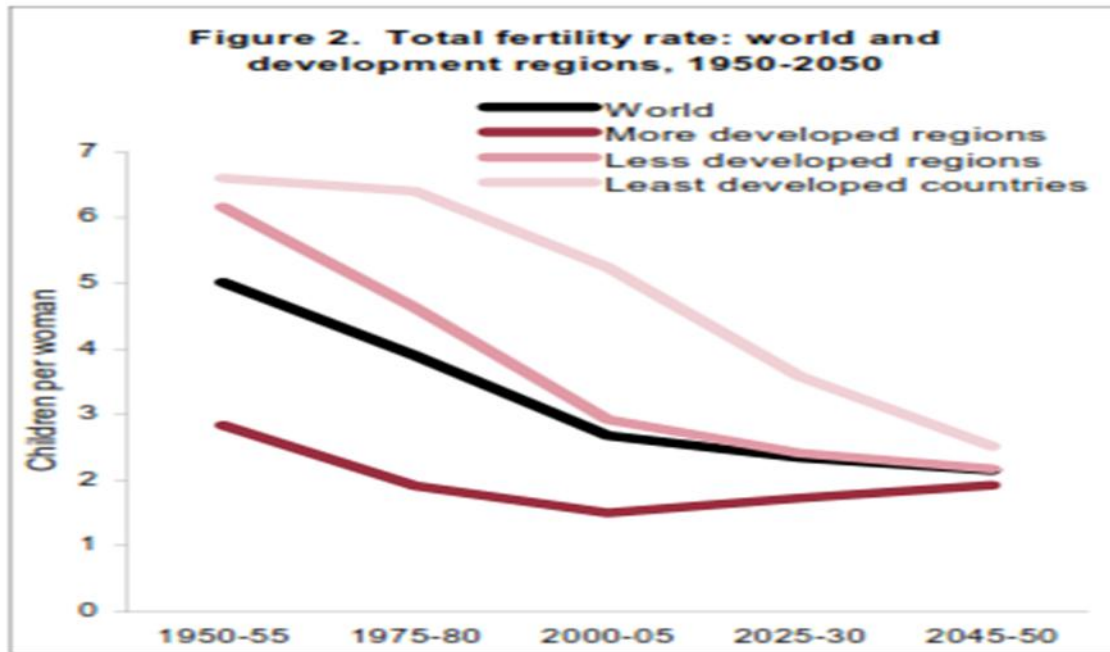
Population Pyramid





Underlying global population ageing is a process known as the “demographic transition” in which mortality and then fertility decline from higher to lower levels. Decreasing fertility along with lengthening life expectancy (figure 1) has reshaped the age structure of the population in most regions of the planet by shifting relative weight from younger to older groups. The role of international migration in changing age distributions has been far less important than that of fertility and mortality (Lesthaeghe, 2000).

REDUCTION IN FERTILITY



According to data from *World Population Prospects: the 2012 Revision* (United Nations, Department of Economic and Social Affairs, 2013), the above figure reflects that

- Fertility has been falling in most regions of the world over the last several decades, and this decline has been the main factor driving population ageing.
- The world's total fertility rate (TFR) has dropped by about a half, from 5.0 children per woman in 1950-1955 to 2.5 children per woman in 2010-2015.
- The decline in global fertility will continue during the coming decades. The faster the speed of fertility decline, the more rapidly ageing will take place.

➤ **Fertility is projected to continue to decline in the less developed regions**

- Most countries of the world experienced declining fertility during the last decades
- The reductions in fertility levels were generally faster in the less developed regions, with respect to the more developed regions.
- Total fertility in the less developed regions stood at 6.1 children per woman in 1950-1955, and fell sharply during the 1970s to the 1990s, reaching 2.7 children per woman in 2005-2010.
- Even though total fertility in the less developed regions is still well above that of the more developed regions, it is projected to fall to 2.3 children per woman in 2045-2050.
- Fertility started to fall more recently in the least developed countries (LDCs), only since the 1980s and a significant decline has taken place since, from 6.6 births per woman in 1980-1985 to 4.2 births per woman in 2010-2015.

Reasons for fertility decline:

Late Marriage- There is a large literature now on how a delay in the age at marriage can lead to declines in both natural fertility (because it reduces the length of exposure to the risk of pregnancy) as well as volitional fertility (because delayed marriage comes with a number of other things that reduce the demand for children).

Growing Awareness- Government programmes and schemes and initiatives by various non-governmental organizations helped in spreading awareness about the benefits of birth control, its economic advantages and demerits of having a large family etc. Education further helped in spreading the goals of government programmes.

Birth control Programmes and measures- Family planning has become an indispensable reason for fertility reduction. The motto of family planning is – “child by choice and not by chance” and “child by desire and not by accident”. Birth control methods include – use of rubber contraceptives by males, use of pills by females, use of loops by females, sterilization for both males and females, abortion, i.e., medical termination of pregnancy.

Education- A woman's level of education is essential to explain fertility trends. Many studies have documented the strong relationship between a mother's pattern of fertility

and the survival chances of her children. Infants have a higher risk of dying if they are born to very young mothers or much older mothers, if they are born shortly after a previous birth, or if their mothers already have many children. In total, higher female education is universally associated with lower and delayed fertility. Education also helps in eroding the superstitious beliefs associated with child bearing.

Urbanization and Industrialization- Though, factors like urbanization and industrialization lead to concentration of population in cities leading to population explosion in those areas but they also resulted in disintegration of joint families as people moved to better places in search of employment and educational opportunities. Because of the effect of migration, there was decline in fertility. High cost of living in cities coupled with inflation further acted as catalyst in fertility reductions.

Women in labor force- With the advent of new economic forces and education, women's participation in labor force increased significantly, which resulted in higher status. They had the choice to decide the age of their marriage, no of children they will have and when to have and they were able to choose their career over motherhood. Women were no longer puppets in the hands of male members.

➤ **The number of births is beginning to stabilize at the world scale**

Through most of the twentieth century, the number of births in the world increased from one decade to the next. However, the world has just entered a period, in which the number of births is likely to stay near 140 million per year, and then decline slowly to levels approximating 130 million births per year by the end of the century. This trend in the number of births, coupled with a long term trend of declining mortality, is changing the shape of the population pyramids into a nearly rectangular form until about age 60, a shape that is characteristic of a demographically "aged" population.

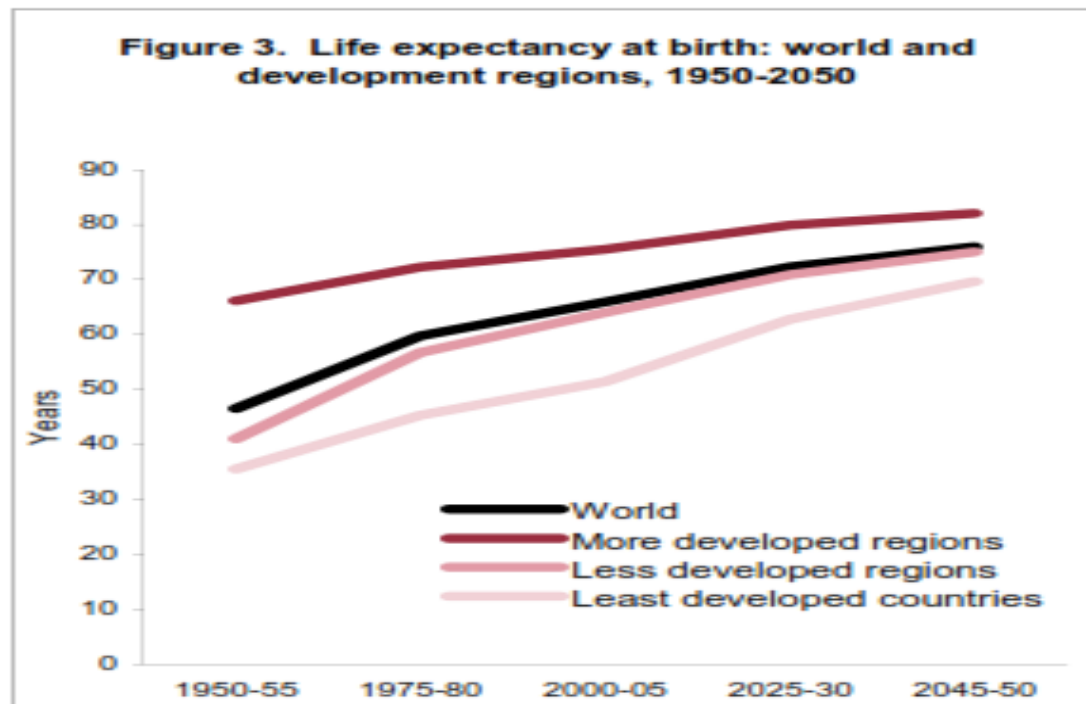
Developed Countries: The number of births in the more developed regions, after declining during most of the second half of the twentieth century, has been stable since the early 1990s. This has produced significant ageing in the population of these regions. China, the most populous country in the world, has also had a declining number of births since the 1990s, which will make its population age faster than many other developing countries.

Developing Countries: The projections show that the stabilization in the number of births in the least developed countries will not occur until after the middle of the twenty-first century. By contrast, India, the country with the highest number of births in the world, experienced a steady increase in this number—from 7 million to 26 million per annum—between 1950 and the mid-2000s. From then on, the number of births in this country is expected to decline slowly.

INCREASE IN LIFE EXPECTANCY

Increases in life expectancy at birth have been registered in all major regions of the world. The extension of average life span is one of the greatest achievements of humanity.

However, the increase in life expectancy does not result immediately in population ageing. Since early improvements in life expectancy come mostly from declines in child mortality, this tends to produce, in a first instance, *increased* numbers of infants and children, and a *reduction* in the proportion of older individuals. Continued progress in life expectancy contributes to the increase in the proportion of older people, as more individuals survive to ever older ages. Thus, eventually, lower mortality and higher life expectancy end up reinforcing the effect of lower birth rates on population ageing.

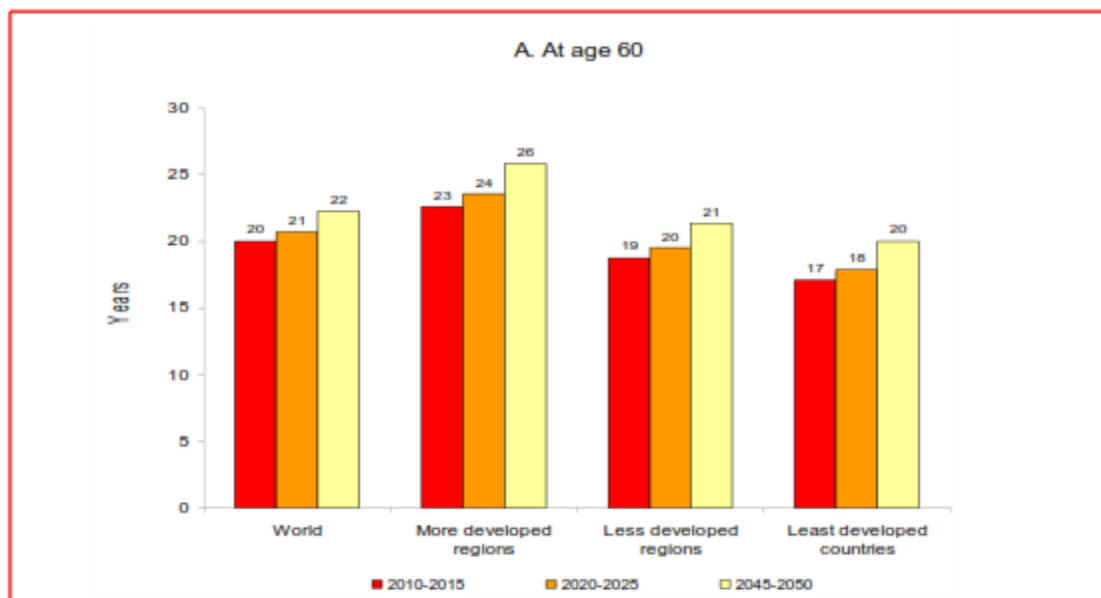


- Life expectancy at birth is projected to continue to rise in the coming decades in all major regions of the world.
- Life expectancy was 65 years in 1950 in the more developed regions compared to only 42 years in the less developed regions in the same year. By 2010-2015, it is estimated to be 78 years in the more developed regions and 68 years in the less developed regions.
- The gap between the more developed regions and the less developed regions has narrowed and it is expected to continue to get smaller in the coming decades. The reasons for this could be availability of improved medical facilities,

government intervention, growing awareness among people, pivotal role played by non- governmental organization in less developed regions.

- By 2045-2050, life expectancy is projected to reach 83 years in the more developed regions and 75 years in the less developed regions. Thus longer life spans will contribute to future ageing in all major regions of the world.

Graph for number of years of survival after 60.



The above chart demonstrates that number of years the aged will survive after 60 is increasing in all regions and will continue to rise also.

- In 2010-2015, at the world level, people who survive to age 60 can expect to live 20 additional years.
- But again, this indicator varies by development region; in the more developed regions, 60-year old people will live on average 23 additional years while in the less developed regions and the least developed countries, they will only live an additional 19 years and 17 years, respectively.
- However, with better medical facilities, invention of new medicines and government intervention in less developed and least developing regions, the gap between them and developed region will narrow down.

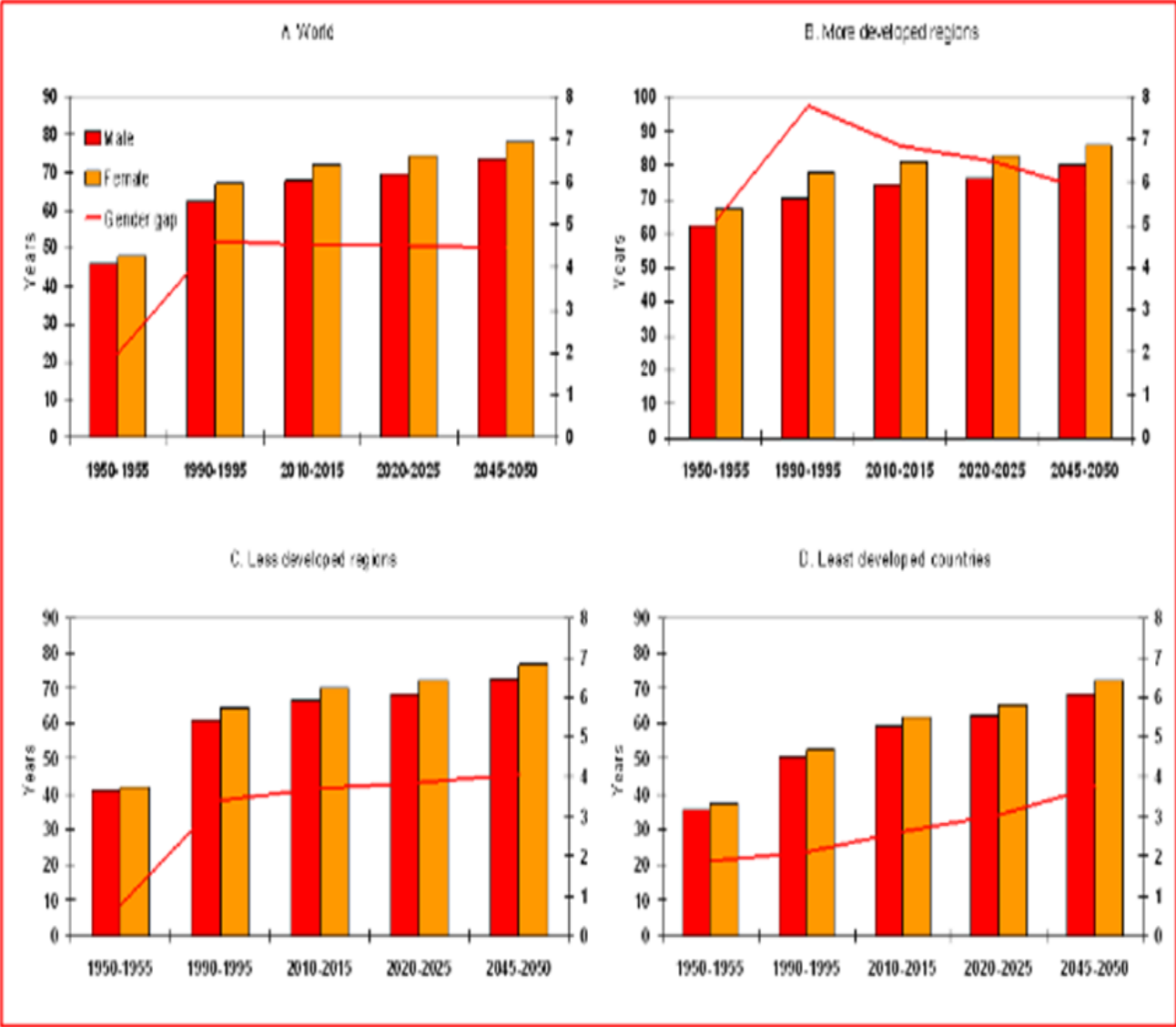
➤ **The gender gap in life expectancy is expected to narrow in the more developed regions, but to widen in the less developed regions**

Women live on average longer than men. While this gender gap in survival widened at the global level in past decades, current projections suggest that the gap will remain relatively constant in the next four decades at the world scale. However, in the less developed regions their improvement in female life expectancy are expected to be larger

than the improvement for men, and this will lead to a widening of the gender gap in mortality. In contrast, the gender gap in life expectancy in the more developed regions is expected to narrow from 6.8 years in 2010-2015 to 5.8 years in 2045-2050.

The following figure shows the gender differences in life expectancy at birth among three regions.

Male and female life expectancy at birth and gender gap: world and development regions, 1950-2050

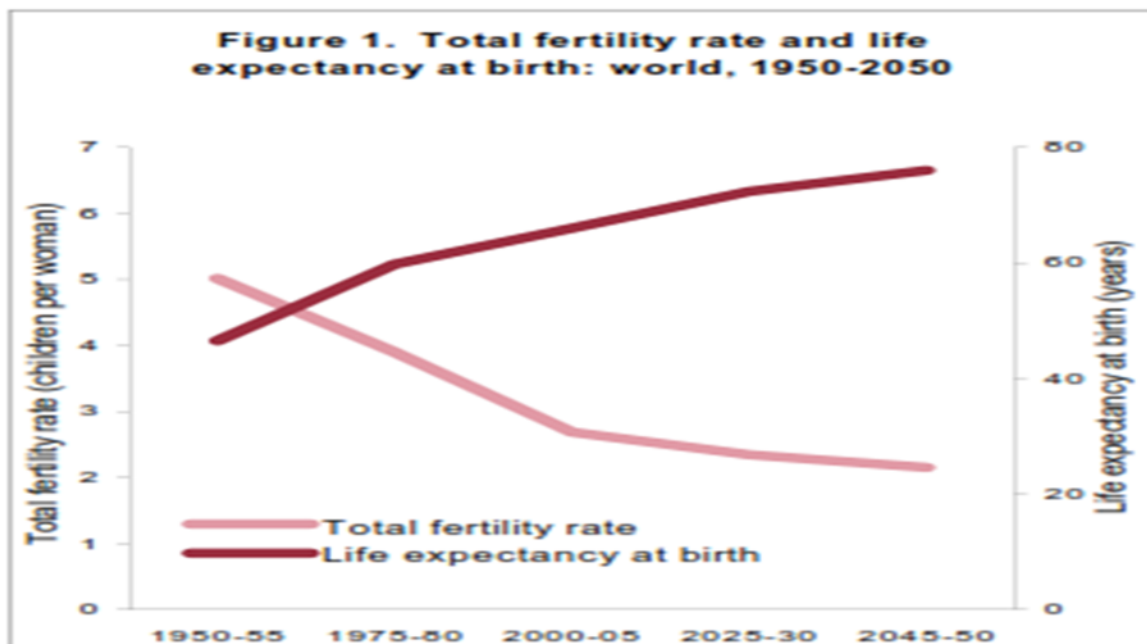


NOTE: The vertical axis on the right side of each panel indicates the gender gap in life expectancy at birth (in years, female minus male values).

The shorter life expectancy for adult males may be attributed to a combination of factors, including increased homicide and accident rates, war fatalities, excessive alcohol consumption, poor diet, and environmental/ workplace degradation (Kinsella and Phillips, 2005). It has also been noted that throughout the life cycle women generally have lower mortality for most of the common causes of death (Kinsella and He, 2009).

Total fertility rate and life expectancy

The following figure reflects the decreasing fertility rate and increasing life expectancy at birth at world level.



Decreasing fertility alongwith lengthening life expectancy hasreshaped the age structure of the population in most regions of the world by shifting relativeweight from younger to older groups. The combination of both of these phenomena has led to population ageing.

MAGNITUDE AND SPEED OF POPULATION AGEING

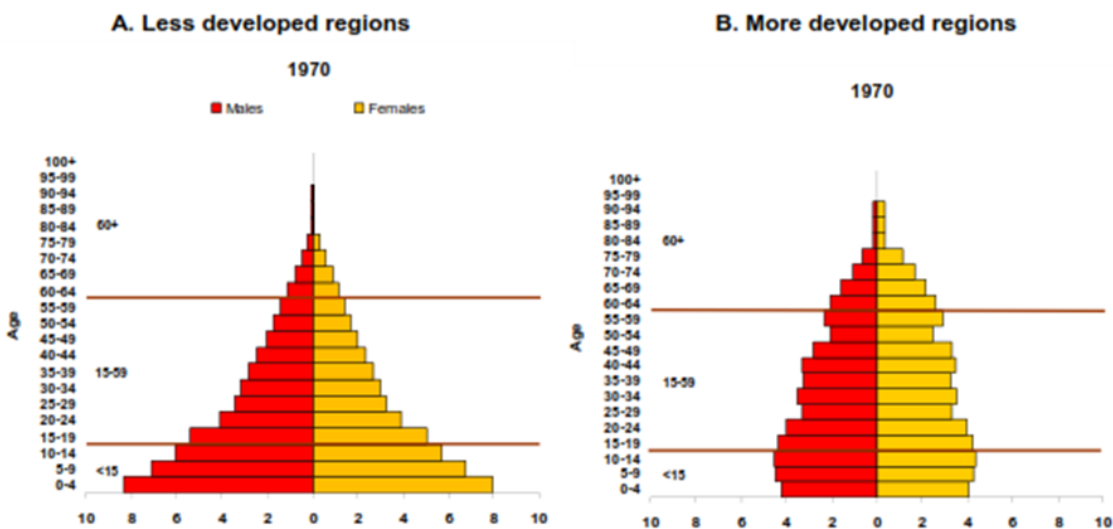
- **The world is in the middle of a transition toward significantly older populations**

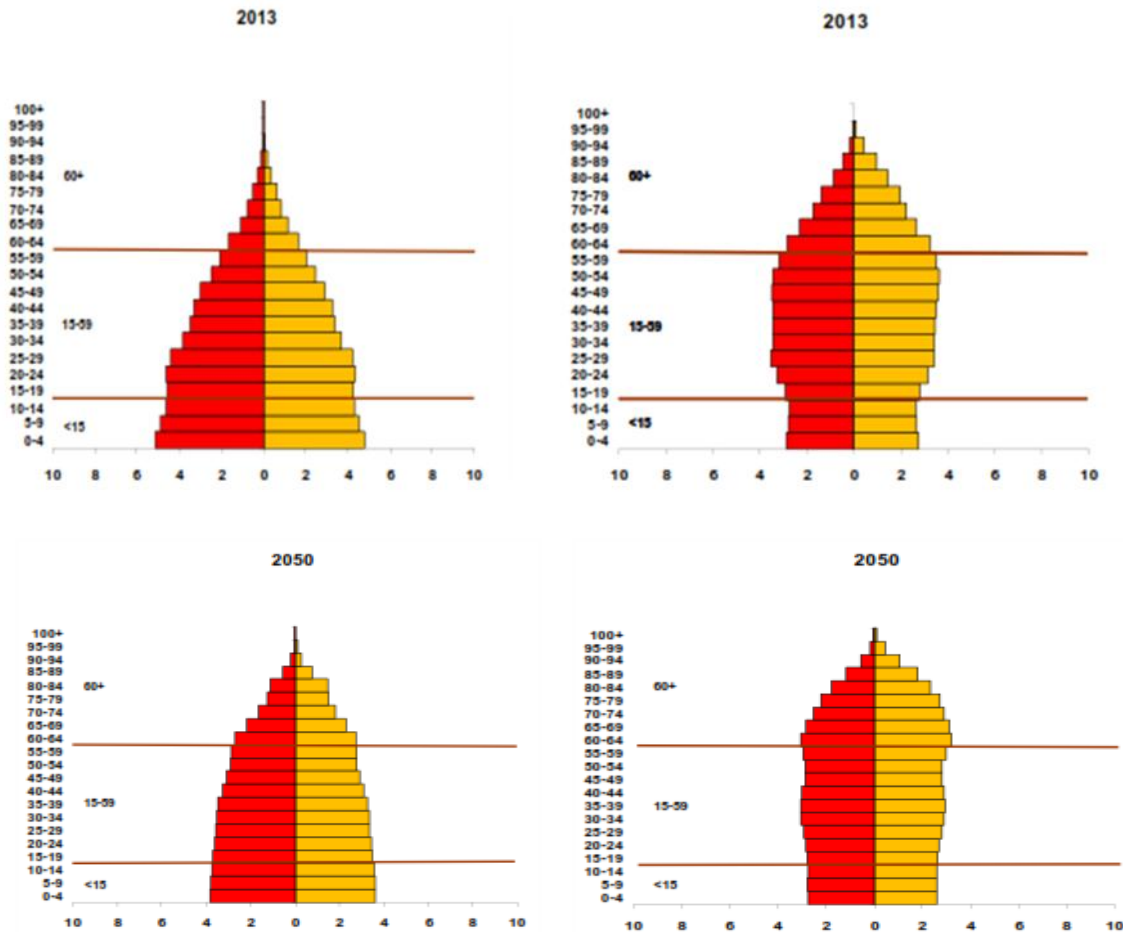
The world's population is changing in both size and age composition. Although the globalpopulation growth rate has been falling for around 40 years, the world has experienced recordhigh annual additions to population size in recent years. These

annual increments will soon begin to decline. The age composition of the world population has also experienced significant change, but the largest proportional changes will take place in the coming decades.

Less developed regions: The pyramid for the less developed regions in 2013 shows a transformation from the wide base of a youthful population in 1970, to the more rectangular shape of an older population in 2050. This signifies that in the 1970s, the less developed countries had more youthful population than in 2013 and in 2050 older people will have greater proportion in population i.e. they will be more in number.

Developed regions: The age composition of the more developed regions is also in a transitional phase. In the more developed regions, the 2013 pyramid shows a full mid-section, an indication that there is a predominance of young and middle-age adults, together with significant volume at the older ages, which indicates that population is ageing. But this structure is in rather rapid transition to a more aged population in the more developed regions, with more than 30 per cent of older persons by 2050.





The number of older persons is growing very fast

At the root of the process of population ageing is the exceptionally rapid increase in the number of older persons. It is the consequence of the high birth rates of the early and middle portions of the twentieth century and the increasing proportions of people reaching old age.

- The number of older persons is 841 million in 2013, which is four times higher than the 202 million that lived in 1950.
- The older population will almost triple by 2050, when it is expected to surpass the 2 billion mark.
- The proportion of the world's population aged 60 years or over increased from 8 per cent in 1950 to 12 per cent in 2013. It will increase more rapidly in the next four decades to reach 21 per cent in 2050.
- The projection of older people has a higher degree of certainty than that of younger age groups, because all the individuals older than 60 years in 2050 were already born at the time the projection was made.

- The trend in the number of older persons in the world is dominated by the fast growth of the older population in the less developed regions, where the size of the older population is 554 million in 2013, which is five times greater than it was in 1950 (108 million).
- The number of older people in these less developed regions will further triple by 2050 to attain 1.6 billion.
- Nearly 80 per cent of older persons will live in the less developed regions in 2050
- The speed of change in the more developed regions has been impressive too, but significantly slower than in the less developed regions.
- The older population of the more developed regions tripled between 1950 and 2013, from 94 million to 287 million, and it will increase further in coming decades, reaching 417 million in 2050.

The stages and speed of ageing are quite different between the more and less developed regions. Ageing in the more developed regions started many decades ago, but it is just taking off in less developed regions, while it has yet to unfold in the least developed countries.

Ageing also differs substantially *within* the more and less developed regions, which display different trends in their variance over time. While the more developed regions have same pace of ageing across countries, in the less developed regions, there is much greater variability across countries.

It is well-known that population ageing is taking place much more rapidly now in developing countries than it had in developed countries in the past. For example, it took France 115 years and Sweden 85 years, and it will take the United States of America 69 years, to change the proportion of the population aged 60 years or over from 7 per cent to 14 per cent. In contrast, it will take China only 26 years, Brazil 21 years and Colombia 20 years to experience the same change in population ageing (Kinsella and Phillips, 2005). Indeed, change was slow during the early, “take-off” phase of population ageing. However, the speed of population ageing in the more developed regions during the past three decades has been very fast. From 1980 to 2010, the more developed regions experienced the largest and fastest increase in the proportion of the population aged 60 years or over, from 15.5 per cent to 21.8 per cent.

➤ **Older persons could outnumber children by 2047**

As a consequence of declining fertility, the proportion of children (persons under the age of 15) in the global population dropped from around 38 per cent in 1965 to 26 per cent in 2013, and will continue to decline in the future. The reason for this is the population control policies and programmes and change in attitudes and values. During the same period, the proportion of “working-age” adults (persons aged 15-59 years) rose from 54 per cent to 62 per cent and is projected to decline gradually in the future. The population

aged 60 years or over has shown a consistent increase in both number and proportion of the world's population. According to the most recent United Nations population projections, older persons aged 60 years or over will outnumber children in 2047. This will pose serious economic problems as old age dependency will grow which means there would be less number of working population to support the old.

MEDIAN AGE

The **median age** is the **age** that divides a population into two numerically equal groups; that is, half the people are younger than this **age** and half are older. It is a single index that summarizes the **age** distribution of a population.

A manifestation of population ageing is the shift in the median age. Globally, the median age moved from 24 years in 1950 to 29 years in 2010, and will continue to increase to 36 years in 2050. The faster ageing in the less developed regions is reflected in the big shift in the median age from 26 years in 2010 to 35 years in 2050, which represents an eight-year increase during a period of 40 years. Meanwhile, the median age in the more developed regions increased rapidly between 1950 and 2010, from 28 years to 40 years. From 2010 on, the pace is expected to slow down and the median age is projected to reach 44 years in 2050. Half of the population in least developed countries was 19 years or younger in 1950. The median age barely changed in these countries as total fertility was still high during the past several decades. By 2010, the median age had remained at 19 years. The projections show that, over the next four decades, half of the population in the least developed countries will be aged 28 years or over.

DEPENDENCY RATIO

The potential effects of ageing for social and economic development are often assessed using so-called dependency ratios. These ratios compare the size of some group within a population that is considered to be economically dependent to that of another group that is considered economically active. Since precise determinations of the number of persons who are producers (and thus, economically active) and those who are exclusively consumers (inactive) are typically not available, dependency ratios are usually calculated based solely on age ranges.

The ratio is generally used as an indicator of the burden of demographic dependency in a population; that is, how many "dependents" need to be supported by each person of working age. Support for dependents can be provided in various ways, including familial and public transfers.

The demographic dependency ratio is defined as the ratio of the number of children under age 15 plus older persons aged 65 years or over, to the number of persons aged 15 to 64 years. Three ratios will be considered here: (a) the child dependency ratio,

which relates the number of persons aged 0-14 to those aged 15-64; (b) the old-age dependency ratio, which relates the number of persons aged 65 years or over to those aged 15-64; and (c) the total dependency ratio, which is the sum of the child and old-age dependency ratios. All dependency ratios are expressed in terms of the number of dependents (children or older persons or both) per 100 persons aged 15-64.

However, there is a need to take into account The Old-Age Dependency Ratio (OADR), which is the number of persons 65 years of age or older per one hundred persons aged 15 to 64 years of age. This is required because changes in the dependency ratio of the world have been driven by the combined effect of the declining proportion of children and the rising proportion of older persons. In 1950, 87 per cent of dependents were children and 13 per cent were older persons. That mix is changing rather rapidly and older persons are growing in number. It is projected that older people will grow to represent half of all dependents in 2075.

This simple dependency ratio implicitly assumes that all persons younger than 15 years and older than 65 years are unproductive and that all persons aged 15 to 64 years are productive, which is not always the case. For example, in the less developed regions, there are significant numbers of workers among children under the age of 15 and persons aged 65. In middle and high-income countries, many young adults are not fully productive until in their late twenties. The dependency ratio is therefore a good initial approximation to assess the degree of economic-demographic dependency in a society, but it should be interpreted with caution.

- The total dependency ratio for the world as a whole had increased from 65 dependents per 100 persons aged 15-64 in 1950, to 76 in 1975 at the world level and to 84 per 100 in the less developed regions.
- These high levels were reached as a result of high fertility rates in the 1950s and 1960s. This means increase in total dependency was mostly due to an increase in the number of children relative to the working-age population, which is reflected in the rise of the child dependency ratio.
- As total fertility declined, the world dependency ratio also started to fall gradually, to about 52 per 100 in 2013.
- Globally, the minimum of 52 dependents was reached in 2010 and it is projected to stay nearly at that level for about 15 years.
- The dependency ratio is expected to rise to 58 per 100 in 2050 and to increase further by the end of the century. This projected increase in the total dependency ratio is entirely due to increased dependency at older ages, since the child dependency ratio is expected to maintain its decreasing trend.

Regional differences in age-related dependency

Developed Countries:In developed countries, the total dependency ratio was roughly constant between 1950 and 1975, at a level of about 54 or 55 dependents per 100 persons aged 15-64, but had then declined to 49 by 2005. It is expected that the level observed in 2005 will be a historic low point, since a steadily increasing path for the total dependency ratio is projected for these regions in the future, caused by a continually rising old-age dependency ratio. Indeed, by 2050 the old-age dependency ratio for the developed countries is expected to attain a value of 45, which is close to the total dependency ratio estimated for 2005. Adding the dependent children is expected to a total dependency ratio of 72 in 2050, a level that is 37 per cent higher than the average value of this same ratio for the developed countries between 1950 and 2005.

Less Developed Countries:The trends in dependency ratios in the countries with economies in transition (i.e. the less developed countries) are similar to those in the developed countries. After having changed little from 56 dependents per 100 persons aged 15-64 in 1950 to 54 dependents in 1975, and then declining to a historic low point of 42 dependents in 2010, the total dependency ratio is projected to increase to 49 in 2025 and then to 61 in 2050. As in the case of the developed countries, the expected increase in the dependency ratio in the economies in transition is due exclusively to a steady rise in the old-age dependency ratio.

Least Developing Countries:For the least developing countries, both the historical experience and the future prospects are quite different. First, their total dependency ratio in 1950, which stood at 71 dependents per 100 persons aged 15-64, was quite high in comparison with that of the developed countries or the countries with economies currently in transition, owing mostly to a very high level of child dependency in the least developing countries (65 per 100 persons aged 15-64). Between 1950 and 1975, as the proportion of children in the population of these countries increased further owing to reduced mortality, the child and the total dependency ratios soared to 75 and 82, respectively. However, a subsequent reduction in the proportion of children due to reduced fertility, coupled with a rising proportion of persons aged 15-64, led to major reductions in the child and total dependency ratios after 1975.

OLD-AGE SUPPORT RATIO

The demographic old-age support ratio measures how many persons in the main working ages there are to support each older person. In this report, the old-age support ratio is calculated as the number of persons aged 15 to 64 years divided by the number of persons aged 65 years or over.

- The old-age support ratio varies widely across development groups and over time.

- Since 1950, the world's old-age support ratio has been declining continuously, meaning that there are less people in the working ages to support every person aged 65 years or over.
- The ratio went from 12 working-age persons for each older person in 1950 to 8 in 2013, and is expected to drop to 4 in 2050.
- The differences in the old-age support ratio across development regions are quite large.
- In 2013, there were 16 persons of working age for each older person in least developed countries, compared to 11 working-age individuals per older person in the less developed regions and just 4 in the more developed regions.

ECONOMIC SUPPORT RATIO

The economic support ratio is an alternative measure of dependency that explicitly incorporates age variations in consumption and labor productivity. It is defined as the number of equivalent producers or workers divided by the number of equivalent consumers in a given population. This ratio weights the population of a given age by the productivity and consumption of persons of that age. For example, a support ratio of 1 to 2 (that is, 0.5) indicates that on average, each worker is supporting him or herself and one other person's consumption in that population. Therefore, a higher economic support ratio indicates more equivalent workers per consumer and a lighter burden of dependency than a lower support ratio.

By taking into account productivity at the different ages, the economic support ratio addresses three shortcomings of the simple demographic dependency ratio: (1) not all older and younger persons are economically dependent, or dependent to the same degree; (2) not all persons between the ages 15 and 64 years are identically productive; and (3) persons of different ages do not have the same level of consumption as implicitly assumed by the simple dependency ratio.

Economic life cycle for the less and more developed regions

Often between the ages of 25 and 60 years, there is a surplus, where individuals produce more than they consume, on average. Social institutions such as the family, the government and financial markets allow inter-generational transfers of resources from the surplus to the deficit ages.

Between 1950 and the 1990s, the support ratio was below 0.5 in both the less and more developed regions. However, more developed regions had higher economic support ratios because their populations were more concentrated around the peak earning ages and had relatively high productivity at these ages, while developing countries had a larger concentration of their populations in children and youth, who have low or zero productivity. After the 1990s, these two development groups took divergent paths with

less developed regions experiencing higher support ratios than more developed regions. In the more developed regions, the support ratio had been decreasing since 2000 and is projected to continue falling, reaching 0.42 in 2050. On the contrary, the support ratio in the less developed regions has been rising so far, but is projected to turn around from its peak of 0.54 till 2024 to reach nearly 0.50 by 2050.

Demographic dividend:The growing global economic support ratio could have beneficial effects on the macro-economy, through the so-called *demographic dividend*. The demographic dividend is defined as the increase of per capita consumption brought about by a growing economic support ratio. Demographic dividend, as defined by the United Nations Population Fund (UNFPA) means, “the economic growth potential that can result from shifts in a population’s age structure, mainly when the share of the working-age population (15 to 64) is larger than the non-working-age share of the population (14 and younger, and 65 and older).” In other words it is “a boost in economic productivity that occurs when there are growing numbers of people in the workforce relative to the number of dependents.” UNFPA stated that, “A country with both increasing numbers of young people and declining fertility has the potential to reap a demographic dividend.”

➤ **Demographic profile of the older population**

Ageing is taking place in the world’s adult population and within the older population itself.

- The proportion of persons aged 80 years or over within the older population increased from 7 percent in 1950 to 14 per cent in 2013.
- According to the projection, this proportion of “oldest-old” within older persons is expected to reach 19 per cent in 2050 and 28 per cent in 2100.
- If this projection is realized, there will be 830 million persons aged 80 years or over by the end of the century, seven times as many as in 2013.
- The rise in the population aged 80 years or over is occurring at a faster pace in the less developed regions than in the more developed regions.
- In 1950, there were 6 million people aged 80 years or over in the less developed regions and 8 million in the more developed regions, but by 2013, people aged 80 years or over are already slightly more numerous in the less developed regions than in the more developed regions

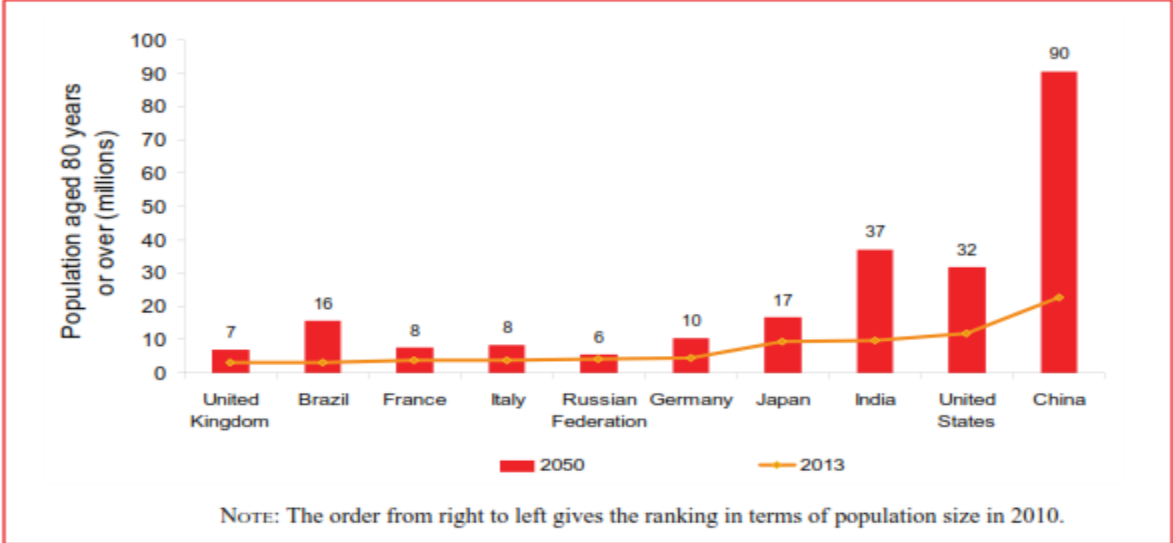
The present number of persons aged 80 years or over is the result of

a) The birth rates of many decades ago, which determined the initial size of these cohorts and

b) The survival rates, which have been improving dramatically since these cohorts were born.

The number and proportion of centenarians (people aged 100 years or more) is growing even faster. The number of centenarians in the world is projected to increase rapidly from approximately 441,000 in 2013 to 3.4 million in 2050 and 20.1 million in 2100.

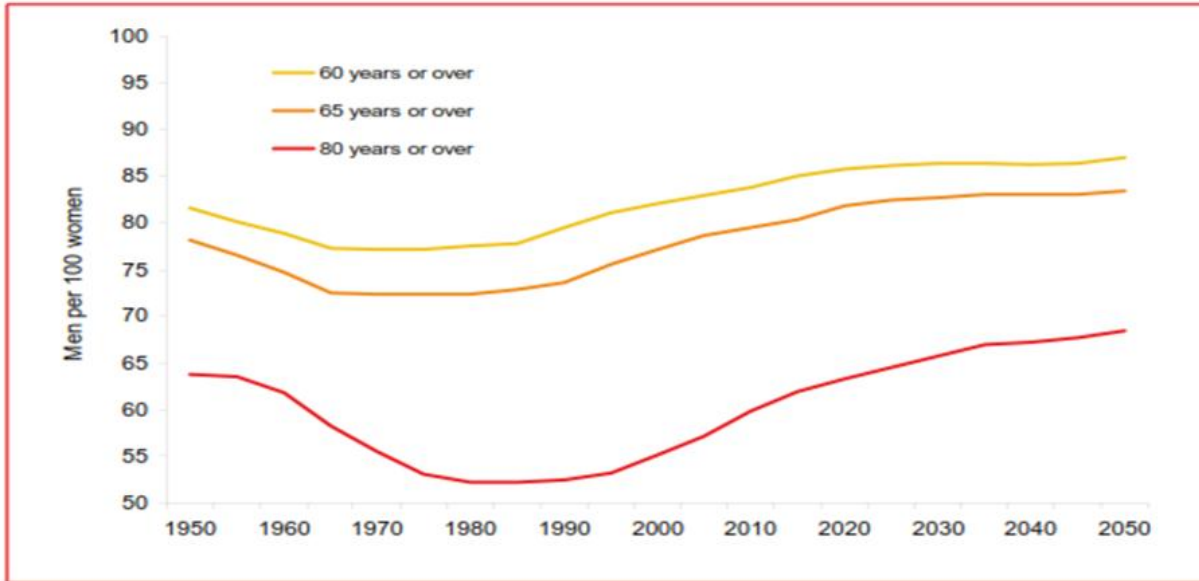
Top ten countries with the largest population aged 80 years or over in 2013



SEX RATIO OF THE OLDER POPULATION

Usually women live longer than men and this fact is also reflected in the sex ratios (**number of men per 100 women**). Not only are women more likely than men to survive to age 60, but having once reached that age they can expect to live longer than similarly aged men.

Sex ratios at ages 60 years or over, 65 years or over and 80 years or over: world, 1950 2050

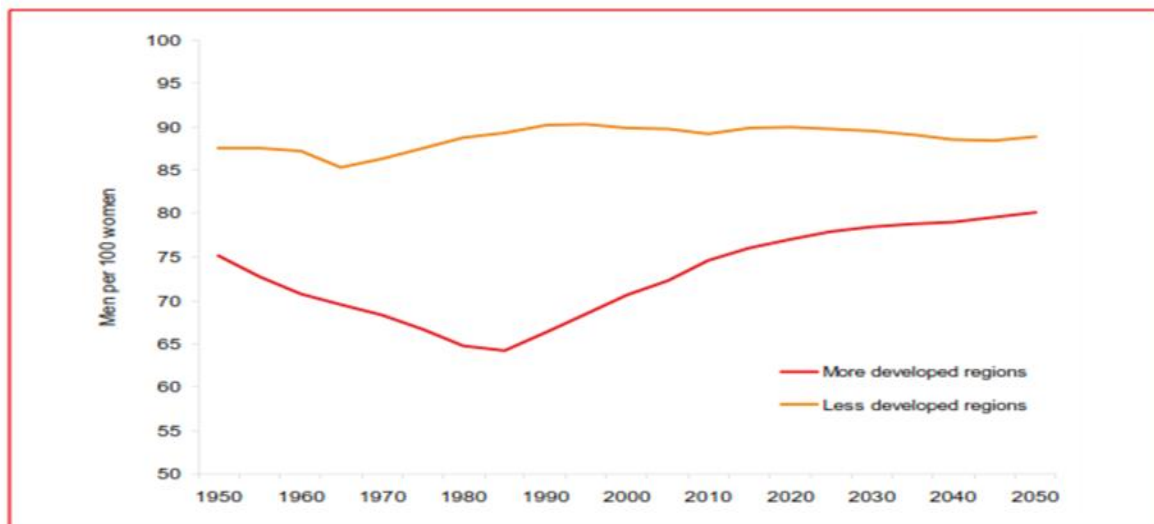


The above figure reflects the sex ratios after 60s.

- While there were 101 males per 100 females in the world population in 2005, among those aged 60 years or over the ratio was 82 men to 100 women.
- Consequently, the proportion of women in the older population tends to rise substantially with advancing age.
- In 2013, the global sex ratio was 85 men per 100 women in the age group 60 years or over, 80 men per 100 women in the age group 65 years or over and only 62 men per 100 women in the age group 80 years or over. This is the result of long life expectancy of women.

Sex ratio of elderly by development regions.

Sex ratio at age 60 years or over by development region, 1950-2050



The above figure shows how trends in the sex ratio of the older population differ by major development region. In the less developed regions, the sex ratio hovered narrowly between 85 and 90 men per 100 women until now, and is projected to stay slightly under 90 men per 100 women between 2013 and 2050. In the more developed regions, by contrast, the sex ratio among persons aged 60 years or over has been increasing significantly since the mid-1980s, and it is projected to rise further from 76 men per 100 women in 2013 to 80 men per 100 women in 2050. The sex ratios for persons in older-age groups follow similar time trends, albeit at different levels.

MARITAL STATUS

The marital status of older persons is mostly determined by the mortality rates of spouses and remarriage rates. Male spouses are more likely to die before their wives because of the higher male mortality, higher life expectancy of women, men tend to marry younger wives and remarriage rates is higher among old male than among old female. In most societies, remarriage probabilities are lower for older women than for older men, partly because of the reduced availability of men of similar or older age and other social taboos and values. These two factors reinforce each other and result in a rather wide gender gap in the marital status of older persons. In most societies, there are much more widows than widowers.

- In both the less and more developed regions, the proportion married among men aged 60 years or over is around 80 per cent and among women aged 60 years or over, it is slightly below 50 per cent.
- The marital status of older persons doesn't vary much by development region.
- The overall proportion of married (both sexes combined) among older persons aged 60 years or above in the less developed regions is 64 %, which is a little higher than the 60 % in the more developed regions.
- In the least developed countries, the percentage married among older men is higher than the world average, and the percentage married among women is significantly lower (United Nations, 2012).
- The proportion married among older men is highest in Africa and Asia with 85 % and 82 %, respectively and lowest in Oceania, where it is 73 %.
- Among older women, the proportion married is highest in Asia (51 %) and lowest in Africa (38 %). The gender gap in the proportion married among older persons is substantial everywhere, but is highest in Africa (47 %).
- Some countries in the Middle East, Northern Africa and Southern Asia, have exceptionally high proportions of married older men around 90%.
- The largest gender gap of marital status in the world occurred in Chad, where only 16 per cent of older women were married, compared to 85 per cent of older men.

- Other countries with a large gender gap in marital status were the United Arab Emirates, Bangladesh and Kuwait, where the proportion married was greater than 90 per cent among older men compared to only between 30 to 38 per cent among older women.

Cultural norms encourage men to marry women younger than themselves, so widowed men may opt to remarry a peer or a younger woman, whereas older widows do not typically have access to a similarly expanded pool of potential spouses (Cattell 1997; Velkoff and Kinsella 1993). There is a social stigma attached with female widowed remarriage than with male widowed remarriage.

LIVING ARRANGEMENTS

Trends of declining fertility and mortality rates help to explain profound changes in the size and composition of the nuclear family associated to the decreasing importance of extended families in many parts of the world. Rapid migration from rural to urban areas, mainly as a result of industrialization processes, has been a contributing factor to the decreasing importance of the extended family. More recently, large flows of international migrants have further contributed to this trend. In addition, increasing educational attainment has been found to have an impact on fertility levels and on the composition of the family (Oppong, 2006; Bongaarts and Zimmer, 2001; United Nations, 2005b).

The living arrangements of older persons are determined by cultural norms regarding co-residence and inter-generational ties and familial support. In countries or regions which have an aged population, older persons have relatively fewer children and grandchildren than in countries which have a youthful population. Partly because of this situation, older persons in more aged populations are more likely to live independently, that is, either alone or with a spouse only. The longer life spans associated with ageing populations open opportunities for more complex intergenerational living arrangements, such as three- or even four-generation households in some countries (United Nations, 2005).

Other cultural and social factors, such as late marriage and an increase in singleness and divorce rates, also influence the size and structure of families. These reflect important changes in values and lifestyles in countries around the world. Age at first marriage has increased in all regions of the world during the last 30 years (United Nations, 2000) and divorce rates increased significantly in most countries.

The emancipation of women, including their more active participation in labour markets and increased control over reproductive behaviour through modern contraceptives, has been an important factor in the lowering of fertility rates. In developed countries, childlessness has become a widespread phenomenon. In the western part of Germany,

for instance, one third of all men and women born after 1960 are expected to remain childless (Dorbritz and Schwarz, 1996).

The majority of older persons in all countries continue to live in their own homes and communities, a phenomenon that is sometimes referred to as "ageing in place".

- In the developed world the largest proportion of older people live with a spouse in a single-generation household (43 per cent) and another 25 per cent live alone. Older persons in developed countries are more likely to live in non-familial residential settings, but overall only a small proportion of older people in all countries live in centers of institutional care.
- Living independently is rare among older people in developing countries, but is the dominant living arrangement in developed countries.
- In the developing world, the large majority of older persons continue to live in multigenerational households, most of them with their children and grandchildren, and some also with other adults. Only 13 per cent of older people live with a spouse and a very small proportion (7 per cent) live alone. In these countries where older persons have limited resources to sustain themselves and rely heavily on support from children, living independently, especially alone, could be a disadvantage or even an indication of neglect.
- In societies where older persons have sufficient economic resources, including public pensions and asset income, living independently tends to be a sign of economic self-sufficiency and higher standards of living.
- At the world level, 40 per cent of the world's older population lives independently, with no significant difference by sex

A key issue on older persons who do not live independently is the nature of the co-residence. Is the older person living in the household of others or are the other household members living in the home of the older person? This question is relevant because it reflects the status of the older person in the household, who may either be the person controlling the resources and making the decisions, or a dependent person who is subordinated to others. An indirect way of addressing this question is by examining who is the reported household head in the survey or census. The available data show that

- A large majority of older persons not living independently, specifically, 85 per cent of older men and 69 per cent of older women are household heads or their spouse is the household head.
- In other words, only 15 per cent of older men and 31 per cent of older women live in households in which neither themselves nor their spouses are the head of the household. These figures can be taken as an indicator of the proportion of older persons in a "subordinated" position within the household hierarchy.

- Subordination is far more prevalent among women—45 per cent of older females are subordinated, compared to only 13 per cent of males
- Subordination is much larger in the less developed regions than in the more developed regions

Characteristics of the older population

HEALTH OF THE OLDER POPULATION

The health profile of populations has changed in parallel with the demographic transition. The importance of communicable or infectious diseases has declined and that of non-communicable or chronic diseases has increased. This phenomenon is referred to as the epidemiological transition. Its implications, particularly for the delivery of health and long-term care services to older persons, needs to be examined.

While episodes of communicable disease can have disabling consequences, non-communicable diseases, such as cardiovascular disease and cancer, often bring about a long period of poor health and diminished functioning. In addition, some non-fatal (but often chronic) conditions can have an important impact on the quality of life and health-care costs for older individuals. Examples of such conditions include hearing and vision loss, musculoskeletal conditions such as osteoarthritis, and cognitive impairments including Alzheimer's disease and other dementias.

Increasing life expectancy raises the question of whether longer life spans result in more years of life in good health, or whether it is associated with increased morbidity and more years spent in prolonged disability and dependency.

The major causes of disability and health problems in old age are non-communicable diseases including the “four giants of geriatrics,” namely:

1. Memory loss,
2. Urinary incontinence,
3. Depression and falls or immobility,
4. Communicable diseases and injuries.

As population ageing takes place, health expenditures tend to grow rapidly since older persons usually require more health care in general and more specialized services to deal with their more complex pathologies. The number of deaths also increases sharply due to the exponential increase in mortality with age. Furthermore, older women generally experience higher rates of morbidity and disability than older men, in large part because of their longer life expectancy (WHO, 2007).

The world's crude death rate is defined as the ratio of annual total deaths to the total population. This is increasing because population ageing shifts the age distribution

towards the older ages, which are subject to higher risk of mortality. Because of this, population ageing causes two seemingly contrasting situations:

(1) An increase in the crude death rates despite the increasingly longer life expectancy and

(2) Highest crude death rates observed in regions with the lowest overall levels of mortality.

- The annual number of deaths in the world was rather stable, even slightly declining from 1960 to 1970, a decade in which the lowest level—51 million—of deaths per annum was recorded.
- From then on, the annual number of deaths has been rising; in 2010, it reached 64 million.
- The global crude death rate is expected to reach its lowest point in 2015 with about 8.0 deaths per 1,000 population per year, and to gradually increase thereafter, reaching 9.8 deaths per 1,000 population by 2050.
- In 1950-1955, 45 per cent of deaths were of children under the age of 15, while deaths of persons aged 65 years or older represented only 22 per cent of the total.
- As countries have made progress in their demographic transitions, the distribution of deaths has shifted towards older ages.
- In 2005-2010, over half (53 per cent) of all deaths in the world were concentrated in the population aged 65 years or over, while the proportion of deaths among children (aged 0-14) had declined to 15 per cent.

As more people are living longer almost everywhere in the world, the causes of death and disability are changing from infectious to non-communicable diseases, and in some countries, to injuries. The disability-adjusted life years (DALY) measure the burden of disease, injury and death in a given population. The main causes of DALY for the older population are almost everywhere non-communicable diseases such as heart disease, cancer and diabetes, in all development groups.

- The distribution of DALYs by age group varies greatly across development regions and it is closely associated with the level of development.
- In the more developed regions, 33 per cent of persons aged 60 years or above in 2004 had Disability Adjusted life years.
- By contrast, in the less developed regions, only around 12 per cent were affected with DALY, and in the least developed countries, the proportion was even lower, of only 6 per cent.
- At the world level, 85 per cent of persons aged 60 years or above died from non-communicable diseases in 2008.

- The percentage by region for persons aged 60 years or above who died from non-communicable diseases are
 - More developed regions –92%,
 - Less developed regions --83%and
 - Least developed countries–74%.
- Furthermore, the increasing levels of exposure to risk factors such as tobacco use, unhealthy diet, physical inactivity, sedentary lifestyle and the harmful use of alcohol enhances the chances of non-communicable diseases (Palloni, 2013).
- Communicable diseases are also responsible for death among elderly but it varies according to regions. In 2008, the proportions of old-age deaths due to communicable diseases were
 - More developed regions –5%,
 - Less developed regions –13%and
 - Least developed countries–21%.
- Deaths caused by communicable diseases are commonly associated with low income, poor diets and limited sanitary, health care infrastructure, low awareness, and less government intervention found in developing regions (WHO and U.S. NIA, 2011).

Per capita health expenditure, both public and private, tends to increase with population ageing. Population ageing is associated with higher health expenditure due to the increase in the proportion of older persons, which have higher prevalence of morbidity and demand for health care than younger adults. Again, because of scientific developments life expectancy has increased which leads to survival of all old age groups (60 and above) and this lengthens the period between onset of significant morbidity or disability and death.

In the more developed regions with comprehensive social security systems, the majority of the health expenditure is covered by social insurance schemes. In the less developed regions with low levels of health care coverage, health expenditure is mainly financed with private spending by individuals.

LABOUR FORCE PARTICIPATION

Though the global labour force will continue to grow over the next 50 years. Yet, relatively high levels of fertility in some parts of the world, accompanied by declining fertility in others, will generate asymmetries in labour-force growth across economies. Relatively strong labour-force growth will take place in low-income countries that are already experiencing significant labour surpluses, while limited gains (or even reductions) in the workforce are projected for most middle- and high-income countries. By 2020, the global labour force will be about 833 million workers larger than it was in 2000, with the bulk of the increase taking place in the developing countries. For the developed countries as a group, the labour force will grow by less than 14 million

workers over this same period, owing in large part to increased participation by women. While an increasing labour force may imply a potential for accelerating growth, and thus improving the standard of living for all, a declining labour-force growth may have opposite effects and lead to slower output growth.

Therefore, the policy option for offsetting the decline in labour supply is to increase the labour participation rates of older workers. Ideally, older persons should be able to continue working for as long as they wish and for as long as they are able to do so productively. To this end, new work arrangements and innovative workplace practices can be developed to sustain the working capacity and accommodate the needs of workers as they age. At the same time, it is important to combat damaging stereotypes concerning older persons by fostering a positive awareness of their skills and abilities in the workplace. In particular, emphasis needs to be placed on increasing the participation rates of older workers so that the effective retirement age is brought more closely in line with the statutory retirement age.

Additionally, those who have reached the statutory retirement age should be given the choice of continuing to participate in the paid labour force wherever practicable.

There is also a need to mention about formal sector and informal sector. In developing countries, most of the people are concentrated in informal sector where labor laws are flexible and sometimes not applied, wages are not paid properly, working conditions are hazardous etc. Many older persons still need to work into older ages and even continue working in the prevailing conditions. But in formal sector, the retirement age is fixed and pension system is there, though it varies from regions. The statutory retirement age is defined as the minimum age at which people can qualify for full pension benefits. In most countries, qualifying for pension benefits requires a minimum period of contributions, commonly ranging from 30 to 40 years of employment and attaining a specified age.

- In 2010, the labour force participation of persons aged 65 years or above was around 31 per cent in the less developed regions and 8 per cent in the more developed regions.
- In both development regions, men made up a large majority of the total labour force among older persons.
- In the less developed regions, 42 per cent of older men were in the labour force in 2010, compared to only 11 per cent in the more developed regions.
- There were also, proportionately more, older women working in less developed regions (22 per cent) than in the more developed regions (6 per cent).

- According to data from the International Labour Organization (ILO), at the world scale, the labour force participation of the older population gradually declined from 1990 to 2005 and is projected to remain relatively stable until 2020.
- At the regional level, the total labourforce participation of the older population is declining in the less developed regions and increasing in the more developed regions.
- The labour force participation of older women is increasing in both the more and less developed regions, but since men still outnumber women by far in the labourforce the total labour force participation trend is decreasing in the less developed regions.
- There is wide regional and international variations in old-age labour force participation. Labour force participation among older persons is highest in Africa (40 per cent), followed by Latin America and the Caribbean (31 per cent), Asia (21 per cent), Northern America (17 per cent), Oceania (12 per cent), and finally Europe (7 per cent).
- In Asia, the majority of countries experienced an increase in the labour force participation of older women between 1980 and 2010. Bangladesh, India, Israel and Japan were among the few countries where the participation rate of older women declined.
- The retirement age for men is 65 years or higher in the majority of the developed countries of Europe and Northern America. By comparison, the retirement age for men is between 60 and 64 years in the majority of the developing countries of Africa, Asia and Latin America and the Caribbean.

Gender differences in labour force patterns among older populations are likely to be the consequence of life course factors. For example, women are the traditional caregivers within families and thus may have had lower labour force participation throughout their lives. Women also experience a decline in income as widows (Kinsella and Phillips, 2005). Even those women who did participate in the labour market may have experienced role strain due to limited availability for child and elder care, leading to early departure from the labour market.

Economic Support systems

In most modern societies, older persons consume more than they produce and therefore resort to other sources of support, such as income from their assets, savings and transfers from their family and from the Government (Mason and others, 2009;

United Nations, 2013). How older people finance their consumption differs widely across countries and depends on cultural, institutional and economic factors.

To analyse the different types of economic support systems, four sources of finance of consumption are undertaken by Department of Economic and Social Affairs Population Division of United Nations. They are: Labor income, Net public transfers, Net private transfers, and Asset-based reallocations.

- Labour income includes employment earnings and self-employment income.
- Public transfers are cash and in-kind transfers received from government such as health care, public safety and national defence and cash transfers such as pensions and other cash allowances for older people, net of taxes and social contributions paid to the government.
- Private transfers include both inter-household transfers and intra-household transfers. Again, these are net values of transfers received minus transfers given.
- Asset-based reallocations are basically net asset income and dis-savings.

Many older persons in developing countries still need to work to finance their consumption. Many developing countries in Asia and Africa have early statutory retirement ages, which is less than 65 years. However, many older persons in developing countries have little choice but to continue to work into old age to finance at least part of their consumption because there is absence of comprehensive social security programmes by government. Income generated from work can be significant for some older persons, but on average and for older people as a whole, it does not finance a large share of old age consumption.

Another means of financing old-age consumption is through public transfers such as pensions and health care, which are provided through formal government programmes. In developed countries, these transfers, are the major source of income security after retirement. Indeed, in about half of developed countries, net public transfers cover more than 50 per cent of older persons' consumption.

The role of public transfers varies greatly among developing countries, but they are on average less important than in the more developed regions. Public programmes for old-age security are just emerging in countries like India, Thailand, Indonesia and the Philippines, where the data shows that net public transfers to older persons are very small or close to zero.

In most countries, older persons are net givers of familial transfers

Another way of supporting old age consumption is through private transfers from family members that may live either in the same or in a separate household. Familial support in old age is especially important where other formal mechanisms such as social protection systems and financial markets are weak or non-existing. In this context, older persons tend to rely much more on private transfers and more often live with their adult children than in the more developed country settings. This source of support can be unreliable since the filial responsibility is often not formalized and the value of the transfers provided can vary as family members are subject to market shocks and instability, including unemployment and low wages.

Contrary to what is sometimes assumed, however, the evidence indicates that older persons on average, tend to be net givers of private transfers, that is, they give more than they receive from their family and this holds true in most developed and developing countries. This outcome is not surprising for the more developed countries because older persons are insured by comprehensive social security systems and their higher income and more developed financial markets allow them to accumulate savings and more substantial assets.

In some countries such as Japan and Slovenia, older persons switch from net givers to net receivers of private transfers after they turn 70 years. But this situation may not last much longer, for example, in Japan—a society with a tradition of caring for old parents—where private transfers seem to be on the decline, as these transfers are crowded out by increasing public pension benefits and by asset income and labour income generated by older generations during the considerable economic growth between the 1980s and 2000s (Ogawa, Matsukura and Chawla, 2011). Older persons are also net private transfer givers in most developing countries.

In economies dominated by the informal sector such as Indonesia, the Philippines and Mexico, many older persons own farms and other forms of property and they often continue to work until very old ages and this enables them to make transfers to younger family members. Many older persons continue to be the head of households in extended living arrangements and thus, remittances received by them are redistributed to other younger family members (Lee and Others, 2011).

Private transfers nevertheless, are still an important source of old-age income in a few developing countries in Asia. Cultural values of filial obligation and inter-generational co-residence are commonly observed, although the culture and practices are changing. As these transfers seem to be declining in some parts of Asia, countries such as China and Singapore have enacted legislation mandating adult children to support their elderly parents.

Assets are a major source of old-age support in countries with limited public transfer systems

Over their life-cycle, people accumulate assets such as property, pension funds and savings and rely partly on income from these physical and financial assets for their retirement. Examples of net asset income are interest, profits, dividends and imputed rent. As with other sources of sustenance in old age, the extent to which older persons rely on asset-based reallocations varies widely across countries.

Mason and others (2011) found that the reliance on asset income during old age is inversely related to the level of public transfers. Older persons receiving substantial public transfers such as in Europe tend to rely less on asset income, while those in regions with less generous or extended public transfer systems such as the United States of America, Japan, Mexico and Asian countries tend to depend more heavily on asset income.

Economic security for older persons is an issue in every country. In most developing countries, older persons need to work beyond the statutory retirement age due to the lack of comprehensive social security programmes. To fill the gap between what they need and what they earn, older persons rely heavily on assets accumulated earlier in life and in some countries, also on their families. In the majority of these countries, public social programmes play a minor role. Conversely, older persons in developed countries are less likely to work into old age. They rely heavily on public programmes. Social protection for older persons is and will continue to be a fundamental pillar of development in all types of societies. As populations continue to age, however, the design of public programmes needs to be adapted to avoid overburdening younger generations, sacrificing economic growth or becoming financially unsustainable.

AGEING AND POVERTY

Poverty can be broadly defined as deprivation according to some dimension of well-being (World Bank, 2005).

Three components are needed to compute a measure of poverty:

- 1) The welfare measure;
- 2) The poverty line or the threshold below which a given household or individual will be classified as poor; and
- 3) The specific indicator of poverty.

Most measures of welfare (first component) are based on data on income or consumption of individuals, or more commonly, of the average household income or consumption.

To define the poverty line (second component), which separates the poor from the non-poor, an absolute or relative level of income or consumption is often determined as the relevant threshold. An *absolute* poverty line refers to a set standard of what households should be able to have in order to meet their basic (mostly food) needs. The international poverty lines used by the World Bank (at \$1.25 a day and \$2.50 a day in terms of purchasing power parity or PPP) are examples. A *relative* poverty line is defined in relation to the overall distribution of income or consumption in a country. For example, the main poverty line used in the Organization for Economic Cooperation and Development (OECD) and the European Union is a relative poverty measure based on “economic distance,” a level of income usually set at 50 or 60 per cent of the median household income.

Finally, regarding the third component of the poverty concept, the most commonly used poverty indicator is the poverty rate which refers to the proportion of the population whose percapita income or consumption is below the poverty line.

In much of Africa, older persons traditionally rely on their extended family, especially their own children, for their welfare. However, as a result of the HIV/AIDS pandemic, conflicts, shocks such as recurrent droughts and rapid urbanization, many older persons in sub-Saharan Africa have become primary sources of support for their families and/or caregivers for grandchildren because prime-age adults have fallen ill, died or migrated.

Poverty is still prevalent in sub-Saharan Africa and is slightly higher for older persons than the total population (Kakwani and Subbarao, 2005). National poverty rates varied from 36.7 per cent to 68.9 per cent in the general population and between 43.7 per cent and 79.4 per cent among older persons.

The findings of the study confirmed older persons’ disadvantage especially when they have become either principal breadwinners for the family or caregivers for children. In assessing the role of social pensions in the economic welfare of older persons, Kakwani and Subbarao (2005) conclude that in sub-Saharan Africa, even in the 11 countries where the older population is at high risk of poverty, universal social pensions, that is, for all older persons, would be fiscally costly and probably unsustainable for most countries.

One of the most substantial changes in income inequality and poverty over the past two decades in OECD countries has been the shift in poverty rates between age groups (OECD, 2008). The risk of poverty among older persons has fallen, while poverty rates among young adults and families with children have risen. However, because the initial

old-age poverty rates were very high, persons aged 75 years or over remain the group most likely to be poor.

By the end of the twentieth century, ageing was well under way in the more developed countries where the demographic transition started earlier. Ageing was beginning to take place in many developing countries that had experienced significant and sometimes quite fast fertility declines, mostly in Asia and Latin America. If the current projections are realized, ageing will become a virtually universal phenomenon during the twenty-first century, although it will progress with different intensity and speed across countries and regions. This global demographic shift entails fundamental social, economic and development challenges and opportunities, not the least of which is the increasing priority to satisfy the needs of older persons while enabling them to have longer, healthier and more productive lives.

1.9 AGEING IN INDIA

DEMOGRAPHIC TRANSITION IN INDIA

Population ageing is the most significant result of the process known as demographic transition. Population ageing involves a shift from high mortality/high fertility to low mortality/low fertility and consequently an increased proportion of older people in the total population. India is undergoing such a demographic transition. In 1947, when India became independent from British rule, life expectancy was around 32 years.

The National Sample Survey Organisation (NSSO) for the first time, conducted a survey on the elderly (persons of age 60 years and above), along with the survey on social consumption in its 42nd round (July 1986 – June 1987), to assess the nature and dimensions of the socio-economic problems of the aged. Again NSSO repeated the survey on social consumption in its 52nd round (July 1995 – June 1996) and in 60th Round (January – June, 2004). Information on the socio-economic condition of the aged, data on some chronic diseases and physical disabilities were also collected during these rounds of the NSS surveys where the main objective was to focus on the socio-economic and health conditions of the current aged population, and the emerging policy issues for elderly care in India in the coming years.

The UN defines a country as 'ageing' where the proportion of people over 60 reaches 7 per cent. By 2000 India will have exceeded that proportion (7.7%) and is expected to reach 12.6% in 2025.

DEFINING AGEING IN INDIA

In ancient India, life span of one hundred years was divided into four stages: life of a student, householder, forest dweller and ascetic. There was a gradual move from personal, social to spiritual preoccupations with age.

In most gerontological literature, people above 60 years of age are considered as 'old' and as constituting the 'elderly' segment of the population.

In the traditional Indian culture, a human life span is one hundred years. Manu, the ancient law giver, in his Dharmasastra divided this span of life into four 'ashramas' or life stages. The first, 'brahmacharya' (life of a student), Grihastha (household life), Vanaprastha (retired life), Sannyasa (renounced life).

Indian culture, like many other Asian cultures, emphasized filial responsibility. Parents were to be honoured as gods. It was considered the duty of a son to respect and care for his parents. Even today, in India, old parents live with son/s and their families. Living with the eldest son and his family is the most common living arrangement. Indian society is patriarchal and after marriage sons bring their wives to the parental household to live. This tradition assured that old people would have younger in-laws and grandchildren to care for them. Also, caste and kin group exerted pressure on younger members to obey and respect elders. In modern India, retirement age is fixed at 60 in most Government jobs, and 65 years in the Universities. There is a move to increase the retirement age by another two to five years. For all practical purposes people above 60 are considered to be 'senior citizens'. In academic research, retirement age is often taken as an index of aged status. Chronological age of 58 or 60 is considered as the beginning of old age.

Past changes in age structure

Till 1920s the population of India was stable and started growing slowly and gradually. Before the independence of the country, both mortality and fertility level at high levels: the life expectancy was around 32 years (1941-51) and Total Fertility Rate was around 6 live births per woman. The mortality rate declined faster in 1960s, 1970s, and 1980s due to improvement in public health and which led to control of specific infectious diseases and along with that food scarcity problem reduced a bit. In the 1980s, the family planning program helped to reduce the growth rate to certain extent. Improved sanitation and increased attention to maternal health, improvement in nutritional requirement and childcare services did help greatly to reduce infant mortality. Life expectancy at birth rose steadily and by 1996-2001 life expectancy at birth was 62.4 for males and 63.4 for females

Table 1: Crude Birth Rate (CBR), Total Fertility Rate, Crude Death Rate (CDR), and Expectation of Life at Birth, 1951-2006

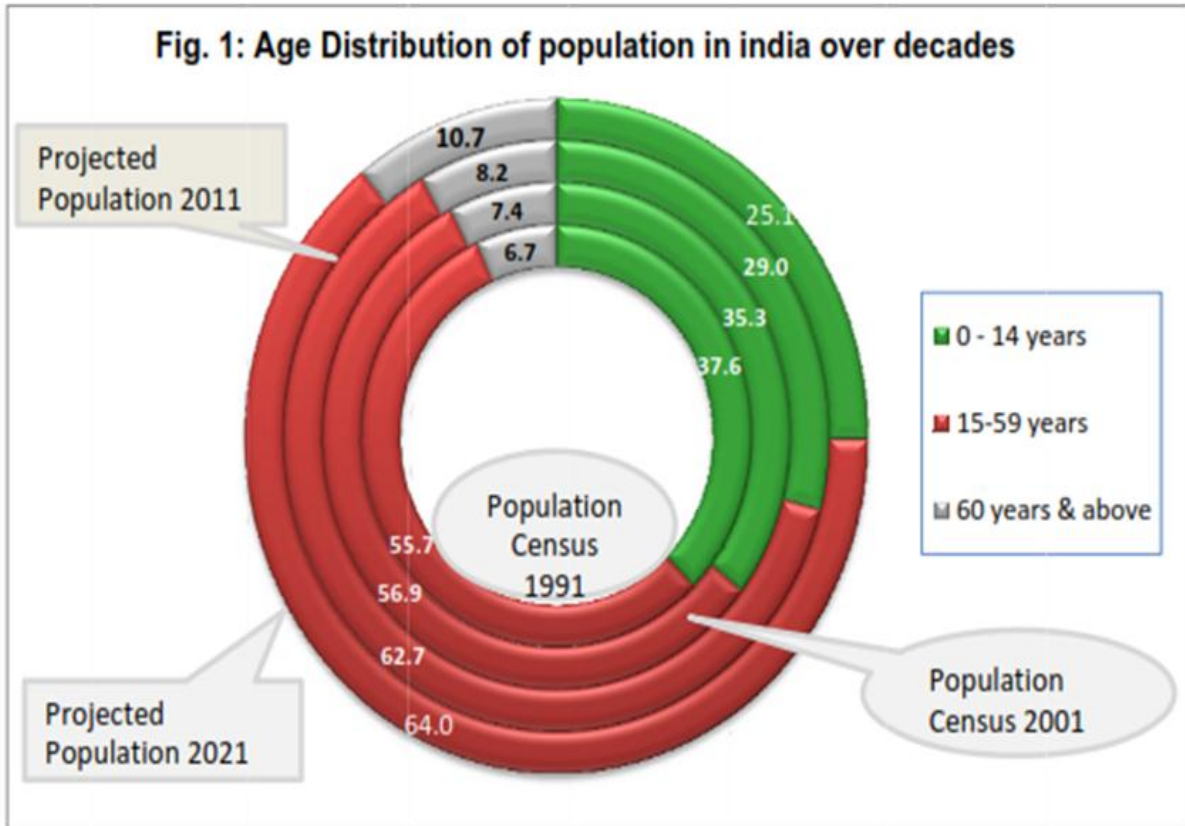
Year	CBR	Total fertility per woman	CDR	Expectation of life at birth	
				Males	Females
1951-61	45.5	6.11	25.9	36.8	36.6
1961-71	43.5	6.50	21.3	44.0	43.0
1971-81	38.0	5.40	16.0	50.0	49.0
1981-91	35.0	4.60	13.6	55.5	56.0
1991-2001	28.2	3.50	9.3	60.8	62.3
2001-2005	23.2	2.90	7.5	63.8	66.1

Source: Dyson (2004a: 21); Registrar General and Census Commissioner, India (2006:143).

CURRENT SCENARIO AND FUTURE PROJECTIONS

In India if we divide the total population into three major age-groups, i.e. age in years (0 – 14), (15 – 59) and (60 & above), we find clear that during last few decades the share of children (age 0-14) is decreasing from 37.6% in 1991 and is projected to be about 25% by the year 2021. On the other hand the proportion of population in the working age-group (15-59 years) and the aged (60 years & above) both are increasing rapidly. **The grey population which accounted for 6.7% of total population in 1991 is expected to increase its share to more than 10% by the year 2021.**

Fig. 1: Age Distribution of population in india over decades



- The Indian aged population is currently the second largest in the world.
- The absolute number of the over 60 population in India will increase from 76 million in 2001 to 137 million by 2021. According to official population projections, the number of elderly persons will rise to approximately 140 million by 2021.
- From 5.4 percent in 1951, the proportion of 60+ people grew to 6.4 per cent in 1981 and is close to 7.4 percent in 2001.
- A decadal growth rate of 24 percent recorded for the elderly population during 1951-61, increased to more than 33 percent during the decades 1961-71 and 1971-81 as against around 25% decadal growth in general population during the period.
- For males the rise was more modest from 5.5% to 7.1%, while for females there had been a steep rise from 5.8% to 7.8% during the five decadal Censuses from 1961 to 2001.
- It can also be observed that the percentage (of elderly) had all along been higher in rural areas than in urban and usually more among females than among males. About 75% of persons of age 60 and above reside in rural areas.

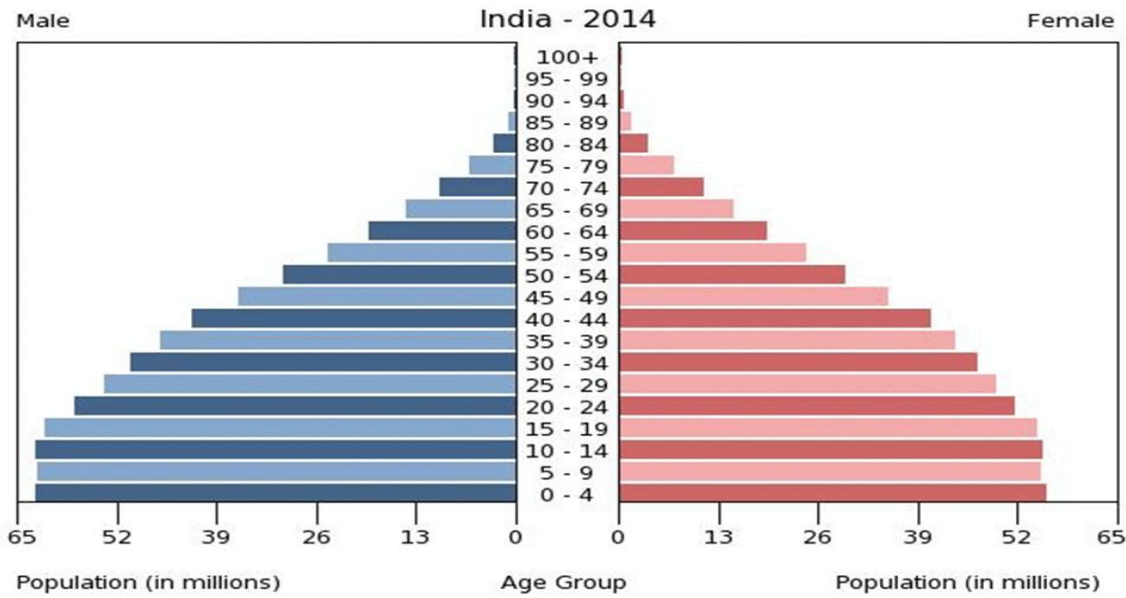
Indices of Age Structure of India's Population in Census					
Year	1961	1971	1981	1991	2001
Total Population (In millions)	439.2	548.2	683.3	846.3	1028.6
Total 60+ Elderly (in million)	24.7	32.7	41.5	55.6	76.6
(0-14) per cent	40.9	42.3	39.9	37.5	35.3
(15-59) per cent	53.4	51.8	54	56	57
(60+) percent	5.63	5.97	6.28	6.58	7.4
(70+) percent	1.96	2.06	2.33	2.51	2.8
Median age	20.49	19.59	20.22	21.58	22.5
Index of Aging	13.7	14	15	17.6	21

Population pyramid of India

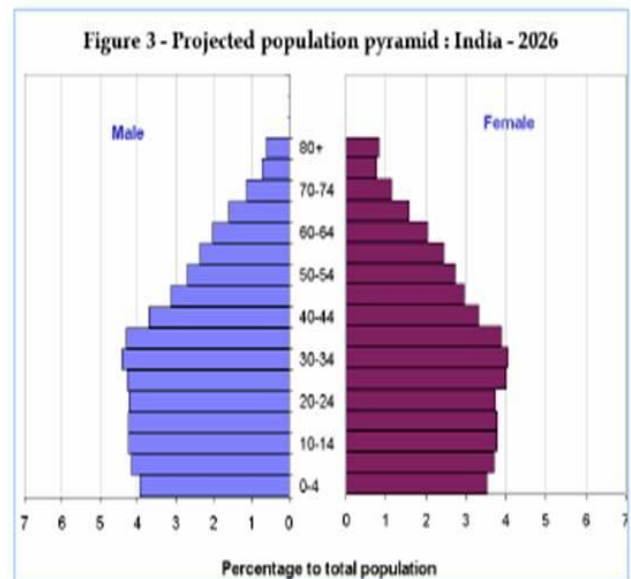
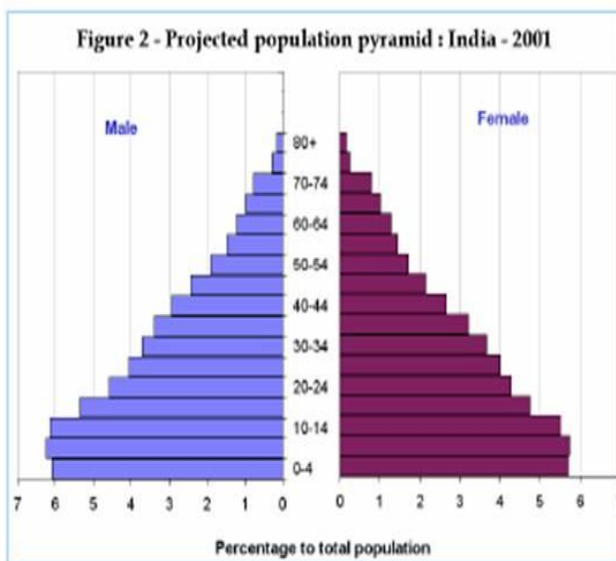
A population pyramid, also called an age pyramid or age picture diagram, is a graphical illustration that shows the distribution of various age groups in a population (typically that of a country or region of the world), which forms the shape of a pyramid when the population is growing.

Most often, a population pyramid consists of two back-to-back bar graphs. Population is plotted on the X-axis and age on the Y-axis. One bar graph shows the males, while the other graph shows females in a particular population. Males are shown on the left and females on the right. The number of males and females may be shown as absolute numbers or as a percentage of the total population.

The present population pyramid suggest that India has got an expansive population pyramids which means larger numbers or percentages of the population in the younger age groups. These types of pyramids are usually found in populations with very large fertility rates and lower than average life expectancies.



Population pyramid based on Future projections.

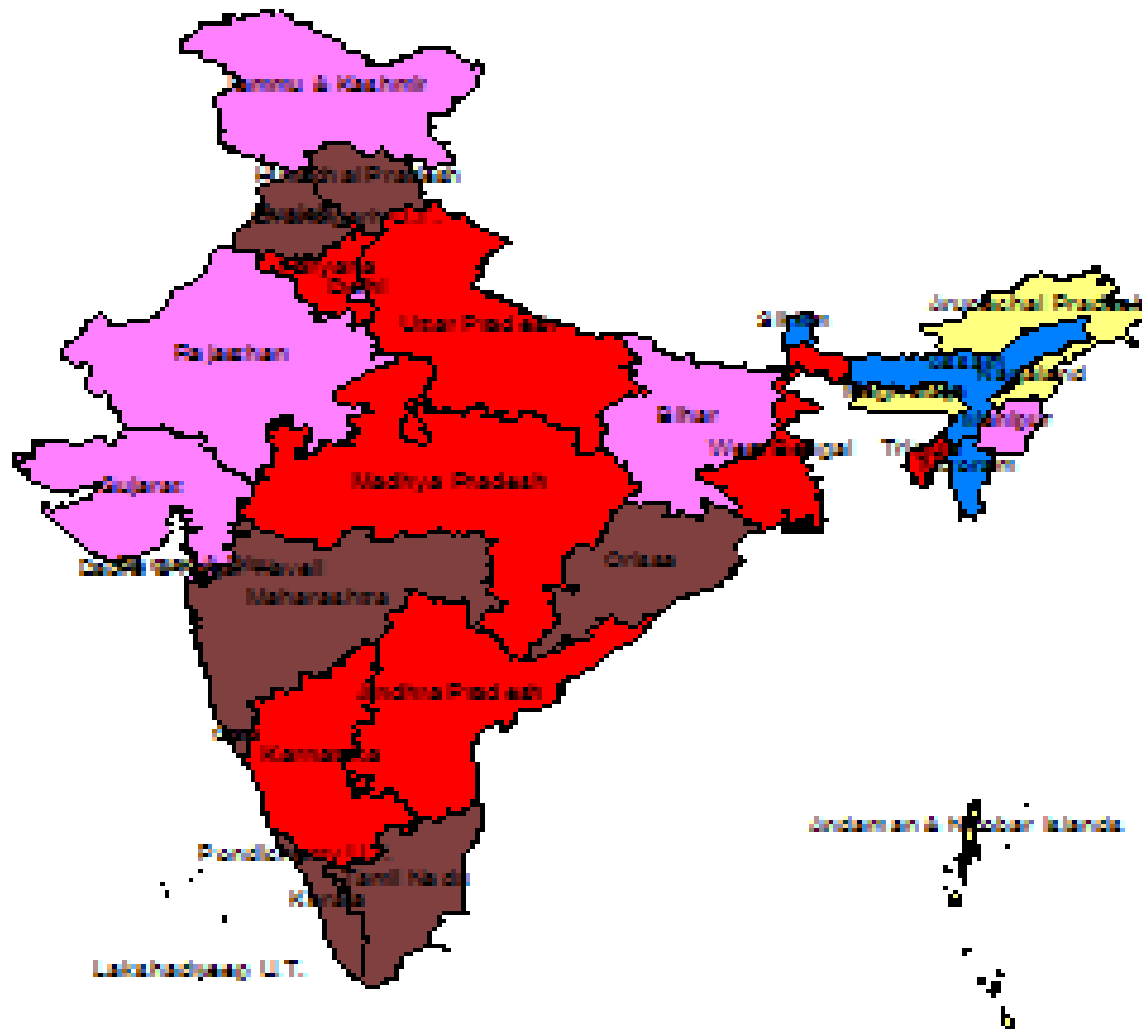


The shape of the population pyramid is gradually changing from a wide-based and narrow topped form to a barrel-shaped form in recent future. This diagram reflects that in the previous decade, the youth and child population was more, therefore the base was broad. However according to projections for 2026, the base will contract which means that child and youth population will be less and there would be significant increase in old population. This are the result of population control policies and changing values of individuals.

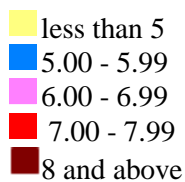
State differentials among elderly Population

As of 2001, the highest proportion of elderly among states and UTs was observed in Kerala (10.5%) and lowest in Dadra Nagar Haveli (4%). According to 2001, UP has 11.6 million elderly people (highest) followed by Maharashtra has 8.4 million and Andhra Pradesh and West Bengal has 5.8 and 5.7 million respectively. The lowest number of elderly population lives in Lakshadweep (1.4 lakh).

The proportion elderly residing in various states and UTs is classified into five groups. The states are grouped in the following manner: states where less than 5 percent elderly live, 5 percent to 5.99 percent, 6 percent to 6.99 percent, 7 percent to 7.99 percent and 8 percent and above. There were only two states namely Punjab and Himachal Pradesh that exceeded 7 percent of elderly population during 1971 and now, 15 states exceeded same percent during 2001. It may be noted that states like Punjab, Himachal Pradesh and Kerala exceeded 9 percent during 2001 census. Surprisingly, elderly population proportion (less than 5 percent) in small states and UTs has not been increasing much during last 30 years.



Proportion of 60+ population, Census 2001

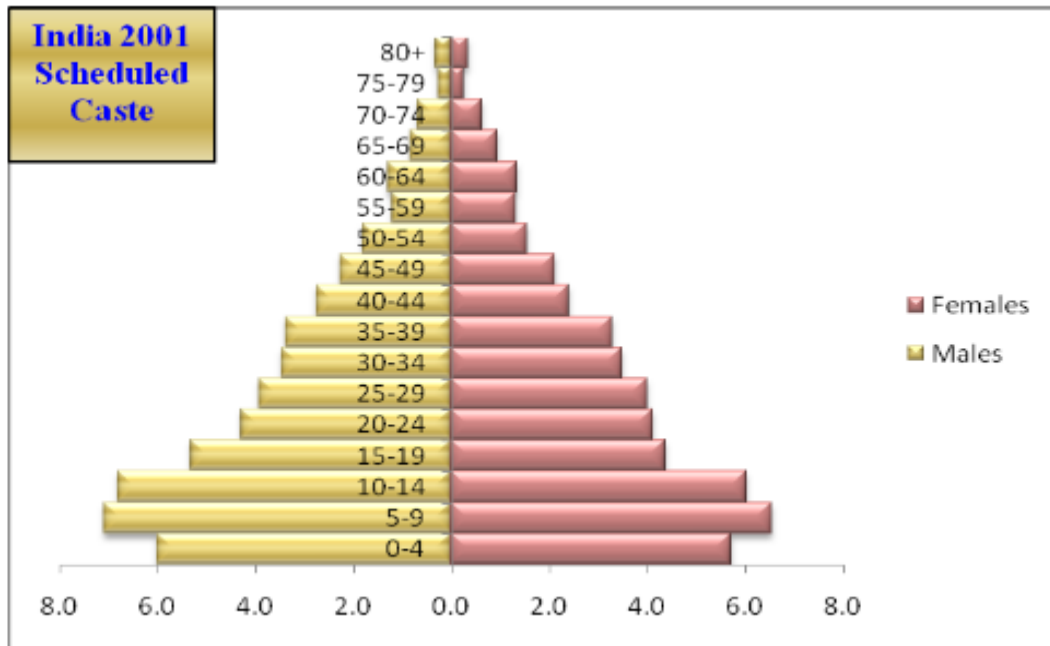


Ageing in social groups of India:

In India, Scheduled castes and Scheduled tribes constituting about one-fourth of population are two groups which have lagged behind the economic development compared to rest of the population. As such, in both the groups ageing is lower than the national average and this is true for most of states. The Scheduled tribes show the lowest ageing among all social groups in India. Among both Scheduled caste and Scheduled tribes, life expectancy is lower and fertility is high which is consistent with lower economic status and the lowest educational level among them. But the trend that

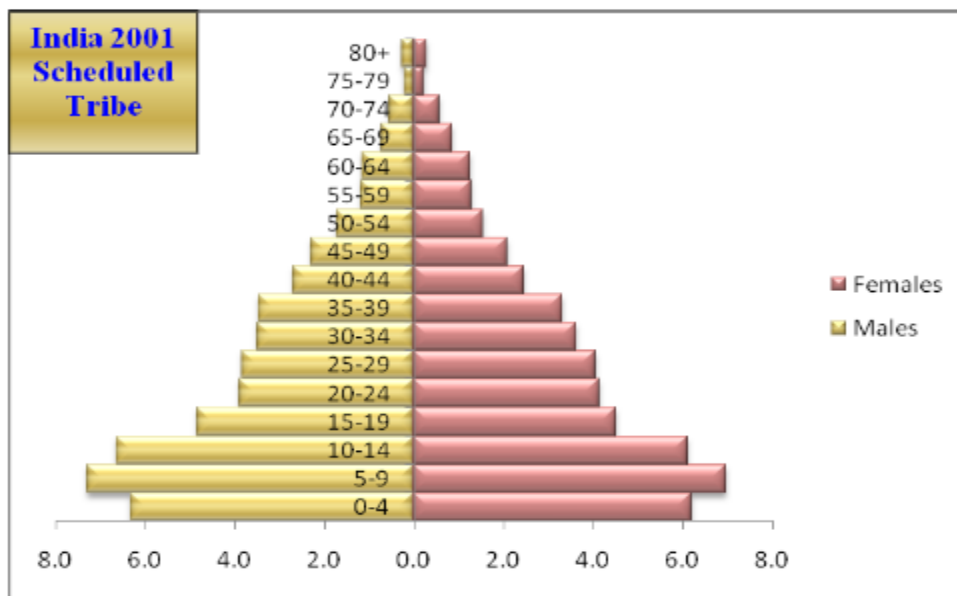
females have higher proportion of aged compared to males is visible among all social groups in India.

Scheduled castes.



The above figure reflects that scheduled castes population have a youthful population as they have more children and youth to support the old.

Scheduled Tribe



Just like scheduled castes, situation is same for scheduled tribe.

Trend in the Sex Ratio of Elderly Population

The progressive increase in the proportion of females to males in the elderly population is also evident in the trend in the sex ratio of elderly population aged 60 years or over. The sex ratio among elderly people was as high as 1028 in 1951 but subsequently dropped to about 938 in 1971, but has finally increased again to about 972 in 2001.

Another feature is a relatively higher ratio of females to males in the elderly population than in the general population for all the years since independence. The following table shows increasing trend of elderly population in India on basis of sex.

Table 2(Growth of elderly population aged 60 and over, by sex, in India 1901-2001)

Year	Population 60+ (in millions)		
	Persons	Males	Females
1901	12.06	5.50	6.56
1911	13.17	6.18	6.99
1921	13.48	6.48	7.00
1931	14.21	6.94	7.27
1941	18.04	8.89	9.15
1951	19.61	9.67	9.94
1961	24.71	12.36	12.35
1971	32.70	16.87	15.83
1981	43.98	22.49	21.49
1991	55.30	28.23	27.07
2001	75.93	38.22	37.71

Source: Sharma, S.P. & Peter Xenos. 'Ageing in India: Demographic background and analysis based on census materials' Occasional paper No. 2 of 1992, Office of the Registrar General and Census Commissioner, India, New Delhi, 1992 (4).

Table 3 Sex ratio (females per 1,000 males) of elderly population and general population, India, 1961-2001)

Year	All Ages (General Population)	Age 60+	Age Group		
			60-64	65-69	70+
1961	941	1,000	969	962	1,064
1971	930	938	921	922	970
1981	933	956	931	978	970
1991	929	904	904	953	1,024
2001	947	987	969	965	1,022

Source: same as in Table 2

The above table demonstrates that though the sex ratio is low for general population but as the age group of the elderly increases, the sex ratio also increases. As women tend to live longer than men because of high life expectancy so in the age group of 70+ women are more as compared to men.

Life Expectancy at Selected Ages

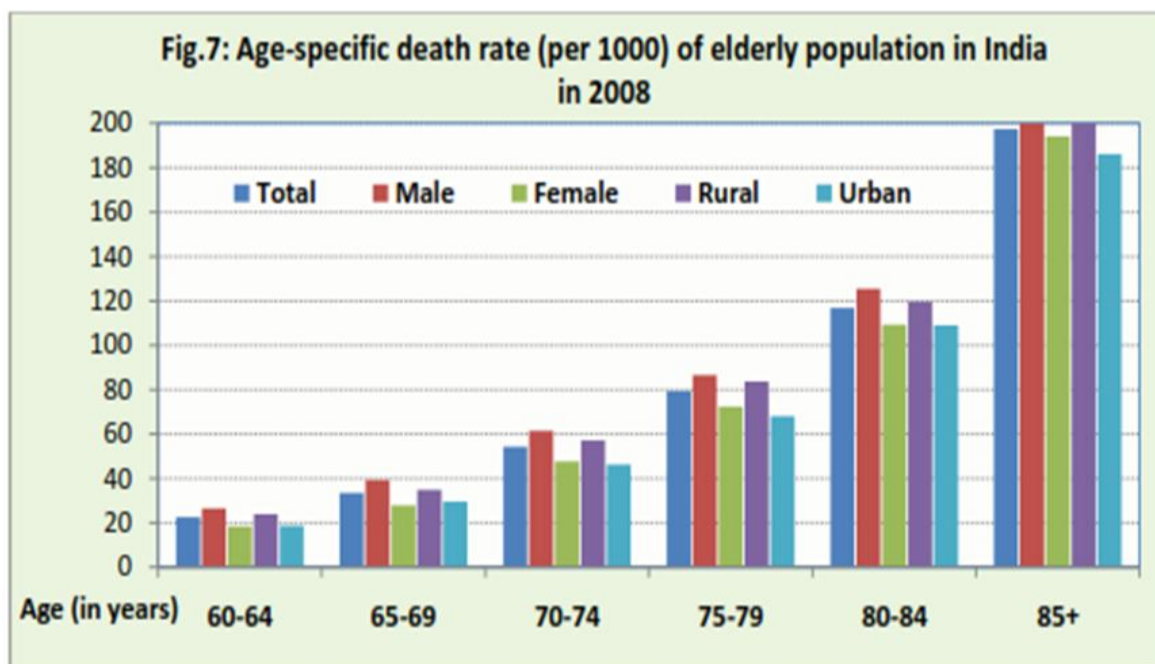
With the rapid advancement in medical science and technology, greater health care facilities and health awareness, government intervention, endeavors of NGOs and people being conscious of their health, it has now become easier to control various dreaded diseases which were the cause of high mortality earlier. This has resulted in a steady increase in the expected length of life or life expectancy at birth. Due to various biological factors, generally women live longer than men but still because of some social factors adverse to women, India was one of the few countries of the world where life expectancy at birth was slightly in favour of males till about 1980. However, because of improvement in the various socio-economic conditions since then, women's life expectancy is now higher than men's in India as observed in most of the other countries of the world. It is also worthwhile to note that in the period 1970-75, average length of life was only 48 years and 59 years in rural and urban areas respectively. Thus the rural-urban gap in life expectancy is considerably reduced during the last 30 years.

The life expectancy at birth for females has been rising continuously and during 2002-06, it was 64.2 for females as against 62.6 years for males. Also life expectancy is generally considerably higher among urban people than among the rural ones as in 2002-06 it was 68.8 in urban areas as against 62.1 years in the rural.

Interestingly while the expectation of life at birth is highest in Kerala (70.8 for males and 76.2 for females) followed by Punjab (67.2 for males and 69.3 for females), but if we look at the expectation of life at the age 60, Punjab stands at top (20.2 for males and 21.2 for females). This means that after reaching the age of 60, in Punjab, males are expected to survive on an average, 20.2 years more and females 21.2 years. In terms of male expectation of life at age 60, Punjab is followed by Haryana (19.0) whereas in female life expectancy at 60, Kerala (20.6) follows Punjab. Demographically disadvantaged states such as Bihar, Madhya Pradesh and Orissa have lowest life expectancy at birth but for Bihar, life expectancy at age 60, is higher than Maharashtra, Tamil Nadu and Gujarat.

Age-Specific Death Rate of the Elderly Population

The age specific death rate gives the number of deaths, during a given time period, of persons of a particular age group per 1000 persons in that age group. The following figure gives an idea about the age specific death rates in the older age groups by sex and place of residence which reveals the health status of the elderly persons in the Indian society.



It is discerned from the figure that there is sharp rise in age-specific death rate with age from 20 (per thousand) for persons in the age group 60-64 years to 80 among those aged 75- 79 years and 200 for persons aged more than 85 years. Also for all the broad age-groups, the rates for males were invariably more than that for females and higher in rural areas as compared to that in urban areas. Among states the age-specific death rates among elderly were relatively lower in states like Kerala. Delhi and higher in the states of Assam, Madhya Pradesh etc.

The improvement in life expectancy and decline in age-specific death rate among the elderly are particularly due to the improvements in public health and medical advances in the prevention of many fatal infectious diseases. Increases in the life expectancy of older people reflect some of the achievements of medical science, although India is not yet successful in combating some of the illnesses that are major causes of death among the elderly such as heart attacks, lung infections, cancer, stroke and circulatory diseases. These are major causes of death for both men and women at the older ages, but they do not become as important for women until later in the age curve. Thus these factors differentially affect the sexes within the same age cohort and contribute to the increasing longevity of women to men.

Old age dependency ratio

Old age dependency ratio is defined as number of person of 60 and above to the working age group between 15 and 59 years.

In particular case of India, there is a need to focus on the gender dimension of old age dependency. Most of the female elderly are either dependent on their husband's pension or on their children. Therefore, female old age dependency can be considered more than male old age dependency. Again, those aged who come under the formal sector receive their pension and lead a better life than those who were engaged in informal sector. As the percentage of very old rises, the dependency increases too. Again when the age of the aged further increases which means as 60 years old turn 75 or 80, then old age dependency further accelerates.

Table 4 (Dependency ratios and indices of ageing, India 1951-2001)

Year	Dependency ratio		Total	Index of ageing
	Child	Elderly		
	a	b		
1951	68.49	9.80	78.29	14.31
1961	76.97	10.56	87.53	13.72
1971	80.82	11.47	92.29	14.20
1981	73.64	11.92	85.56	16.18
1991	61.43	11.31	72.75	18.42
2001	50.94	12.59	63.53	24.72

Source as in Table 2

a) No. of persons aged 0-14 per 100 aged 15-59

b) No. of persons aged 60+ per 100 aged 15-59

c) No. of persons aged 0-14 and 60+ per 100 aged 15-59

d) No. of persons aged 60+ per 100 persons aged 0-14

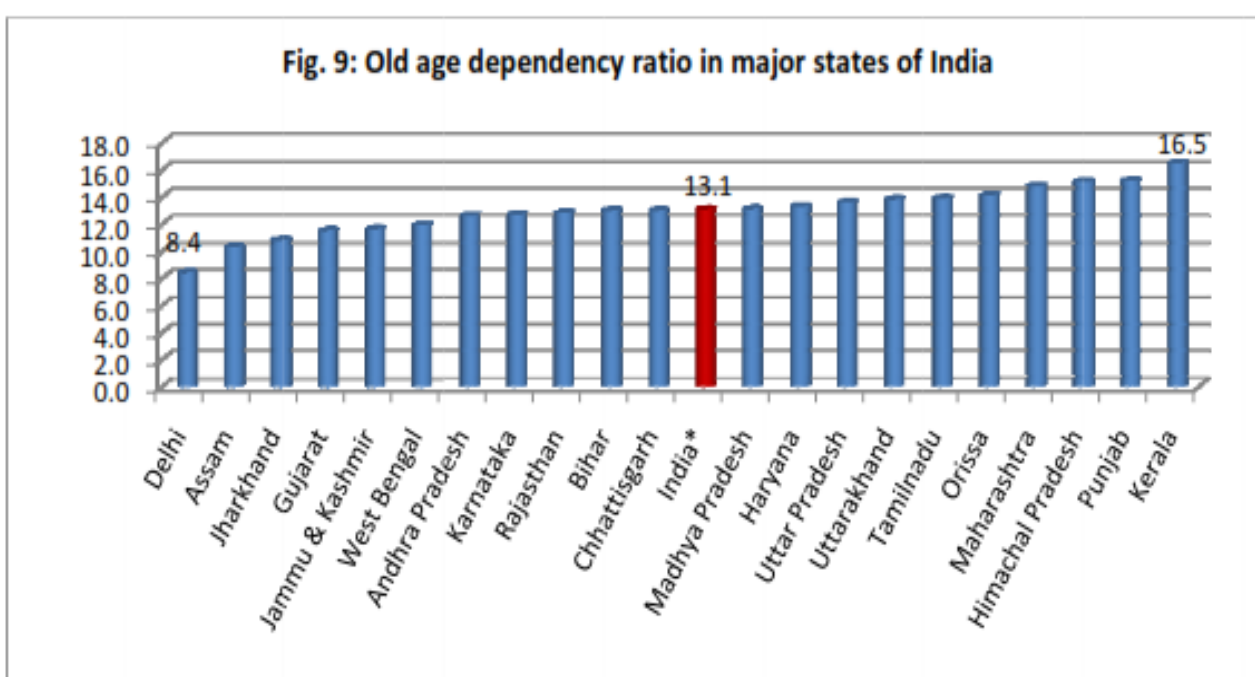
The above table depicts the rising trend of old age dependency ratio and the decreasing share of child dependency ratio. With decline in fertility, the child dependency is likely to decline and old age dependency is likely to increase with changes in the age-structure of the population as well rising life expectancy. This reflects that the index of ageing is constantly growing

- In India, old age dependency ratio has consistently increased from 9.8 per cent in 1951 to 11.9 per cent in 1981 and is projected to be 12.6 in the year 2001.
- While in 1971, there were nearly 14.2 older persons for every 100 children, the ratio is 24.7:100 by 2001.
- The female old-age dependency ratio as well as the gap between female and male old-age dependency ratio are increasing over time and the two assumed the values 13.8% and 12.5% respectively in 2001, which is a matter of grave concern.
- Between rural and urban ratio there has been considerable difference all through with urban old-age dependency ratio hovering between 8 to 10 per cent, while in rural areas it increased from 11.4 to 14 per cent during 1961 to 2001. This is often due to relatively higher concentration of working age population in the urban areas.

Population ageing will have several implications for health, economic security, family life and well-being of people.

Although, merely measuring dependency through age-composition is very crude as everybody in the adult population is not employed nor every elderly sits idle at home. A high old age dependency ratio is supposedly indicative of the dependency burden on the working population, as it is assumed that the economically active proportion of the population will need to provide for the health, education, pension, and social security benefits of the aged, either directly through family support mechanisms or indirectly through taxation.

The following figure shows old age dependency in various states of India.



- Among major states the overall old-age dependency ratio varied from 8.4% in Delhi and 10% in Assam to more than 15% in Himachal Pradesh & Punjab and 16.5% in Kerala.
- Migration could be a possible reason to explain the higher old age dependency ratio in Kerala as most of the young population migrate to Gulf countries in search of jobs, leaving behind their parents.

Old age dependency ratio is measured only in economic terms but dependency is not only a monetary problem, it has other dimensions too. For example, the families who cannot afford to give private care facilities to the aged will have to abandon them at old age homes or any productive female member has to stay at home to take care of them

and provide all necessary support. This again, shrinks the ambit of working population who support the old age population.

Health:

Demographic changes influence health, economic activity and social condition of people. As the age structure of developing countries changes, demands on resources by different segments of population are expected to grow.

From the available information, two assumptions could be made.

First of all, the extension of life span does not necessarily guarantee healthy living. Secondly, the state is not likely to have adequate resources to meet the demands on its services created by a larger number of elderly people. India, as one of the largest and most stable democracies in the Asian region, has its share of developmental problems. There are many priorities that may push the interest of the older people into the background.

In order to analyze the health situation of elderly, it is necessary to understand basic trends of their physical mobility, morbidity pattern etc.

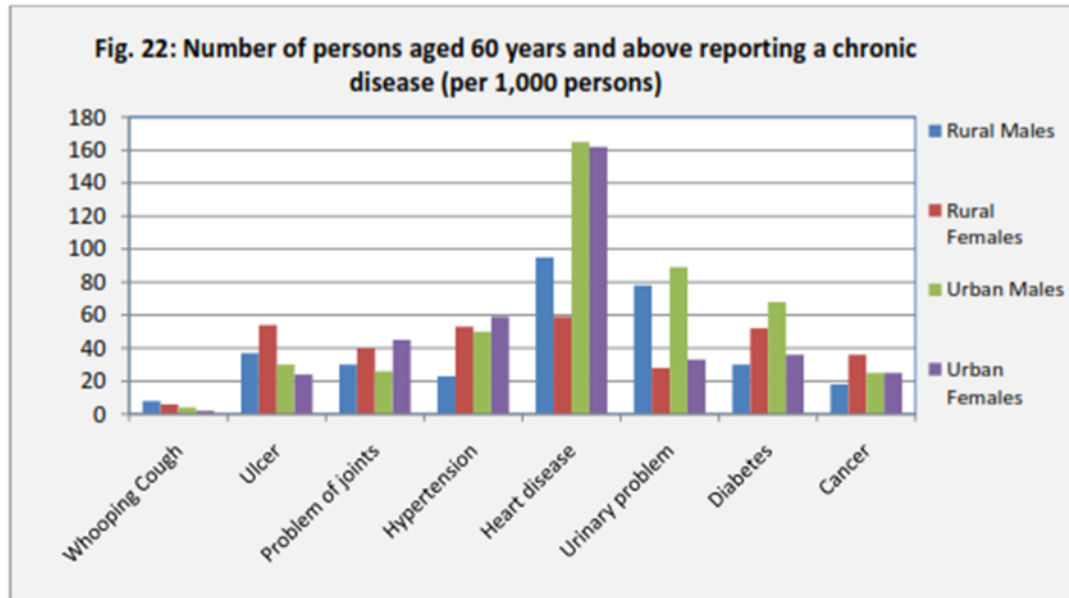
Physical Mobility:

The proportion of elderly men and women physically mobile decline from about 94 to 95 per cent among those in the age-group 60 – 64 years to about 72% for men and 63 to 65 per cent for women of age 80 or more. Also the proportion of elderly physically fit to move was invariably higher in urban areas as compared to their rural counterpart and higher among men than women in various age-age-groups.

Morbidity

Morbidity is a term used to describe how often a disease occurs in a specific areas or in specific age groups. However, there is a difference between morbidity and mortality. The difference is that, Morbidity refers to the state of being diseased or unhealthy within a population whereas Mortality is the term used for the number of people who died within a population. **Morbidity rate** looks at the incidence of a disease across a population and/or geographic location during a single year. **Mortality rate** is the rate of death in a population.

In the following figure, comparison has been made for morbidity between urban and rural aged and also on basis of sex.



- Earlier in life, infections are still the leading causes of death but among older people most deaths are due to non-communicable diseases (Guha Roy, 1994).
- The leading cause of death in old age in India is cardiovascular disease (CVD) or heart disease.
- The prevalence of heart diseases among elderly men and women was much higher in urban areas than in rural parts. Urinary problems were more common among aged men while more aged women reported to suffer from problem of joints.
- The total number of blind persons among the older population was around 11 million in 1996, eighty per cent of them due to cataract (Angra et al. 1997). The consequences of blindness are not limited only to physical disability that ensues, but also impinge on economic, social and psychological domains of the affected individual's life. The calculated economic costs for maintenance of the blind is Rs.432,000 million, and loss productivity is Rs.86,400 million over a decade.
- Nearly 60 per cent of older people are said to have hearing impairment in both urban and rural areas. The hearing loss and resultant communication problems adversely affect the well-being of older people (Kacker, 1997).
- In 1996 the number of hypertensive among the elderly population was nearly nine million.

- The prevalence rate of coronary heart disease among the urban population was nearly three times higher than rural population and the estimated number of cases was around nine million in 1996 (Shah & Prabhakar, 1997).
- An estimated five million were diabetic and the prevalence rates were about 177 for urban and 35 per 1000 for rural elderly people.
- Older persons surviving through peak years of stroke (55-65 years) with varying degrees of disability are already a major medical problem (Dalal, 1997).
- The number of older persons with cancer in 1996 was 0.35 million. The incidence of cancer increases with age and more than 12-23% of all cancers occur after the age of 65 years (NCCP 2002, NCRP 2001). Although more than 25% of cancers are diagnosed in people over 60 year, this group is less extensively investigated and probably receives less appropriate treatment than younger patients.
- Age related changes in immune system make people susceptible to a variety of infections and tumours. Though tuberculosis related mortality has declined, it is still not eradicated effectively and the prevalence rate is reported to be higher in the older age group (Dey & Chaudhury, 1997). Adverse reactions and major side effects to anti-tuberculosis therapy have been reported in as much as 40 per cent of the cases.
- Disabilities arising from ageing assume greater significance as a large segment of this population is below the poverty line. About 64 per thousand elderly persons in rural areas and 55 per thousand elderly persons in urban areas suffer from one or more disabilities. Most common disability among the aged persons was loco motor disability as 3% of them suffer from it, next only to hearing disability (for about 1.5%) and blindness (1.7% in rural areas, and 1% in urban areas).
- Under-nutrition is also common in this population (Srivastava et al. 1996). Elderly people in low socio-economic groups, in urban slums or among those living alone are at higher risk of poor dietary intake (Wadhawa et al. 1997).

Health is a key contribution factor to quality of life and is therefore closely associated to low socio-economic conditions (Bali, 1997).

Mental Health

In India, the physical health is given utmost prominence and psychological health or mental health is mostly neglected. In case of elderly, they hide many of their mental health problems because of stigma and fear from society and sometimes they

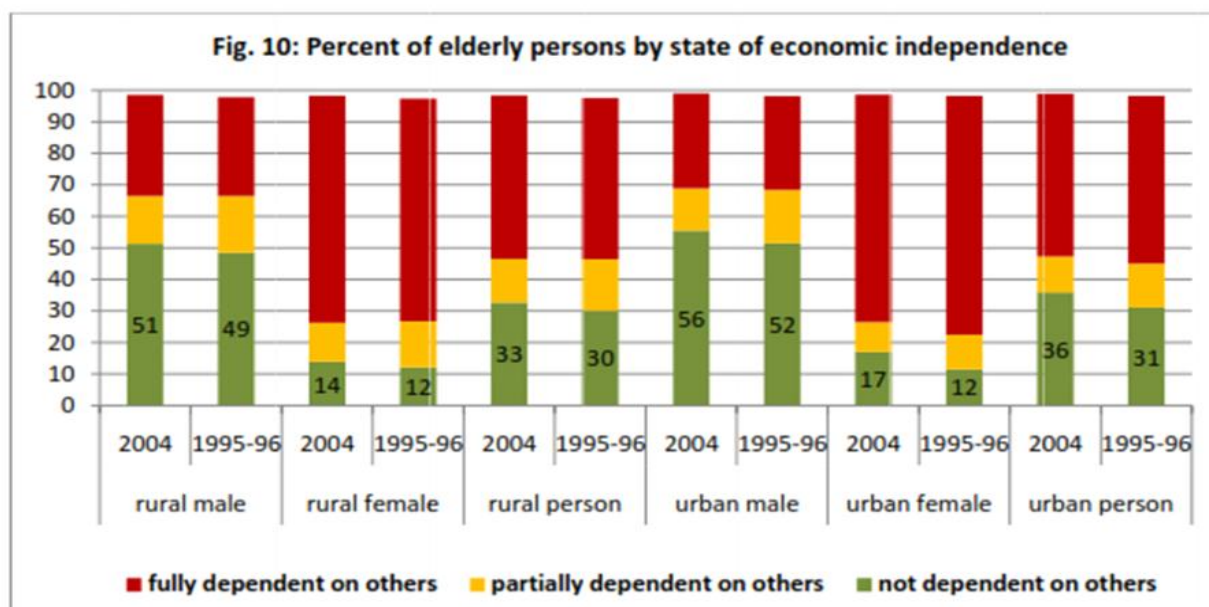
themselves are not aware about these problems. Hence, most of the cases go unreported.

- Information about mental health of the older people is available from hospital and community based studies but they are insufficient.
- The prevalence rate of mental morbidity among those 60 years and above was estimated at 89 per 1,000 population, about 4 million for the country as a whole.
- The risk of specific psychiatric illnesses increases with age.
- The overall prevalence rate rises from 71.5 percent for those over 60 to 124 for those in 702, to 155 for those over 80 years (Venkoba Rao & Madhavan, 1983).
- The risk of senile dementia increases with age. As the country moves from being 'young-old' to 'old-old', senile dementia of Alzheimer's type (SDAT) may become a major problem of the next century (Venkoba Rao, 1997).
- Affective disorders in later age in India, particularly depression, late paraphrenia and dementias form the bulk of total mental morbidity.
- Neurotic disorders are relatively infrequent (Venkoba Rao, 1997).
- Mental health of older persons is influenced not just by ageing changes in the body and brain, but by socio-economic and psychological factors.
- Older people are at high risk of self-destructive behaviour. The suicide rates rise sharply from the young-old to old-old.
- The rate of suicide in the 50+ group is around 12/100,000, a figure higher than 7/100,000 for general population. Under reporting to the extent of a third of suicides is also noticed.

Physical diseases of painful and incurable nature are prominent among the 'causes' of such suicides. Among the other causes, economic factors take the prime place. It is interesting that there are certain inbuilt cultural 'suicide counters'. These are ethical, religious and familial deterrents that may hold back the person from attempting suicide (Venkoba Rao, 1985). Problems related to health and economic conditions lead to suicides in older people. In India, certain socio-cultural and religious beliefs act as deterrents to suicidal behaviour.

Economic Independence

The economic independence reveals the problem of day-to-day maintenance of livelihood of the elderly as captured in the NSS Survey on Condition of the Aged (2004). The following figure reflects the status of elderly in terms of economic independence and provides a comparison between urban and rural area.



- About 65% of the aged had to depend on others for their day-to-day maintenance.
- Even those with pensions find their economic status lowered after retirement. An accurate estimate of economic status of older persons is made difficult as agricultural workers do not have any fixed or regular income
- The situation was worse for elderly females with about only 14% to 17% being economically independent in rural and urban areas respectively while the remaining are dependent on others - either partially or fully.
- The elderly males were much better off as majority of them (51 to 56 per cent among them in rural and urban) did not depend on others for their livelihood.
- More distressing are the high proportions of elderly females and males totally dependent on others, which was above 70% among women as against 30% among men in the year 2004 and there was only minor difference between rural and urban scenario.

Situation Analysis of the States.

Among the major states, in urban Himachal Pradesh, highest proportion of elderly men (72%) and women (30%) were economically independent. In urban parts the proportions were least in Bihar (44%) for males and in Orissa (6%) for females. On the

other hand in the rural part of the country the proportion of economically independent elderly men were least in Kerala (36%) and highest in Jammu & Kashmir (65%), while the proportion of economically independent elderly women was least in West Bengal (6%) and highest in Tamil Nadu (19%).

Among economically dependent elderly men, in either rural or in urban part of the country about 6-7% were financially supported by their spouses, almost 85% by their own children, 2% by grandchildren and 6% by others. For elderly women, there were minor differences between the rural and urban scenario. In rural areas, 16% depended on their spouses, 75% on their children, 3% on grandchildren and 6% on others, while in urban areas 19% depended on their spouses, 71% on their children, 3% on grandchildren and 7% on others including the non-relations.

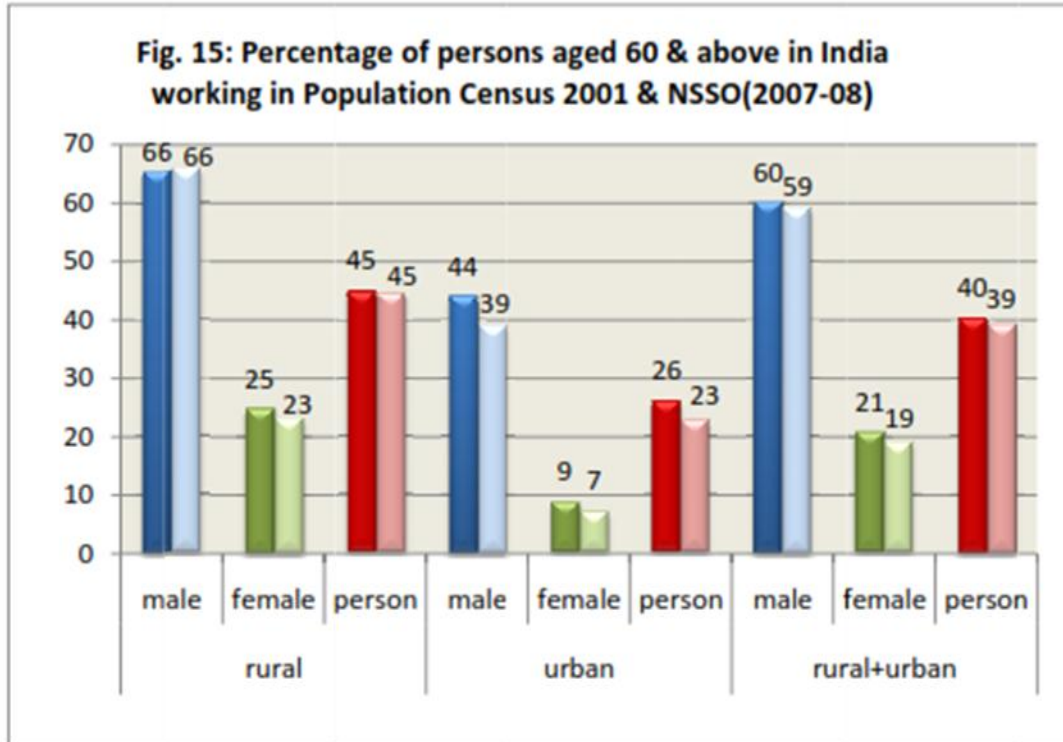
Among the rural elderly persons almost 50% have a monthly per capita expenditure level between Rs.420 to Rs.775 and as expected more males than females are there in higher expenditure classes. On the other hand, among the urban elderly persons, almost half of males and females have monthly per capita expenditure between Rs.665 and 1500.

Another related aspect to be considered is medical expense. There has been a progressive decline in the allocation of resources for the health sector. Public investment in health care provision has not kept pace with population growth and the demand for basic health care. There is also considerable discrepancy in provision between urban and rural areas in availability and access to health care resources. Rural poor, and those living in tribal areas have little access to modern, high cost, urban based medical care. It is well documented that as people live longer, medical expenses will consume a major share of their savings. When people are already poor, living longer may ultimately mean living with unattended medical problems as health services cannot be readily purchased.

Elderly Population Working

Another important aspect is to find out the proportion of elderly population working. For this in case of Population Censuses both main workers and marginal workers are considered while in case of NSSO Employment-Unemployment surveys, both the principal and subsidiary activity status are to be taken into consideration and there was not much variation between the proportion of elderly persons working as obtained from these two sources for almost all the population categories.

The following table reflects the percentage of aged persons who are working.



In India, both Population Census 2001 and NSSO Survey on Employment-Unemployment (2007-08) revealed that nearly 40% of persons aged 60 years and above (60% of men and 19% of women) were working. In rural areas the proportion was still higher as 66% of elderly rural men and above 23% of aged rural women still participating in economic activity, while in urban areas it was only 39% among elderly men and about 7% of elderly women who were economically active even after the age of 60 years. The possible reasons for this could be that 93 % of the total work force is in unorganized sector, the pensions and other schemes for elderly are only meagre. Therefore, in order to financially sustain themselves the aged need to work. Again the reasons for low participation of elderly women in work is due to traditional Indian patriarchal system where women are not allowed to enter the workforce.

Social security for older people

Social security schemes are available in India mainly for those retiring from the organized sector. In India, ninety per cent of the total work force, however, is employed in the informal sector. National old age pension schemes provide assistance to destitute persons above 65 years. India, with its predominantly agrarian based economy, has inadequate social security provisions for its older people.

The concept of social security implies that the state should make itself responsible for ensuring a minimum standard of material welfare to all its citizens. Although since independence India has been making efforts to achieve the desirable goal of being a

welfare state, social security still covers only a small proportion of the population. For government employees, pension scheme and contributory provident fund schemes are the major security provisions. There are several Acts which make provision for labourers in the organized sector. But nearly 90 per cent of the total workforce is employed in the unorganized sector. Among these, only 40 per cent are wage earners. Low wages, job insecurity and lack of legal and governmental provisions to protect their rights, make this group vulnerable to economic hardships.

Life insurance scheme is a public sector undertaking and is a popular security measure. The primary purpose of insurance is to provide protection to the family in case of death of the breadwinner. It also combines elements of saving for old age with family protection. There are several schemes for the self-employed, in addition, the General Insurance Corporation formed by the Government in 1972 has schemes for personal accident insurance, medical insurance, cancer insurance and tax rebate for senior citizens. For the poor, destitute and infirm persons above 65 years of age, the Government provides pensions at the rates ranging from Rs.250 to Rs.500 per month under the National Old Age Pension scheme (i.e., at the time of writing this, the equivalent of US\$4-5). It is obvious that older people have to depend mostly on their own earnings/savings or on their family. Work participation rates among the elderly was about 40 per cent in 1991 and varies from region to region.

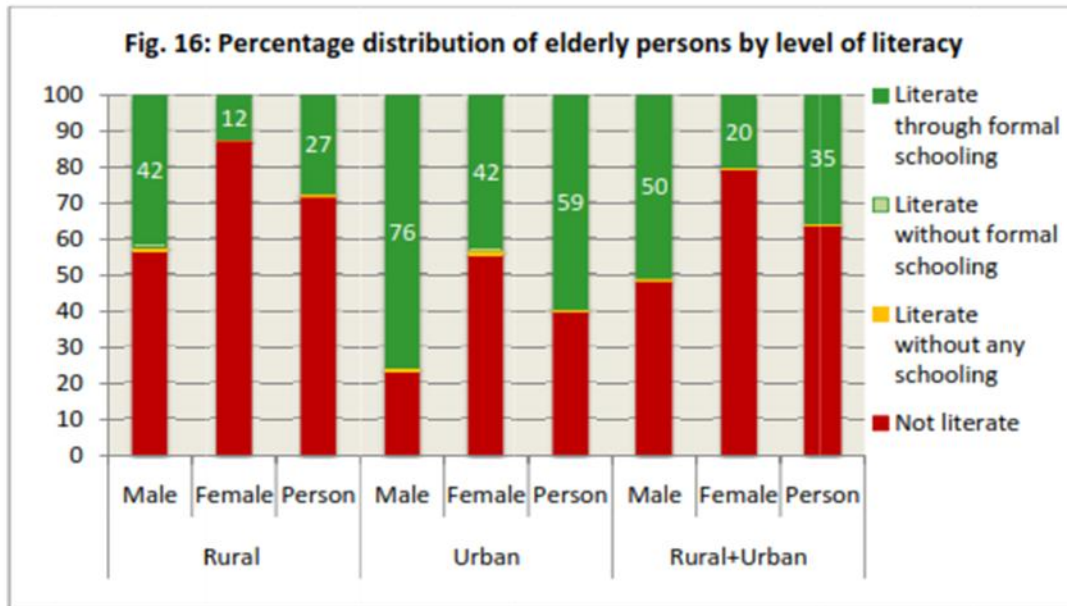
People employed in agriculture sector continue to work as long as they physically manage the job. Around 60 per cent of male and 65 per cent of female elderly work as agricultural labourers. In urban areas, retired men may take up part time jobs, if available, to supplement their incomes. A vast majority of women are housewives, and as such, 'invisible workers', depend on their families. Women's work is hardly quantified and monetized.

Level of Literacy of Elderly Persons

Education empowers an individual to think rationally and logically. Literacy has been found to be the most important determinant of various demographic decisions of individuals. It has been found that levels of birth rate, death rate and infant mortality rate are higher in states where female literacy rates are lower. Like in overall population, among elderly persons also there is a huge gap between male and female literacy as well as that in rural and urban parts of the country.

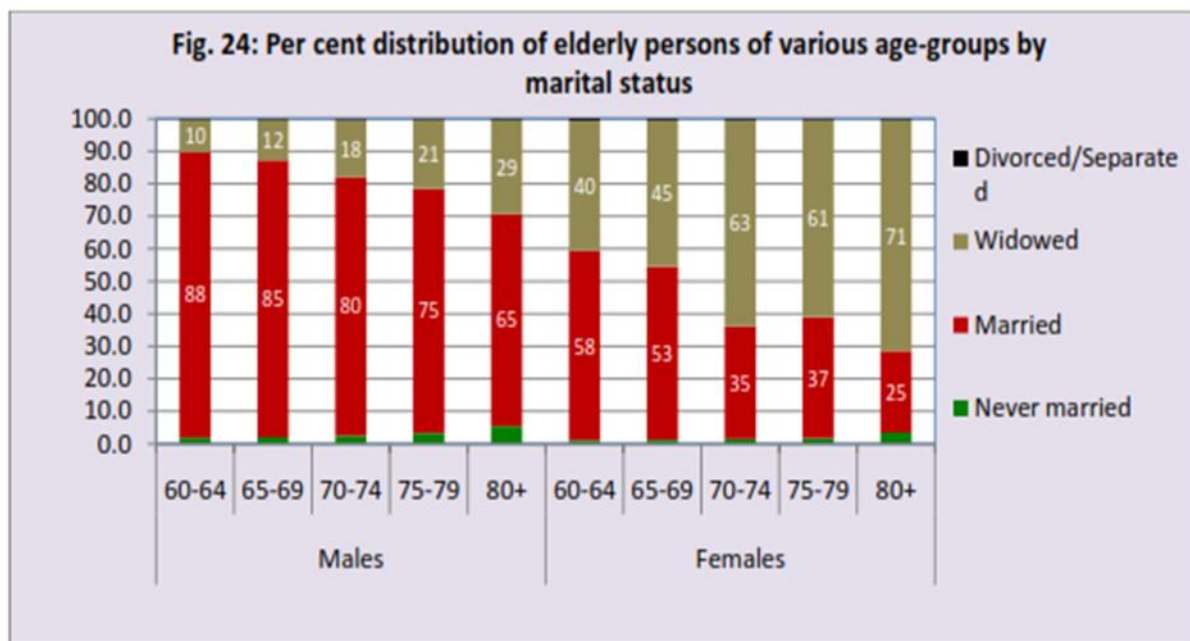
The following figure shows the level of literacy among elderly. The difference in literacy among urban and rural areas is also highlighted. As revealed by the figure only 50% of elderly men and 20% of women aged 60 years or more were literate through formal schooling. In rural areas the proportion was further lower at 42% among men and 12% among elderly women. However, there is no denying of the fact that literacy

levels among elderly males and females have improved over time in both rural and urban areas. Reasons for this are Government initiatives towards education of aged and programmes for sensitizing them and spreading awareness and effort of various NGO's who strive towards empowering the aged.



According to NSSO survey, among major states, the overall literacy rate among persons aged 60 years & above was less than 25% in J & K, Rajasthan while it was 65% or more in Delhi, Kerala etc.

Marital Status of the Elderly Persons



From the above figure which demonstrates the marital status of elderly persons, various interesting observations emerge. In all the age-groups the percentage of elderly women married was markedly lower than the percentage of men married. As for example, in the age-group 60 to 64 years 88% of males and only 58% females reported to be married and 40% of women were widowed. Similarly for the other higher age-groups also such huge difference between the women and men were quite apparent. It is interesting to note that divorce percentage was almost nil. According to NSS 42nd round, there were 654 widows and 238 widowers per 1,000 old persons in rural areas. The respective figures were 687 and 200 for urban areas. The reasons for this could be

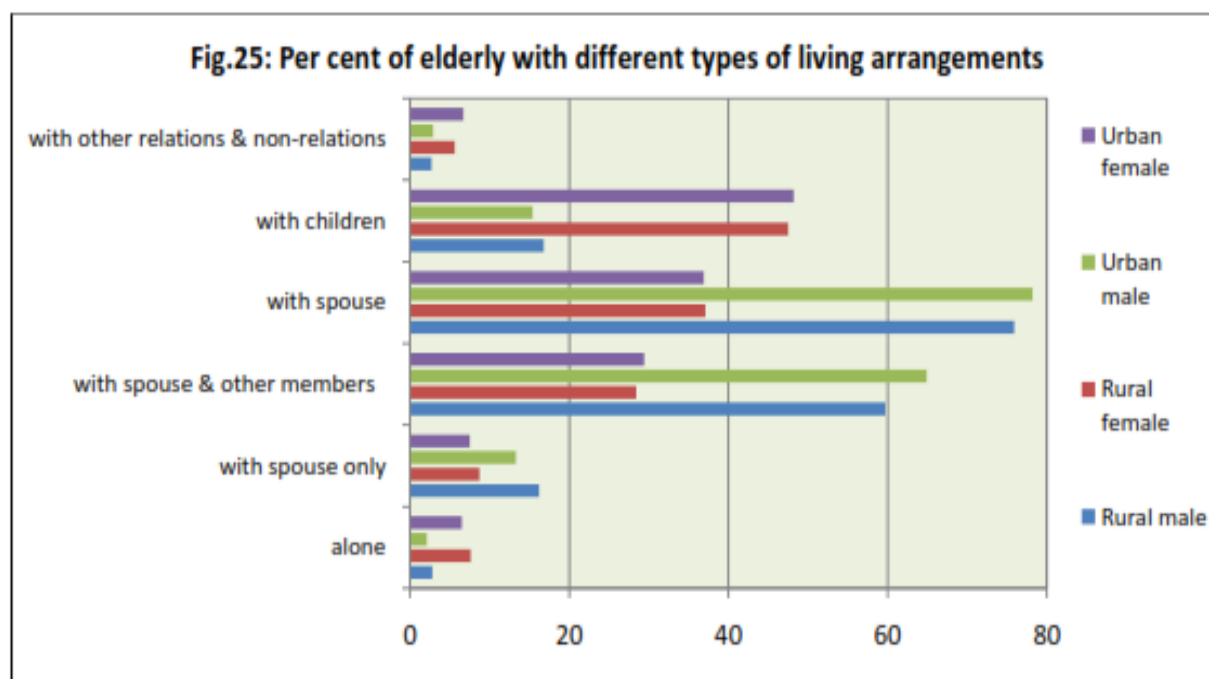
- The prevalent practice of men getting married to women of relatively much lower age-groups. Many cases are found where aged men of age above 50 marrying girl who are 20-30 years younger to them but the vice-versa is rare.
- Higher life expectancy of women in comparison to men
- India's patriarchal social system that degrades the position of women and puts all restrictions on her and
- The generally low status of women which forbids widow remarriage.

Living arrangements

Living arrangements of older people are influenced by several factors such as gender, health status, and presence of disability, socio-economic status and societal traditions. Generations of older Indians have found shelter in the extended family system during crises, be these social, economic or psychological. However, the traditional family is fast disappearing, even in rural areas. With urbanization, families are becoming

nuclear, smaller and are not always capable of caring for older relatives. Yet, in India, older people are still cared for by their families.

Living in old age homes is neither popular nor feasible. Allowing parents to live in old age homes draws criticism from the family network and society at large. There is strong cultural pressure to 'look after' the parents in the family.



The above figure regarding living arrangements of the older people in India based on the NSS report.

- More than 75% of elderly males and less than 40% of elderly females live with their spouse, which again reflect the differences in their marital status.
- Less than 20% of aged men and about half of the aged women live with their children.
- 8 per cent of urban and 5.9 per cent of rural elderly lived alone.
- About 2-3% of elderly men live alone while another 3% live with other relations and non-relations.
- Among elderly women, 7-8% live alone and another 6-7% reported to live with other relations and non-relations. Living alone is usually due to widowhood, childlessness or migration of children.

Currently, in urban areas, women have started working outside the home. Women were the traditional carers for old people. Women's labour force participation has reduced the number of workers available to care for their elderly relatives. Where people live in their later years will make a significant difference to the quality of their living. Availability

of carers in case of illness, disability, emergencies, depend on living arrangements. Living with a married daughter's family is a less preferred alternative.

Reported number of Old Age Homes in India was only 354 in 1997. Many of such Homes are run on charity and the inmates are poor and destitute.

In recent years, in large cities relatively well-to-do people are considering living in special condominiums built for older people. In metropolitan cities, senior housing projects with medical and recreational facilities are being promoted by construction companies. Integrated housing schemes where older people can live in their own apartments in a building complex that also houses orphanage, hospital, bank and other services, are also being introduced. The South Indian states of Kerala and Tamil Nadu have together 57% of all old age homes. These states have witnessed emigration of young people in large numbers to Middle Eastern and Gulf countries. People are now more affluent but have no one to care for them.

Social status of older Indians

Social scientists report that there is a general lowering of social status of elderly people in India. Increasingly, older people may be perceived as burdens due to their disability or dependence. Rapid changes in the family system, even in rural areas, are reducing the availability of kin support. With modernization of the country, older values are being replaced by 'individualism'. The family's capacity to provide quality care to older people is decreasing. The Government had been complacent that the joint family system and traditional values would provide the social security cover in old age. This view is being drastically revised. In non-agrarian societies older persons who are 'economically unproductive' do not have the same authority and prestige that they used to enjoy in extended families where they had greater control over family resources.

The unconditional respect, power and authority that older people used to enjoy in rural extended traditional family is being gradually eroded in India in recent years.

Efforts are being made to revive cultural values and reinforce the traditional practice of interdependence among generations. Families need help in caring for the older persons. Such help may be in economic terms or practical support in care giving. It is neither desirable nor affordable to open a large number of old age homes in a country like India.

Urban and Rural differences

India is a country of villages, and nearly three quarters of its population is rural. Urban and rural areas provide striking contrasts in terms of living conditions, availability of resources and facilities. There are regional variations in the condition of villages but in

general, most villages have poor sanitary conditions and less access to education and health facilities. Most rural folk work on their own land or as agricultural labourers. There is no income security nor any systematic provision for old age. Children are perceived as old age security. In most surveys, the urban old are found to have better health and better economic security than those in rural areas. Urban areas in India have benefited disproportionately from improvements in housing, sanitation, education and health care.

Urban males are in the most advantageous position compared to urban females, rural males and rural females. Urban men are better educated, likely to work in the organized sector, to retire with a pension and to be insured. They are also more likely to use health facilities more often and have better health status (Prakash, 1997). Senior citizen clubs are becoming popular in cities. In metropolitan areas, older people organize themselves to fight for better facilities and to pressurize the Government for tax benefits and user-friendly public services.

Migrants and Refugees

Migration is a most important and worldwide phenomenon with multiple implications. In India, major cities have grown in size due to the influx of refugee migrants since independence. Industries and developmental projects draw rural migrants to the cities. In India between 40 and 68 per cent of migrants come from rural areas. A large proportion of them is likely to be male, young and unmarried. Two major consequences of uncontrolled migration are unemployment and poverty which are reflected in the sprawling slums that spring up in the periphery of cities. During the British rule there was forced tribal emigration in different parts of India. Most rural migrants came from lower socio-economic strata and continue to live in poverty in cities.

In recent years, South Indian states have seen large scale migration of young people to middle-eastern and Gulf countries. There are two important issues to be considered here. One, relates to what happens to migrant people as they grow old in a different culture. Second, what happens to old people who are left behind when young and able bodied people migrate? The problem of refugees is also quite severe. Refugees from Pakistan, Bangladesh, Sri Lanka and Tibet have been relocated in different parts of India. Illegal migration is a demographic reality, and with the creation of Bangladesh, eight border districts of West Bengal have registered population growth of over 30 per cent in one decade. In-between 1971-81, more than 5.5 lakh illegal immigrants entered West Bengal while the number estimated for the state of Assam was around six lakhs (Ghosh, 1998). There are no reported studies of the condition of older refugees.

Slum dwellers

Slums have become part of the urban landscape in India. The population of slums is usually a mixture of persons from different religions, language groups and occupations. In a study of a well-established slum, (Ara, 1996) found 33 per cent of people above 58 years. Most migrants had come from rural areas to escape famine in their native villages. Most of them were illiterate and very poor. In the older group, there were more females than male, and nearly half of them were widowed. Economic necessity forced them to work even in old age. While 41 per cent of the old people were covered by pension schemes, these were not sufficient to meet their needs. Half of the older people had health problems. Impaired vision and hearing problems were common. Most migrants had come with their families in search of a livelihood and tended to live together. This slum was found to be a closely knit group with all the members belonging to the same socio-economic class with very similar needs and problems. Though economically and in terms of health they had disadvantages, they did not report feelings of loneliness or isolation.

HIV and AIDS

HIV/AIDS has traditionally been viewed as a disease of the younger generation. Health professionals, educators, researchers and service planners have tended to neglect the considerable impact of the AIDS epidemic on older persons, as people with or at risk of HIV infection, as care takers of their adult children who have AIDS and, when those children die, as care takers of the orphaned grandchildren. In September 1998, the Tata Institute of Social Sciences, Mumbai, held a conference on HIV/AIDS and elderly people in collaboration with HelpAge India. Figures available indicate that older persons constitute a small but significant proportion of HIV/AIDS cases as a whole. In India the percentage of HIV cases in the group aged over 50 is around 11 per cent.

1.10 Conclusion

The practical implications of the population ageing for India are far-reaching. The numbers are increasing, the resources are limited and perceived social priorities lie elsewhere. Hence, the response to such demands has to be well orchestrated, multisectoral and based on systematic planning (Kalache & Sen, 1998). The first step is advocacy, to raise policy makers' awareness of the multiple issues related to ageing in the country. Professionals, politicians, voluntary workers, NGOs and the general public need to be targeted by these awareness-building exercises.

1.11 References

1. Achenbaum, W Andrew (1995): *Crossing Frontiers — Gerontology Emerges as a Science*. Cambridge: University Press.

2. Alam, Moneer, 2006, 'Ageing in India: Socio-Economic and Health Dimensions', Academic Foundation, New Delhi.
3. Alam, Moneer, 2007, 'Ageing, Socio-Economic Disparities and Health Outcomes: Some Evidence from Rural India', paper presented at the Conference Titled 'Expanding Freedom: towards social and economic transformation in a globalising world', organised by Institute of Economic Growth, April 12-15, Delhi.
4. Ara, S. (1996) Old age among slum dwellers. New Delhi: South Asia Publishers
5. Baars, Jan; Dannefer, Dale; Phillipson, Chris and Walker, Alan (2006): 'Critical Perspectives in Social Gerontology' in Jan Baars, Dale Dannefer, Chris Phillipson and Alan Walker (ed) Aging, Globalization and Inequality — The New Gerontology, New York: Baywood Publishing Company, INC.
6. Bali, A. (1997) Socio-economic status & its relationship to morbidity among elderly. Indian Journal of Medical Research. 106, pp 349-360
7. Bali, Arun, (2001): Care of the Elderly in India Changing Configurations, Indian Institute of Advanced Study, Shimla.
8. Bose, A.B and K.D. Gangrade, (ed.), 1988, Aging in India: problems and potentialities, Citizenship Development Society, Abhinav Publications, New Delhi.
9. Central Statistical Office (2011): Situation Analysis of the Elderly in India. CSO, Ministry of Statistics and Programme Implementation, Government of India.
10. Central Statistics Office. New Delhi: National Sample Survey Organization, Ministry of Statistics and Programme Implementation, Government of India; 2006. Morbidity, Health Care and the Condition of the Aged. NSSO (64th round) Jan-June 2004.
11. Chahana, H.B., & Talwar, P.P. (1987) Ageing in India: Its socio-economic and health implications. Asian Pacific Population Journal 2 (3) pp 24.
12. Chakrabarti, S., & Sarkar, A. (2011). Pattern and Trend of Population Ageing in India. The Indian Journal of Spatial Science. Vol. II No. 2. Article 4
13. Chen, Martha Alter (ed), 1998, Widows in India: Social Neglect and Public Action, Sage Publications, New Delhi. Goldman, N., S. Korenman and R. Weinstein, 1995, 'Marital Status and Health among the Elderly', Social Science and Medicine, 40(12).
14. Dandekar, K. (1986). The elderly in India. New Delhi: Sage publications
15. Government of India (1998) Ministry of Health and Family Welfare. Family Welfare Programme in India year book, 1986-87. New Delhi.
16. Goyal, R.S. (1997) Implications for the elderly of the demographic transition: An illustration from India. BOLD quarterly journal of INIA (UN), 7 (2), 2-10.

17. Gubrium, J F (1992): Qualitative Research Comes of Age in Gerontology, *Gerontologist*, 32: 581-582.
18. Gubrium, J F (1993): "Voice and Context in a New Gerontology" in T Cole, W A Achenbaum, P Jakobi & R Kastenbaum (eds) *Voices and Vision of Aging — Toward a Critical Gerontology*. New York: Springer.
19. Guha Roy, S. (1994) Morbidity related epidemiological determinants in Indian aged. An overview. In Ramachandran C.R. & B. Shah, (eds) *Public health implications of ageing in India*. New Delhi: Indian Council of Medical Research, p 114-125.
20. Kinsella, K. and He, W. (2009). *An Aging World: 2008*. U.S. Census Bureau, International Population Reports, P95/09-1. Washington, DC: U.S. Government Printing Office.
21. Kinsella, K. and Phillips, D.R. (2005). *Global Aging: The Challenge of Success*. Population Reference Bureau, Vol.60:1.
22. Kumar, V. (1997) Ageing in India – an overview. *Indian Journal of Medical Research*, 106, pp 257-264.
23. Kumar, Vinod; Dey, A B; Nagarkar, Kalpana (1993): Ageing — Current Perspectives, in P M Dalal (ed) *Current Concepts in Internal Medicine*. Bombay: The Association of Physicians of India.
24. Lubinsky, M R and Sankar, A (1993): "Extending the Critical Gerontology Prospective", *The Gerontologist*, 33: 440
25. Martha, B. H., Jennifer, A. P., and Mark H. W. (2011). *Ethics, Aging, and Society the Critical Turn*. New York. Springer.
26. National Sample Survey Organization. *Socio-economic profile of aged persons*. Sarvekshana, (1991) XV, Nos. 1-2, Issue No. 49.
27. Phillips, J, Ajrouch, K and Hillcoat-Nallétamby, S (2010) "Key Concepts in Social Gerontology". London, Sage.
28. Prakash, I.J. (1997). Women and Ageing. *Indian Journal of Medical Research*. 106, pp 396-408.
29. Prakash, J. Indira (1999): *Aging in India*. World Health Organization (WHO) Report, Geneva.
30. Putney, N.M., and Bengston, V .L. (2003). Intergenerational relations in changing times. In J. Mortimor and M. Shanahan (Eds.), *Handbook of the Life Course* (pp, 149-164). New York: Kluwer Academic/Plenum.
31. Quadagno, J. (2008). *Aging in the life course: An introduction to social gerontology* (4th ed.). New York: McGraw-Hill.

32. Rajan, I. S., U. S. Mishra and P. S. Sarma, 1999, *India's Elderly: burden or challenge?* Sage Publications, New Delhi.
33. Ramamurthi, P V and Jamuna, D (1993): *Psychological Dimensions of Aging in India*. *The Indian Journal of Social Science* 6(4): 309-331.
34. Rao, M.S.A. (ed) (1986). *Studies in Migration*. Delhi: Manohar Publications.
35. Registrar General and Census Commissioner, India, 2006, 'Population Projections for India and States, 2001-2026, Report of The Technical Group on Population Projections Constituted by the National Commission on Population, New Delhi.
36. Sathyanarayana, K. & Medappa, N. (1997) Editorial: care of the aged – a long haul ahead. *Indian Journal of Medical Research* 106, pp I-ii.
37. Settersten, R, A, Jr., Angel, J, A. (2011). *Handbook of Sociology of Ageing*. New York. Springer.
38. Shah, B. & Prabhakar, A.K. (1997) Chronic Morbidity profile among elderly. *Indian Journal of Medical Research*, 106, pp 265-272.
39. Shankardass, Mala Kapur (2004): "The Study of Ageing" in *Growing Old in India Voices Reveal, Statistics Speak* by Ashish Bose and Mala Kapur Shankardass, Delhi: B R Publishing Corporation.
40. Shankardass, Mala Kapur and Kumar, Vinod (1996 [a]): "Biographies: their Use for Gerontological Research in a Developing Country — India", *Generations Review: Journal of the British society of Gerontology*,
41. Shankardass, Mala Kapur and Kumar, Vinod (1996 [b]): "A Sociological Analysis of Support Networks in Old Age in India" in V. Kumar (ed) *Aging: Indian Perspective and Global Scenario*, All India Institute of medical Sciences, New Delhi.
42. Sharma, S.P. & Peter Xenos. *Ageing in India: demographic background and analysis based on census materials*. Occasional paper no. 2 of 1992, Office of the Registrar General and Census Commissioner, India, New Delhi, 1992 (4).
43. Srivatsava, M., Kapil, U., Kumar, V., Dey, A.B., Nagarkar, K.M., Sekaran, G. (1996) Knowledge, attitude and practices regarding nutrition in patients attending geriatric clinic at the AIIMS, In Kumar, V. (ed) *Ageing-Indian perspective and global scenario*. New Delhi: All India Institute of Medical Sciences, pp 407-409.
44. Subaiya, L and Dhananjay, W, B. 2011. "Demographics of Population Ageing in India: Trends and Differentials", BKPAI Working Paper No.1, United Nations Population Fund (UNFPA), New Delhi.
45. Subrahmanya, R.K.A. (199.) *Income security for the elderly in India*. *BOLD, Quarterly Journal of INIA (UN)*. 4 (2), PP 28-29.

46. Treas, J. and B. Logue, 1986), Economic Development and the Older Population, *Population and Development Review*, 12(4).
47. United Nations (2005). *Population Challenges and Development Goals*. Sales No. E.05.XIII.8.
48. United Nations (2012a). *Changing Levels and Trends in Mortality: The Role of Patterns of Death by Cause*. ST/ESA/SER.A/318.
49. United Nations, Department of Economic and Social Affairs, Population Division (2013). *World Population Ageing 2013*. ST/ESA/SER.A/348.
50. Victor, C (2005): "The Social Context of Ageing", Abingdon, Routledge.
51. Victor, C.R. (1994) "Old Age in Modern Society", 2nd edn, London, Chapman & Hall.

1.12 Questions

Write short notes on:

1. Dimensions of Ageing
2. Definitional problems of old age
3. Ageism
4. Life course perspective
5. Filial responsibility
6. Gerontology
7. Studies on urban elderly in India
8. Studies on rural elderly in India
9. Magnitude and speed of ageing in global scenario
10. Marital status of elderly in global scenario
11. Living arrangements of elderly in global scenario
12. Workforce participation of elderly in Global scenario
13. International Declarations on Ageing

Long type Questions

- 1) Highlight the scope and significance of sociology of ageing.
- 2) Write an essay on emergence and growth of Gerontology in India
- 3) Discuss the status of elderly in India
- 4) What is the status of elderly in global scenario? Highlight the important aspects.

DEFINITION OF THE INDICATORS OF POPULATION AGEING

A. AGEING INDEX

The ageing index is calculated as the number of persons 60 years old or over per hundred persons under age 15.

B. Crude Death Rate

The crude death rate is the total number of deaths per year per 1000 people.

Number of deaths during the year

= ----- x 1000

Mid-year population

C. DEPENDENCY RATIO

The total dependency ratio is the number of persons under age 15 plus persons aged 65 or older per one hundred persons 15 to 64. It is the sum of the youth dependency ratio and the old-age dependency ratio.

1. The youth dependency ratio is the number of persons 0 to 14 years per one hundred persons 15 to 64 years.
2. The old-age dependency ratio is the number of persons 65 years and over per one hundred persons 15 to 64 years.

D. GROWTH RATE

A population's growth rate is the increase (or decrease) in the number of persons in the population during a certain period of time, expressed as a percentage of the population at the beginning of the time period. The average annual growth rates for all ages as well as for particular age groups are calculated on the assumption that growth is continuous.

E. ILLITERACY RATE

The illiteracy rate of a particular age group indicates the proportion of persons in that group who cannot read with understanding and cannot write a short simple statement on their everyday life.

F. LABOUR FORCE PARTICIPATION

The labour force participation rate consists of the economically active population in a particular age group as a percentage of the total population of that same age group. The active population (or labour force) is defined as the sum of persons in employment and unemployed persons seeking employment. This definition of employment is the one adopted by the Thirteenth International Conference of Labour Statisticians (Geneva, 1982). National definitions may in some cases differ. For information on the differences in scope, definitions and methods of calculation used for the various national series, see International Labour Organization, Sources and Methods: Labour Statistics (formerly Statistical Sources and Methods), vol. 2, Employment, Wages, Hours of Work and Labour Cost (Establishment Surveys), 2nd edition (Geneva, 1995); vol. 3, Economically Active Population, Employment, Unemployment and Hours of Work (Household Surveys), 2nd edition (Geneva, 1990); and vol. 4, Employment,

Unemployment, Wages and Hours of Work (Administrative Records and Related Sources) (Geneva, 1989).

G. LIFE EXPECTANCY

Life expectancy at a specific age is the average number of additional years a person of that age could expect to live if current mortality levels observed for ages above that age were to continue for the rest of that person's life. In particular, life expectancy at birth is the average number of years a newborn would live if current age-specific mortality rates were to continue.

H. MEDIAN AGE

The median age of a population is that age that divides a population into two groups of the same size, such that half the total population is younger than this age, and the other half older.

I. PARENT SUPPORT RATIO

The parent support ratio is the number of persons 85 years old and over per one hundred persons 50 to 64 years.

J. POTENTIAL SUPPORT RATIO

The potential support ratio is the number of persons aged 15 to 64 per every person aged 65 or older.

K. SEX RATIO

The sex ratio is calculated as the number of males per one hundred females in a population. The sex ratio may be calculated for a total population or for a specific age group.

L. SURVIVAL RATE

The survival rate to a specific age X is the proportion of newborns in a given year who would be expected to survive at age X if current mortality trends were to continue for at least the next X years. Survival rates are derived from the life table, which is an analytic procedure designed to produce estimates of life expectancies and other measures of mortality, based on prevailing age-specific death rates.

M. TOTAL FERTILITY RATE

The total fertility rate is the average number of children a woman would bear over the course of her lifetime if current age-specific fertility rates remained constant throughout her childbearing years (normally between the ages of 15 and 49). The current total fertility rate is usually taken as an indication of the number of children women are having at the present.

Table 1: Percentage of 60+ Populations in India and States by Different SocialGroups, 2001-Total

Area Name	Total	SC	ST	Others
INDIA	7.5	6.9	6.1	7.7
JAMMU & KASHMIR	6.7	7.3	6.5	6.7
HIMACHAL PRADESH	9.0	8.2	8.9	9.3
PUNJAB	9.0	7.8	NA	9.5
CHANDIGARH	5.0	3.3	NA	5.4
UTTARANCHAL	7.7	6.3	7.2	8.1
HARYANA	7.5	6.6	NA	7.7
DELHI	5.2	3.7	NA	5.5
RAJASTHAN	6.8	6.2	5.8	7.1
UTTAR PRADESH	7.0	6.7	5.5	7.1
BIHAR	6.6	5.8	5.4	6.8
SIKKIM	5.4	4.5	6.3	5.2
ARUNACHAL PRADESH	4.6	2.2	5.5	2.8
NAGALAND	4.5	NA	4.8	2.6
MANIPUR	6.7	7.3	6.1	7.1
MIZORAM	5.5	0.4	5.7	2.0
TRIPURA	7.3	7.1	6.3	7.9
MEGHALAYA	4.6	4.9	4.6	4.6
ASSAM	5.9	6.4	5.3	5.9
WEST BENGAL	7.1	6.4	5.4	7.5
JHARKHAND	5.9	5.2	5.7	6.1
ORISSA	8.3	8.3	6.6	8.9
CHHATTISGARH	7.2	7.5	7.0	7.3
MADHYA PRADESH	7.1	7.1	6.0	7.5
GUJARAT	6.9	6.3	5.8	7.2
DAMAN & DIU	5.1	6.5	4.9	5.1
DADRA & NAGAR HAVELI	4.0	5.7	4.8	2.6
MAHARASHTRA	8.7	8.9	7.1	8.9
ANDHRA PRADESH	7.6	7.0	5.7	7.9
KARNATAKA	7.7	7.0	6.9	7.9
GOA	8.4	5.7	2.8	8.4
LAKSHADWEEP	6.2	NA	6.4	1.5
KERALA	10.5	9.4	7.5	10.6
TAMIL NADU	8.9	7.1	6.5	9.3
PONDICHERRY	8.3	6.6	NA	8.7
ANDAMAN & NICOBAR ISLANDS	4.9	NA	7.1	4.7

UNIT- II

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In this unit we shall acquaint you with the problem of the aged in general and of the aged in India in particular. We shall do this by showing how and why this problem is becoming larger and more difficult, and by pointing out its different aspects.

2.0 Objectives

After reading this unit, you should be able to:

- explain why the situation of the aged is posing problems;
- describe how changes in the society are rendering the problem more complex and difficult;
- discuss the demographic, economic and health conditions of the aged;
- examine how the aged were able to adjust themselves in the society more satisfactorily in the past and how they are finding their adjustment less satisfactory now;
- contrast the situation of the aged women with that of the aged men; and
- analyze the public policies and programmes to help the aged.

2.1 Factors/ Causes of Ageing

The key question is what has brought about this increase in the percentage of older people within the population? We have, in previous sections, alluded to the two major mechanisms that have brought about changes in population structure: fertility and mortality. We now consider each of these in turn. In addition we also need to acknowledge the third, but less important factor which is migration.

As noted earlier, the age structure of any population is the result of the complex and dynamic interrelationship between three factors: fertility, mortality and migration. The increase in the proportion of the population classified as older is largely attributable to changes in fertility and mortality rates, migration has had much less of an impact upon the age structure population (although this is not true for all countries and may not be true in the future).

For understanding the factors of ageing, it is necessary to understand the concept of demographic transition.

2.1.1 Demographic transition

Demographic transition (DT) refers to the transition from high birth and death rates to low birth and death rates as a country develops from a pre-industrial to an industrialized economic system. This is typically demonstrated through a demographic transition model (DTM). The theory is based on an interpretation of demographic history developed in 1929 by the American demographer Warren Thompson (1887–1973). Thompson observed changes, or transitions, in birth and death rates in industrialized societies over the previous 200 years.

The transition involves four stages, or possibly five.

In stage one, pre-industrial society, death rates and birth rates are high; they essentially cancel each other out, resulting in zero or very low levels of population growth. All human populations are believed to have had this balance until the late 18th century, when this balance ended in Western Europe.

In stage two, that of a developing country, the death rates drop rapidly due to improvements in food supply and sanitation, which increase life spans and reduce disease. The improvements specific to food supply typically include selective breeding and crop rotation and farming techniques. Other improvements generally include access to technology, basic healthcare, and education. For example, numerous improvements in public health reduce mortality, especially childhood mortality. Prior to the mid-20th century, these improvements in public health were primarily in the areas of food handling, water supply, sewage, and personal hygiene. One of the variables often cited is the increase in female literacy combined with public health education programs which emerged in the late 19th and early 20th centuries. Without a corresponding fall in birth rates this produces an imbalance, and the countries in this stage experience a large increase in population.

In stage three, birth rates fall due to access to contraception, increases in wages, urbanization, a reduction in subsistence agriculture, an increase in the status and education of women, a reduction in the value of children's work, an increase in parental investment in the education of children and other social changes. Population growth begins to level off. The birth rate decline in developed countries started in the late 19th century. While improvements in contraception do play a role in birth rate decline, it should be noted that contraceptives were not generally available nor widely used in the 19th century and as a result likely did not play a significant role in the decline then. It is important to note that birth rate decline is caused also by a transition in values; not just because of the availability of contraceptives.

During stage four there are both low birth rates and low death rates. Birth rates may drop to well below replacement level as has happened in countries like Germany, Italy, and Japan, leading to a shrinking population, a threat to many industries that rely on population growth. As the large group born during stage two ages, it creates an economic burden on the shrinking working population. Death rates may remain consistently low or increase slightly due to increases in lifestyle diseases due to low exercise levels and high obesity and an aging population in developed countries. By the late 20th century, birth rates and death rates in developed countries leveled off at lower rates.

To understand why this is not so it is necessary to understand the four technical dimensions of the phenomenon. They are: numerical ageing (the absolute increase in the numbers of elderly), structural ageing (the increasing proportion of the population that is 'old'), natural decline (which occurs if/when deaths exceed births) and absolute decline (which occurs if/when migration is insufficient to replace the 'lost' births and increased deaths).

2.1.2 Numerical Ageing

Numerical ageing refers to the absolute increase in the numbers of elderly. The increase is primarily due to improvements in life expectancy. During the early stages of the demographic transition, the changes drive a massive reduction in infant and child mortality and dramatically increase the probability of people surviving to old age. As a result of declines in mortality, life expectancies have increased. The term 'life expectancy' refers to the number of years that individuals in a particular population (typically that of a country or a region) or a population subgroup (typically based on gender and/or age) can expect to live, assuming that they adhere to the average pattern as based on past evidence and future projections of lifespans.

In India, life expectancy at birth has increased from 59.7 yrs. For male and 60.9 years for female in 1991-95 to over 62.6 for male and 64.2 for female in 2002- 2006. Increasing life expectancy is leading to increasing number of elderly persons in the population, for which specific health facilities will need to be provided.

The improvements of the past 50 years in the field of medicine, technology, education and economy are now beginning to show in a sizeable increase in the number of people reaching old age. Numerical ageing is also 100 per cent guaranteed because those who will be 65+ in ten years' time are already 55+; we know how many there are and the rate at which they will grow. Current birth rates will have no effect on numerical ageing for 60– 70 years.

As the below figure shows, numerical ageing is also now beginning to escalate. Improved life expectancy has contributed to an increase in the number of persons in the age group of 60+ from only 12 million in 1901 to 20 million in 1951, 57 million in 1991 and 77 million in 2001. The proportion of the elderly population rose from 5.96% in 1971 to 6.48% in 1981, 6.80% in 1991 and 7.47% in 2001. This is true of other older age cohorts too. The elderly population in the 70+ age group was only about 11 million in 1971 that rose to about 15 million in 1981, 20 million in 1991 and alarmingly to 21 million in 2001. There were about 130,352 centenarians in 1961 that increased to 132,839 in 1971, and 151,646 in 1991. In 2001, the population of the 80+ age group increased to over 8 million who are of major concern to our society. The volume of supportive socio-economic and emotional infrastructure needed for this fast growing population is huge and it's a big challenge of the planners in the years to come.

The ageing process in India is therefore undergoing at a fast rate. Moreover, the transition from high to low fertility is expected to narrow the age structure at its base and broaden the same at the top. In addition, improvement in life expectancy at all ages will allow more old people to survive, thus intensifying the ageing process

Number and Proportion of Elderly in the Indian Population by Age Groups, 1971– 2001

Age/Year	Number				%			
	1971	1981	1991	2001	1971	1981	1991	2001
60+	21375281	27681981	35607475	47323734	3.90	4.16	4.27	4.61
70+	8124272	11358638	14699654	21259869	1.48	1.71	1.76	2.07
80+	3200178	4126765	6374511	8038718	0.58	0.62	0.76	0.78

Source: Chakrabarti, S. & Ashis Sarkar (2011).

2.1.3 Structural Ageing

Structural ageing refers to the increase in the proportion of the population that is elderly. It is primarily caused by declining birth rates/ fertility rates which decrease the proportion of the population that is young and thereby increase the proportion that is old.

Whether a population of any country is “young” or “old” is mainly determined by the fertility of the woman in that country. When the fertility is high, and the number of children borne by the women is large, then the population is “young”. On the other hand, when fertility is low, birth rates are low, the number of children borne is low, and then the population is “old”. Hence, the fertility rates or birth rates are determinants of the population ageing.

Before the mid-twentieth century, average levels of human fertility were high. Although for Indian women, marriage was both early and universal, there was little or no practice of deliberate birth control, and therefore, fertility level was high for several years. During 1901-51, the crude birth rate was about 45 - 47 births /1000 population (Visaria and Visaria, 1982). The birth rate fell during 1941-51 probably due to the Bengal famine (1943-44) and the Partition. However, fertility increased modestly during the 1950s and 1960s possibly as a result of the medical advances in coping with malaria (Bhat, 1998).

Declining fertility rates are a result of several combined factors, namely economic development and industrialization (rising wealth, improvements in material conditions, healthcare, lifestyles and wider availability of birth-control measures), changes in values (reduced demand for children, shifting priorities), and higher education and employment rates, particularly for women.

In short, some experts argue that increased educational attainment for women is likely to reduce unwanted childbearing (owing to greater access to contraceptives) and to postpone childbearing as a whole as women enter the labour market and have access to a career (Lutz & KC 2011). The evidence shows that women with higher education levels have fewer children than those with low education levels, and that their children have lower mortality rates and higher survival rates (Lutz & KC 2011).

At the same time, the large-scale entry of women into the labour force will contribute to raising the opportunity costs of having and raising children, as individuals prioritise their career and delay childbearing, especially as globalisation increases competition for work and hinders stability (Jackson et al. 2008; Lutz 2007).

Experts claim that the resulting empowerment of women and growing wealth are likely to lead to changes in values that will affect fertility rates in several ways.

Firstly, the rise of a global middle class may favour a new middle- class ethos emphasising the 'quality' rather than the 'quantity' of children, and give rise to new cultural attitudes such as individualism and independence (Birks 2007). The rise in such values will be partly linked to decisions about smaller family sizes in affluent societies, owing to some extent to competing decisions about the consumption of goods (Becker & Gregg Lewis 1974; European Commission 2012b; Jackson et al. 2008).

Birth Rate and Fertility Rate:

The all India birth rate fell from about 35.6/1000 in 1971-75 to around 26.6 /1000 in 1997-98. The total fertility rate (TFR) dropped from about 5.0 births per woman in the early 1970s to 3.5 births in 1994-96 and further to 3.3 in 1997-98. It can be said that in recent three decades, fertility per woman declined by nearly 50 percent.

Both crude birth rate (CBR) and Total Fertility Rate (TFR) are much higher in rural India than the urban areas. However, these declined over the years due to emergence of necessity of family planning through contraception measures. As a result, fertility fell first in the urban areas and then slowly in the rural areas. Between the early 1970s and the late 1990s, the urban TFR fell from about 3.9 to 2.4 births / women, while the rural TFR fell from 5.2 to 3.6 births / women.

Fertility Status of India, 1971-1999

Period	Crude birth rate (per 1000)			Total fertility rate		
	Total	Rural	Urban	Total	Rural	Urban
1971-75	35.6	37.2	29.3	5.0	5.2	3.9
1976-80	33.4	34.7	28.1	4.5	4.8	3.4
1981-85	33.6	35.2	28.1	4.5	4.8	3.4
1986-90	31.4	33.0	26.1	4.0	4.3	3.0
1991-93	29.1	30.7	23.7	3.6	3.9	2.7
1994-96	28.2	29.9	22.5	3.5	3.8	2.6
1997-98	26.6	28.2	21.1	3.3	3.6	2.4

Source: Registrar General, India (1999a, 2000a)

Again it should be noted that, over the longer term, migrants also grow old, adding low fertility, thereby adding to structural ageing at both ends of the equation. The extent to which structural ageing will continue and deepen is thus primarily dependent on what happens with the birth rate. Demographers around the world agree that it is unlikely that fertility will ever return to its baby boom levels. A baby boom is any period marked by a greatly increased birth rate. This demographic phenomenon is usually ascribed within certain geographical bounds. People born during such a period are often called baby boomers. The conditions that facilitated that boom have changed fundamentally; it would take profound social change to see today's women deliver an average of three births.

2.1.4 Natural Decline

Together, numerical and structural ageing usher in the third dimension of population ageing. A point of clarification is often needed when this dimension is outlined: if life expectancy is increasing, why is it that deaths will increase? The answer is simply a numbers game. Life expectancy has indeed increased, and is still doing so, but people cannot live forever—more elderly eventually means more deaths. A fall in the death rate has a more complex effect. A lower rate of infant mortality results in an increase in the number of very young children, thus leading to rejuvenation, just as a rise in the birth rate would do. On the other hand, a fall in the death rate of old people obviously leads to population ageing.

Mortality rate

During the period 1947-70, the mortality rate fell considerably due to reductions in several major communicable diseases and the absence of major famines. However, many infant and childhood diseases remained prevalent, tuberculosis contributed to high levels of adult morbidity (and significantly mortality), and malaria began to re-emerge after a period when it had seemed to have brought under control. The mortality rate continued to decline fairly steadily during the last three decades of the twentieth century.

Changes in India's record in mortality and health are best understood in historical perspective. India's mortality improved quite significantly during the first 25 years following independence. Indeed, between the mid-1940s and the mid-1960s average life expectancy at birth increased almost by 12 years. It was a significant achievement. However, the mortality and health disadvantages suffered by females became much more evident because, for the first time since estimates became available (Visaria, 2004).

The steady decline in mortality that was clearly evident in the 1950s and 1960s continued during the last three decades of the twentieth century. The crude death rate declined from almost 16 deaths/1000 population during 1971-75 to under 9/1000 by 1999. Furthermore, life expectancy at birth for both sexes combined rose from about 50 years in 1971-75 to around 61 years by 1993-97. During 1971-75, male life expectancy exceeded that of females by more than one year, but in the mid-1990s the situation reversed. Between the early 1970s and the end of the 20th

century the gains in female and male life expectancy were by about 12 and 10 years respectively.

In general, mortality rates have been generally higher in rural areas. In the mid-1990s, the life expectation of males in urban areas was some 6 years more than that of their rural counterparts. With average life expectation of almost 68 years, urban females in the mid-1990s had a life expectation that was almost 8 years more than the figure prevailing in the rural areas. During 1971-75, the urban population of India outlived the rural population by about 10.9 years. By 1992-96 this differential had fallen to just 6.9 years.

Table: Mortality estimates for all India and by rural-urban residence, 1971-2000

Period	Crude death rate (per 1000)			Life expectancy at births (years)					
	Total	Rural	Urban	Male			Females		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
1971-75	15.5	17.1	9.8	50.5	48.9	58.8	49.0	47.1	59.2
1976-80	13.8	15.0	8.9	52.5	51.0	59.6	52.1	50.3	60.8
1981-85	12.1	13.3	7.9	55.4	54.0	61.6	55.7	53.6	64.1
1986-90	10.6	11.6	7.3	57.7	56.1	62.0	58.1	56.2	64.9
1991-95	9.5	10.4	6.6	59.7	58.5	64.5	60.9	59.3	67.3
1996	9.0	9.7	6.5	60.1	58.9	64.9	61.4	59.8	67.7
1997	8.9	9.6	6.5	60.4	-	-	61.8	-	-
1998	9.0	9.7	6.6	-	-	-	-	-	-
1999	8.6	9.4	6.3	-	-	-	-	-	-
2000	8.5	9.3	6.3	-	-	-	-	-	-

Notes: for each period the rates shown are averages of respective annual estimates. The life expectations shown against the year 1996 actually relate to the period 1992-6 and those shown against the year 1997 relate to 1993-7.

Source: Registrar General, India, Sample Registration Bulletin, Ministry of Home Affairs, New Delhi (various years); Registrar General, India (1999a)

2.1.5 Absolute Decline

Where there is insufficient migration to replace the 'lost' births and increased deaths, then it is called absolute decline. However such situation is still far in Indian case. This is demonstrated by the fact that, the population of India increased by a whopping 180.6 million during the decade 1991 - 2001. Although the net addition in population during each decade has increased consistently, the change in net addition has shown a steady declining trend over the decades starting from 1961. While 27.9 million more people were added between the decade 1981 - 1991 than between 1971 - 1981, this number decline to 17.6 million for the decades between 1981 - 1991 and 1991 - 2001. This implies that although India continues to grow in size, its pace of net addition is on the decrease.

2.1.6 Premature Ageing

Further clarification of one issue referred to above—migration-driven population ageing—is important. A population can age for any or all of four reasons: low fertility, increased life expectancy, migration-driven gains at the older ages, and migration-driven losses at the younger ages.

Because the latter tends to pertain to the reproductive age population, there is a double impact because of the loss of the children those people have taken with them and/or would have had. The trend has been termed 'premature ageing'. If compounded by migration gains at older ages, structural ageing is even more accelerated. It is possible to identify the age groups which are affected by changes in fertility and mortality, it is not difficult to make firm generalizations about the effects of these factors on age structure of a population. However, no such general rules can be laid down with respect to the effects of net migration on age structure.

2.2 Changing Family and Ageing

The most influential and important of the social domains which shape the experience of ageing is that of family and wider social relationships. Over the life course individuals belong to a variety of kinship and social groups, all of which bring interactions and relationships with family, friends and neighbours. They also provide us with many of our major social roles such as parent, child and spouse. The extent to which an older person is enmeshed within a social network of kin, friends and neighbours will greatly influence her/his experience of ageing. The availability of, and quality of, family and wider social relationships are very important factors in the quality of life experienced by older people and provide a major resource with which the aged can challenge the stereotypes associated with ageing and later life.

Writing in 1997, Chris Phillipson evoked the words of Peter Townsend...

"If many of the processes and problems of ageing are to be understood, old people must be studied as members of families (which usually means extended families of three generations); and if this true, those concerned with health and social administration, must at every stage, treat old people as an inseparable part of a family group, which is more than just a residential unit. They are not simply individuals, let alone 'cases' occupying beds or chairs. They are members of families and whether or not they are treated as such determines their security, their health and their happiness".

According to Phillipson et al. (2001) that the experience of growing older is not shaped solely by family and kinship groups but also encompasses wider social relationships such as friends and neighbours and other social activities. Rowe and Kahn (1997) state that social engagement is a prerequisite for 'successful ageing'.

Jerrome (1993) suggests that five sets of factors have influenced the family relationships of older people.

First, demographic changes have changed the 'distance' between generations and have fundamentally altered the size and age distribution of families. This change in the nature of

family structures has been described as the 'beanpole' structure of long slim family structures created because of increased longevity and decreased family sizes. This has resulted in the creation of family structures in which four or five generations are present but size of each generation of family is small.

Second, changes in employment have altered gender relationships within the family context. Women who were mostly responsible for care of the elderly are actively participating in work force.

Third, legislative change, especially regarding divorce, homosexuals, has affected the structure and composition of families. There is emergence of single parent household, childless couples

Fourth, ideological change i.e. change in value system has altered the way care is provided for dependent people and has resulted in changes within families in terms of expectations of marriage and parenthood.

Finally, rising levels of economic prosperity and the provision of welfare benefits has served to loosen the economic ties within families. In contemporary western societies older people are not, generally, directly economically dependent upon younger members of their families, although there are obvious financial co-dependencies across the generations.

All of these factors combine to influence the family context within which older people experience old age.

Most unpaid care for older people is provided either by their children or by their spouses or partners. Overall, older people aged 65 to 79 are net providers of care to family members (partners, children and grandchildren), while those aged 80 and over are net receivers.

➤ **Let us think**

What is a family?

Defining precisely what does, and does not, constitute a family is a question which policy makers, politicians and sociologists are concerned. What type of living arrangements are described and classified as a family is remarkably problematic. Are gay couples a family? Are children required to be present before the term 'family' can be applied to a living group? Clearly the way the 'family unit' is defined is, at least to some degree, an ideological construct. Some would argue that the term 'family' could be applied only to a heterosexual married couple with children —the stereotypical 'nuclear' family. Others would include single parents, cohabiting or gay couples within the term 'family'. Another way to define 'family' is by the number of generations included within it. A 'typical' nuclear family would constitute of two generations: parent(s) and children. Indian society is known to consist of three generational family, although examples of up to five generations living together have also been found.

A further distinction may be made between the term 'family' and the wider notion of the kinship group. De facto the term 'family' has become virtually synonymous with the concept of the nuclear family. Consequently Finch (1989a) suggests that the term 'kinship

group' should be used when considering the web of wider blood relationships which extends beyond the immediate household while the term 'family' is restricted to groups of co-resident or immediate blood relatives. Again such definitions may be expanded to include the relationships resulting from the 'blending' of groups via (re)marriage, divorce and cohabitation.

Regardless of how the concept is defined, families and kinship groups have been seen as being especially important for older people. Shanas (1979) proposed the primacy of the family for older people because family acts as the primary and favorable source of support whether emotional or instrumental for old people. Proponents of disengagement theory proposed that family relationships are more important for older people because of their loss (or disengagement) from other social spheres such as employment.

More recently, notions such as 'successful' ageing continue to state that social relationships and family bonding helps in participation and enhancing, quality of life in old age. Furthermore, early gerontological research accepted the highly gendered nature of family relationships and posited that women experienced ageing less problematically than men because of their more central location within family relationships and because of the enduring nature of these relationships. Throughout their adult life course women are often defined by their 'caring' relationships such as mother, wife and grandmother rather than by occupational status. Such simplistic notions have been replaced but they have enduring implications because assumptions such as these influenced the type of research questions that have been asked about families and family relationships.

Much of our knowledge of the family life and social relationships of older people is derived from studies concerned with 'caring' and the provision of care within families. Thane (1998) also notes that early gerontological studies were highly uncritical of the data they collected about intergenerational relationships and missed many of the potentially existing tensions. Despite this, Thane (1998) concludes that the family remains central to the experience of old age and later life and indeed other phases of the lifecycle and that this represents a continuation of the broad pattern established across a long historical perspective

Social and political commentators on the family, especially in its relationships with older people, have shown a very narrow and pessimistic picture of the family in modern industrial society and they criticize the neglect of older people by their family members. Cicero, in his study of old age, lamented that families were not what they used to be, especially in the way that they cared for and respected their elders. However, Thane (1998) disagrees with this illustration of neglect of old people and the notions that older people were marginalised by families because of spatial separation. She perceives that along with many other social factors, such as the behaviour of children or relationships with older people, the extended family has been idealised and the nuclear family has been portrayed negatively or at worst 'demonised' as a selfish and 'uncaring' form of family organisation.

Social change is almost universally characterised as having a highly negative and damaging effect upon the social and family circumstances of older people. Hence the move towards nuclear families has been lamented without recognition that the family is a very flexible unit which demonstrates a pattern of almost continual adaptation to changing political, social and economic circumstances.

What types of families did older people live in: anhistorical perspective?

As with many other facets of the social world, it is difficult to reconstruct the different types of families in which older (or indeed other groups) lived at different historical time points. Thane (1998) notes that there is lack of empirical data and suggests that, in the absence of empirical evidence, there is an over-reliance upon anecdotal or highly localised material. The dearth of extensive empirical data means that pre-industrial times are often portrayed as the golden age of both the family and 'ageing', when older people were both respected and cared for by their own families with whom they lived. Wilson (2000) suggests that every age 'invents' its own 'golden age' as a response to the challenges and vulnerabilities posed by their own experiences. Two interrelated assumptions govern our predominant stereotypical and rather idealist historical view of family relationships. The first is that the extended family was the most common, indeed potentially universal, pattern of family organisation. The extended family constituted the 'social norm'. Second, this view assumes that because older people lived in the same dwelling as the rest of the family, they were cared for by the family and remained respected members of the kin network.

It is necessary to find out how realistic these two separate but clearly interrelated stereotypes are.

This idealistic view of the past is highly simplistic and not supported by the available evidence. Historical research suggests that there is no single type of household or family unit that typifies pre-industrial society, as there are variations both over time and between different societies (Thane, 1998). This is exactly the same as the current situation where the pattern of families varies considerably between countries and cultures and is constantly evolving in response to social change.

The second assumption implicit within the 'rose-tinted' perspective upon the past is that co-residence would ensure that older people were loved, cared for and respected. As we know with child and elder abuse evident in modern families' co-residence does not automatically and inevitably result in love, respect and care between or across generations. Hence for previous times in our history there is little direct evidence to support the assumption that co-residence with younger family members necessarily guaranteed that older people would be well cared for. There is also an opposite argument. Qureshi and Walker (1989) note that family care represents the extremes of quality, offering examples of the 'best' and 'worst' types of care. It was fairly common practice in pre-industrial societies for older people and their children to draw up legal contracts and wills in which property was exchanged for care and maintenance in old age. When considering the family relationships of older people at previous points in our history, we need to try to distinguish reality from ideological wishful thinking.

2.2.1 Indian Scenario:

However, in case of India, in traditional Hindu society, the eldest son not only had the obligation to take care of the old parents but also to perform their obsequies. The Upanishads extol the virtue of filial duty and exhorts the young to adore and revere their parents and worship them as God. The Manusmriti further elaborated this concept and declared that all troubles that the parents have gone through in raising their children cannot be adequately compensated by children even if they serve them for hundred years. The Puranic story of Shravan Kumar gives a fair idea of importance of elder's care in olden times in our country, the socio cultural context of ageing and how the filial responsibilities were carried by Indians. The story glorifies the relevance and relation to old age, where, in the act of serving the old parents, Shravan Kumar lost his life

Traditional Indian society was predominantly rural in character and there was no formal age at which one was to withdraw or disengage from work. People continued to work as long as their health permitted. The ceremony of Shashtyabdapurti or completion of sixty years of life was observed and celebrated by all but this was more as symbolic ritual and carried no compulsion to retire from work, even though, for those who wanted and who could afford, this could be used as an occasion for change of life (movement from Garhasthya to Vanaprastha). The Ashramas were meant mostly for the upper castes, who were comparatively affluent and could afford the luxury of a peaceful retired life. The vast majority of the lower caste people continued to work till their health permitted. For, their major (and sometimes only) asset was their labor. As their family had no built in provision for the care of the old, the short span of life and poor health in the later years brought death and also resulted in burden on the family as it had to maintain them during their unproductive years.

However, it must also be noted that the joint family which stands as a unique institution of traditional Indian society provided social security for family members. This is culturally idealized form of Indian family has set down the authority of the elderly. Members were trained and socialized from childhood and guided through life by the rules of conduct set by the elderly of the family in preparation for roles which they were destined to play later in life. Thus, the grandmother was the reigning female and a highly respected figure while the grandfather was the revered patriarch whose whim was the law for the family and controlled all the economic and social affairs in the joint or extended home. In the patriarchal Hindu joint family, the oldest male member was the head of the family. He had two distinct but interrelated roles, namely as an economic head and a social head. Performance of the social role was always related to age and this was recognized and accepted by both family and society. Older people were respected for their wisdom and were provided with security and companionship within a three or four generation household.

Post-war changes

At the macro level numerous changes have taken place in the Indian society as a whole. Colonization of the Indian society exposed it to new cultural values and belief systems and erosion of the economic roots. This process has its concomitant echoes in the social and cultural fabric of the Indian society. After independence India vigorously moved onto the path of social progress and economic development.

Industrialization, physical separation of parents from the adult children as a result of rapid urbanization and age selective rural urban migration affected the family's solidarity and competence in providing care to all its members. The notion that the family may look after its aged members gradually started losing meaning and reverence due to ongoing socio-economic and demographic changes. It has also been reiterated by Gangrade (1999) that Indian society however, had been undergoing rapid transformation under the impact of industrialization, urbanization, commercialization, individualism etc. Consequently, the traditional values and institutions are under the process of adaptation and had often led to sharpening of intergenerational differences.

Some of these changes are as follows:

- Commercialization, industrialization and modernization of the Indian society paved the way for replacing joint families by establishment of nuclear families consisting of only husband, wife and their children.
- Change in the status and role of women in the family and society together with the changing values of the younger generation towards the older people.
- The dependency of family on agricultural income has lessened due to which the centralized power structure of the family system has weakened. The absolute and unquestionable authority of elderly persons has started shrinking gradually.
- The increase in the life expectancy is not accompanied with health and well-being. With the onset of old age, health related problems increase making the elderly dependent on others for the fulfillment of their physical and psychological needs. The situation requires constant care and supervision but also drains the resources of the family.
- The paucity of dwelling units and high cost of living in cities and metropolitan areas makes difficult for the large family to survive. As such elderly are mostly not welcomed, in small houses with low income.
- Technological advancements have also adversely affected the older persons. Earlier, they were storehouse of anecdotes and stories for grandchildren before TV, videogames, comics and Internet robbed this role from them.

The cumulative effect of industrialization, urbanization and modernization challenged and in many cases weakened the traditional value system. Since the position of the old in the family was based on these values, their position was naturally threatened. Many studies indicate that the condition of the aged in many families is deteriorating. The phenomena of longer life span contributed by better medical and health care services has advanced life by at least two decades. This has given rise to two new problems for the family: 1. The generation gap has now widened further. 2. Families face difficulty in providing economic support and meaningful social role to the aged in this extended period of life.

2.2.2 Living Arrangement

The term 'living arrangement' is used to refer to one's household structure (Palloni, 2001). The term is usually used to determine the number of people an older person lives with, the relationships between them, and the location of the household, i.e. community or institution. Irudaya Rajan et al. (1995) explains living arrangements in terms of the type of family in which the elderly live, the headship they enjoy, the place they stay in and the people they stay with. The two rounds of surveys of NSSO give information on living arrangements of the elderly. The 2004 results for Orissa showed that about 50 per cent of the aged were living with their spouses and other members, and another 30 per cent were living without their spouses but with their children, while about three per cent were living with other relations and non-relations. Nevertheless, about 12 per cent were living with their spouses only while about 3 per cent were still living alone. Moreover, the living arrangement of the aged has changed to some extent since 1995-96. A comparison of data between these two survey periods (1995-96 and 2004) reveals the following about living arrangements in Odisha:

1. The proportion of the aged who lived with their spouses only had gone up significantly from 8 to 12 per cent in urban areas and remained the same in rural areas.
2. The proportion of the aged who lived with their children only had however, decreased from an already low of 31 per cent to 26 per cent in urban areas. On the other hand, the proportion of the aged who lived with other relations and non-relations had increased from 3 per cent to 5 per cent in urban areas. This probably reflects the further weakening of the extended family system in the state as evidenced in other part of the country.

However the status of household headship of the elderly in India depicts a different picture.

Household Headship	<i>All Areas</i>			
	Men		Women	
	1992-93	2005-06	1992-93	2005-06
All (60+)	78.1	82.8	12.8	20.7
Age Categories				
60-64	83.8	88.2	13.4	19.7
65-69	82.2	85.8	12.6	21.9
70-74	77.2	79.7	13.6	22.7
75-79	66.8	77.6	11.6	21.7
80+	58.0	65.8	10.8	17.2
<i>N</i>	20,662	22,770	18,089	22,027
<i>Rural</i>				
	1992-93	2005-06	1992-93	2005-06
All (60+)	77.1	82.3	15.1	19.3
60-64	83.8	87.5	12.2	18.3
65-69	82.2	85.3	11.2	20.7
70-74	77.5	78.9	12.9	20.9
75-79	67.0	78.0	11.8	20.6
80+	60.0	65.0	12.0	15.9
<i>N</i>	16,090	16,588	13,646	15,806
<i>Urban</i>				
	1992-93	2005-06	1992-93	2005-06
All (60+)	78.3	84.4	12.1	24.3
60-64	83.9	89.8	16.9	23.6
65-69	82.3	87.1	16.7	25.0
70-74	76.3	82.0	15.8	27.1
75-79	66.2	76.7	11.0	24.4
80+	50.4	68.2	7.2	20.4
<i>N</i>	4,572	6,183	4,443	6,221

Age-wise analysis of elderly headship rate indicates an inverse relationship between advancing age and elderly headship. In other words, as the age of the elderly increases, the percentage of the households headed by the elderly tends to reduce. While this explanation suffices for age-wise analysis, on the other hand, if trends between 1993 and 2006 are observed, the elderly men and women headship rates for all age-groups have increased. One plausible explanation is that the elderly life-expectancy is increasing and furthermore with women outliving men in older ages, women household headship rate has increased at higher pace than that of men. This finding also reaffirms that in extended family households, age of the eldest person is still a significant factor in determining or rather reporting as the head of the household in census or surveys despite the fact that other earning members might still be the decision makers.

The 2011 Census results on housing data have also clearly pointed out that the number of households has increased substantially in the last decade and the number of persons per

household too has come down. A combination of declining fertility, migration and nuclearisation of families are three possible reasons for such reduction in the household size implying the need for ensuring appropriate systems to address the declining support base.

2.2.3 The decline of the multigenerational household

	Living Arrangement	Persons		Men		Women	
		1992-93	2005-06	1992-93	2005-06	1992-93	2005-06
A	Living alone	2.4	5.0	1.4	2.6	3.5	7.6
B	With spouse only	6.6	13.7	7.5	15.9	5.6	11.5
	Sub Total (A + B)	9.0	18.7	8.9	18.5	9.2	19.1
C	With spouse, children and grand-children	52.8	48.3	69.9	65.5	33.5	30.5
D	With children and grand-children	28.8	27.2	14.9	12.4	44.5	42.6
E	With married daughter	3.0	2.9	1.3	1.4	5.0	4.4
	Sub Total (C+D+E)	84.6	78.4	86.1	79.3	82.9	77.5
F	With other relatives	5.1	2.4	3.7	1.7	6.7	3.1
G	With non-relatives	0.3	0.2	0.4	0.2	0.3	0.1
	Sub Total (F+G)	5.4	2.6	4.1	1.9	7.0	3.2
	Don't know	1.0	0.3	0.9	0.3	1.0	0.2
	<i>N</i>	38,751	44,797	20,662	22,770	18,089	22,027

Analysis of data in the above table reveals that the percentage of elderly men and women living alone too has increased and has doubled in the 13 years with a larger percent of elderly women living alone. Concerning co-residence with other family members, a differential gender pattern is observed. While a large percentage of elderly men live with spouse, children and grandchildren, it is found that elderly women live with children and grandchildren only (minus spouse). Since a majority of elderly women are widowed, perhaps, a higher proportion is found in this category. Rural and urban areas confirm to the overall trend but percent of those living alone was higher in rural areas than in urban areas. The finding is reinforced even when household is treated as unit of analysis as it shows that a higher proportion of the elderly females live as single members as compared to males (Tyagi 2010). Even, co-residence between older people and their younger relatives (including both children and grandchildren) is becoming an increasingly rare feature of western society (Glaser, 1997).

Although there has been a separation in terms of distance where families move into separate living groups, but still family ties are clearly being maintained and older people, like most of the rest of the population, consider themselves to be members of wider family groups. Again decline in co-residence cannot be used to make any inferences about the nature and quality of relationships between family members.

2.2.4 Intergenerational Relations in India

In India, Intergenerational relations are represented by the works of Sinha, 1972; Gangrade, 1975; Rath, 1971; where they have tried to understand the phenomena of generation gap with the differences on values and attitudes between generations. Rath (1971) in his study found the older generation to have a positive attitude towards religion and negative attitude towards science whereas for the younger generation it is vice-versa. The younger and older generations differ significantly on the meaning given to god and religion (Mishra and Prasad, 1978). Younger and older peoples' perceptions towards old age reveal a pre-dominance of negative attitudes and beliefs indicating minority group position for the older people. Though differences were not only in matter of attitudes, other factors like future, financial insecurity, perception of the problem, role activity and status of elderly in the family too lead to conflict in the relationships (Prakash, 1996). Besides, the literature also suggests that if the generations shared values norms and cultural traditions, i.e. (manifestations of shared values & norms). Grandparents provide care to grand children in financial constraints, grandmothers help bring up the grandchildren, they had higher social adjustment and were willing to take up child care activity, and such elderly who participate in family processes and society experience Solidarity type of relationship and satisfaction (Chaddha & Mongia, 1997; Chaddha & Kolt, 2004; Panda, 2004; Sonar & Prasad, 2004).

Beside this another aspect of the study is to see the interaction pattern generational relations and role of demographic variable like location (rural/urban), education on Intergenerational relations. In the study of intergenerational support it was found that intergenerational support is less common in urban areas than rural locations. Intergenerational gap was more pronounced in urban families between older and younger generation than in the rural families (Martin, 1990; Mishra & Tiwari, 1980, Bhingradiya & Kamla, 1997). In context of education, Vermani and Sharma (1979) found that younger generation carries negative attitudes towards older generation. These negative attitudes are further strengthened among young generation respondent because they have higher level of education, thus negative attitudes towards the older generation increase with increasing education levels. However, Bhingradiya & Kamala (1997) contend that Education and modernization reduce the intergenerational problem within the rural family.

2.2.5 Family and social changes that shape the experience of old age

Marriage and divorce: lonely old age?

Patterns of marriage and divorce influence the number of people who are seen to be 'alone' (although not necessarily childless, friendless or even partner less) in old age. However, a number of factors need to be taken into account in order to obtain an accurate picture of the impact of marriage and divorce rates. In many societies co-habitation without marriage has become a popular choice that can persist into old age. For this reason, marriage statistics increasingly need to be accompanied by information about the proportion of people living in consensual unions or co-habiting. Divorce rates are not a particularly reliable guide to the future numbers of older people living without a spouse or a partner. If divorce is followed by remarriage, the result may not be just the presence of a partner in old age but also the presence of a new kind of 'extended' or 'reconstituted' family with children (and other relatives) from the previous unions and possibly the new union also.

Given that 'reconstituted families' formed as a result of divorce and remarriage are a relatively new phenomenon, it is too early to predict what their impact on life in older age is. However, it is probably safe to say that the increase in the number of relationships in 'reconstituted families' does not automatically translate into increased support for older people. Whereas 'combining' children from previous and new relationships or marriages results in a larger total number of children that one is 'related to', however, this does not necessarily translate into the ties of mutual obligation and affection (Dimmock et al. 2004). Similarly, it would be wrong to assume that divorce and remarriage dilute all feelings of affection, resulting in lack of support or contact with one's own children in old age.

Indeed, there appear to be significant gender differences here. While divorce frequently leaves the relationship between the mother and child(ren) intact or even stronger than before, divorced fathers' contact with their children is often decimated, and sometimes leads to negative consequences for contact, support and care in later life.

Co-habitation of older adults may have a more stable and lasting nature than co-habitation among younger adults, and indeed many older adults may have a preference for a living apart together (LAT) relationship where a couple relationship is forged while the partners continue to live in their own homes (Borell and Ghazanfaraeon Karlsson).

The impact of increased divorce rates can of course extend beyond the child-parent relationship and is often seen as having a negative impact on the grandparent-grandchild relationship. Maintaining contact with grandchildren can become problematic following the parents' divorce or separation if the children remain with the former son- or daughter-in-law. Paternal grandparents, in particular, are at a greater risk of losing contact with their grandchildren following divorce or separation (largely for the simple reason that, post-divorce, children typically remain with their mother). However, it is also possible that divorce leads to a much closer relationship between a grandchild and (one or more of the) grandparents if some or even the bulk of the responsibility for raising the child is transferred to the grandparent(s) (Cox 2000). Similarly, the ageing parents of never married single parents can end up playing a central role in raising their grandchildren in the absence of the other parent.

Lower fertility rates: no children to turn to in old age?

As was pointed out earlier, the drop in fertility rates is one of the important global trends that have brought about population ageing. It is tempting to think that this fall in the average number of children and the rise in childlessness will lead to old age being a lonely experience for many.

But the question arises does the transition from high to low birth rates translate into lack of supports in old age?

It cannot be denied that childlessness or the absence of children in older age as a result of migration, divorce, family enmity, social mobility or the demands of family and work on the younger generations can constitute a painful experience for some older people (Kreager and Schroeder-Butterfill 2005). However, several factors will mitigate the impact of smaller family size on the availability of support in old age. It is important to bear in mind that even though larger number of children were born to previous generations, fewer survived to the age where they could be useful to their parents in old age. If there are few children in a family, then the entire responsibility of old parents comes to them, which may increase their burden but the relationships between children and parents also becomes closer than in large families. In other words, when studying changing family size we should pay less attention to changes in the mean number of children, and more attention to the proportion of people with no children or only one child (Uhlenberg 1993, 1995).

For previous generations the primary reasons for childlessness in old age were poverty or high infant (and adult) mortality, the primary reason for current generation lies in individual and lifestyle choices, in other words, the deliberate decision to remain childless. At an earlier stage in history, a woman may have given birth to, say, six children, but half of them may have died in infancy and the remaining three of diseases, in wars, accidents, and so on, before their mother reached old age (if the mother reached old age, that is). The proportion of people with no children or only one child is therefore prone to change: childlessness may decline among the next generation, only to increase again.

From adult children to spouse carers

It is important to note that the decline in the average number of children is in many countries compensated for by the greater propensity of older people to be married and by greater life expectancy of both men and women. Whereas in the past a widowed mother may have needed to turn to her child(ren) for support and assistance, spouses are now becoming an increasingly important source of family care in old age.

Peter Townsend (1957) describes in his seminal book on the family and community lives of old people in Bethnal Green, London, about the co-existence and in many case the co-residence of two or even three generations in a working class urban environment in the 1950s. A repeat study of older persons' lives in the same area carried out 50 years later found that the 'companionate marriage' had become the central focus of most older persons' lives and that two or three generation households had become very rare. This finding reflects the shift in the

sources of support from adult children (and the daughter–mother relationship in particular) to spouses. This, of course, means that often those who provide care and support to older people are older themselves, and may therefore require support in their caring role.

Another development that has led to an increase in the number of ‘spouse carers’ is the decline, in many countries, in the number of widows and the increase in the number of older women with partners (as a result of the narrowing gap in male and female life expectancies) (Pickard et al. 2000).

Overlapping generations: the beanpole family

Increased longevity in combination with lower fertility has led to the verticalization of family structures (Harper 2004). This term denotes the longer and narrower family structures or what is sometimes called the ‘beanpole family’ in reference to the (longer) co-existence of (fewer members of) several generations.

The likelihood that people in older age groups still have a surviving parent has increased: it has become the majority pattern to have a surviving parent at age 50 and it is increasingly common to have one even at the age of 60.

Young adults, too, are more likely to have a grandparent who is still alive. However, the incidence of four to five generation families naturally depends on the age at which people have children – if the age of childbearing is around 35, it is highly unlikely that more than three generations will coexist for any length of time. Very few individuals are currently members of five generation families and any increase in the prevalence of these particularly lengthy ‘beanpoles’ is dependent on a co-incidence of increased life expectancies and relatively young ages of (first) reproduction.

The duration of the period that people co-exist with members of different generations in their family has therefore been considerably extended. Many more individuals now stand a chance of building a long term relationship with their (great)grandchildren and (great)grandparents than was possible in the past. While the number of grandchildren is now smaller than in the past, more individuals survive to experience grandparenthood.

The ‘sandwich generation’ and women’s labour market participation

Fairly significant proportions of middle aged individuals (and women in particular) are engaged in providing care services to their parents. The term ‘sandwich generation’ refers to a group of people who have care responsibilities towards both their own children and towards their parents. There is much debate and anecdotal evidence regarding this generation (also sometimes referred to as ‘women in the middle’).

The concept of a ‘sandwich generation’ also gives rise to a number of issues regarding the definition of being ‘sandwiched’. What age of a child or how many children does a ‘sandwiched’ person have to have? Clearly, looking after a 2-year-old is rather different from looking after a 16-year-old, and having three children is more demanding than having one. Do we also make

holding a paid job outside the home a requirement for being sandwiched, and do we assume that adults engaged in home duties are better able to handle the pressures of being sandwiched?

The alleged crisis stemming from decreased supply of informal care givers as a result of women's increased employment outside the home is sometimes referred to as the 'care giving crunch'.

Older people's contributions to the resources and well-being of younger relatives

Most data and debates focus on care and support given by younger people to older people – this reflects of how research and policy embody ageism. However, it is important not to view social relations between families and older people as a one way process where older people are in need of and receive (or even demand, at whatever cost to others) various supports and services from younger relatives. Older people make very considerable care and financial inputs into their children's and grandchildren's lives. Research has shown that financial transfers within families are overwhelmingly from the older to the younger generation (Sundstrom et al. 1996). It is not uncommon for parents to make very substantial contributions to their adult children's purchase of a first home and other major investments.

In the area of care, too, the emphasis is usually on care given by younger to older generations: this tends to divert attention away from the very extensive inputs that older generations have into the care of younger generations.

Most contributions of older adults to younger generations are not systematically recorded.

For this reason, they tend to go unnoticed and are usually taken for granted despite the fact that their role in underpinning the formal economy and economic development is crucial. One major area of 'downward' intergenerational transfers of time is 'grandparenting'. This covers a large and varied area of care giving that is often of crucial importance for working, lone or otherwise pressurized parents.

Contact with family members

Even though, the elderly live separately from their family which may consist of their children, grandchildren and siblings, their physical proximity determines their frequency of direct contact. Other factors like health and income also determine their interaction in such cases. This type of living arrangement is commonly found in big and metropolitan cities where the couple want to maintain their privacy but at the same time be easily accessible to their parents. In many cases aged play the role of baby-sitter for their grandchildren.

However, the way in which social contact takes place between family members has changed markedly after internet and telecommunication revolution. Social contact can be achieved by other methods such as telephone calls, letters or now via electronic means. Thus geographical separation does not necessarily imply neglect or lack of contact between the older person and the family. This increase in the ways that social contacts can take place means that we need to

reconsider some of the simple assumptions underlying much research, which presumes that 'direct' face-to-face contacts are the most favoured and highly rated form of social contact. While this assumption may be justified for current cohorts, it may not hold true for future generations brought up on telephones, mobiles, text messaging, email and other newly emerging forms of electronic communication.

2.2.6 Friendship and social network in late life

Gerontological researchers have largely neglected non-kin-based social relationships. The assertion by Shanas (1979) of the primacy of the family in determining the social context of ageing resulted in many investigators ignoring the role and importance of non-kin-based social relationships. Clearly friends are also important for older people, as they are for people of other ages. Friendships, especially those of longstanding, can provide continuity across the life course.

Social network structure has a very meaningful and purposeful scope in the study of the elderly social support systems and their day to day activities. The questions that whether qualities can compensate for quantities can only be answered by the understanding about the patterns of their social network structure. A person who has larger social network linking to the community has greater probability to have better treatment, care and supports from members. On the other hand, members of the many traditional societies have intense fear of social sanction in his/her neighbourhood in which he/she lives and worked. The older people with large social support network, Chadha and Van Willigen (1995) found that they reported higher satisfaction than those with small network. Many studies on depressive symptoms (Dean *et al.*, 1992) psychological distress (Arling, 1987), functional impairment (Boult, *et al.*, 1994), and mortality (Boult, *et al.*, 1994; Sabin, 1993) provide evidence for the importance of social network. Shankardass and Kumar (1996) also found that an active support network strongly influenced the social wellbeing of the elderly. And those who had more contact with their family members, neighbours, and friends and also those who had someone in whom to confide, and had a more positive attitude towards living were found happy.

2.2.7 Loneliness and social isolation

Family and friends constitute an important component of the social context within which we experience ageing. Overall, levels of contact between older people and their family/friends remain high and older people are embedded within extensive social networks. The changed roles experienced with ageing, from employed to retired and from provider to dependant, makes older people prone to the experiences of loneliness and isolation. Loneliness as a concept is both theoretically and conceptually complex. At the most simple level, loneliness is concerned with how individuals evaluate their overall level of social interaction. Loneliness describes the state in which there is a deficit between the individuals actual and desired level of social engagement.

As such loneliness needs to be distinguished from three related, but not coterminous, concepts. These are being alone (time spent alone), living alone (simply a description of the household

arrangements) and social isolation, which refers to the level of integration of individuals (and groups) into the wider social environment.

2.2.8 The dynamics of family relationships

There are several key organising principles, which help us to understand the nature of family and kin relationships. The major social relations are based on the concepts of independence, reciprocity and obligation. The twin issues of dependence and independence are at the heart of understanding and analyzing family and kin group relationships. Children are dependent upon their parents while spouses usually exhibit mutually supporting dependencies. Much of the literature concerning kin relationships are the notions of obligation and filial responsibility. Much is written from a theoretical and conceptual perspective in the area. It is argued that it is level of obligation that distinguishes family relationships from friendship. This means at times of need or crisis, families are supposed to respond whereas friends are under no such 'obligation', although friends may well choose to respond positively to a crisis situation. As part of our family roles we all have rights but along with these come responsibilities. Clearly the rights and obligations we experience vary according to our status within the kinship network. The obligations of mutual care and support, which characterise the marital relationship, are not necessarily the same as those of siblings. The relationship between adult children and parents is qualitatively different from more distant kin relationships.

Reciprocity is a key organising principle of family and kinship groups (and indeed the world of wider social relationships). Reciprocity is concerned with "mutual assistance and transfers support (financial, physical or emotional) towards those family members who need it on the understanding that it will be 'repaid', in some form, at a future date (or where the help being provided is 'repayment' for support given previously)". Antonucci (1985) describes reciprocity as a support bank—'deposits' are made in the expectation of withdrawal at a later date. Gerontologists have tended to concentrate upon studying the role played by younger family members in caring for the older generation. There has been much less study of aid given by the old to the young. It is clear that flows of help between the older person and the family are not unidirectional and that there is a considerable degree of reciprocity within and between the generations. Where such reciprocity has not been built up across the generations, for example where parents have been abusive or neglectful of their children, then there are negative consequences of neglect when the parents become older.

Although Thane (1998) provides examples of where family care is provided in spite of poor relationships between parents and children, there is less certainty about such transfers of support and less 'moral' sanction if it is not provided.

"GROUNDS OF MUTUALITY"

It has been seen that in old age, individuals cease to play certain roles. This role loss may be due to death of a kinship member, retirement or resignation from associations. As a result of this, their role play is very much reduced and they start feeling lonely and isolated. But in Indian

context, one good factor is that the retired men and women have a whole new bunch of roles to play. They still have their roots in the family. Developing connections with a younger generation helps older adults to feel a greater sense of fulfillment. In fact, it is advantageous for both the groups as on one hand it helps the elderly transfer whatever they have achieved emotionally and socially in their entire life and on the other hand the kids gets multiple perspectives on reality which makes them more socially adjusted.

With the changing time, the employment of women has created a functional gap at home and that place has been readily filled in by the grandparents. The emotional care and safe atmosphere is been created by the grandparents at home itself. The grandparents extend a warm care to the grandchildren because they consider it their duty and privilege. The grandparents, by their presence provide peace of mind and trust in their children so that they perform their occupational role well. In spite of their own health problems, the elders manage to take care of the younger ones at a good level. In many industrialized societies the family system is disorganizing leading to several other social problems. But the situation in India is different. Migration, women's employment, new social institutions or the modern culture have not crashed down the social system as such. It is because of the bindings that exist within the family. The role of a mother or father for a short while is substituted by the presence of grandparents.

This kind of adjustment is serving two purposes simultaneously.

a) The problem of the care of the ageing population that threatens many societies is mellowed in India.

b) At the same time childcare, another essential familial responsibility is taken up by the elders. (Nalini, 1997)

The underlying sense of responsibility that goes with this is tremendous. The role of grandparents in children's lives is varied. It is imperial at times, muted at others and goes underground whenever required but the entire time solid and absolutely dependable. Grandparents often bridge the gap between parents and their children. Rebellious independent children who are trying to find their feet are almost always at loggerheads with their parents. The role of the grandparents can be very important here as they act as impartial judges and are able to convey their feelings to both parties. Grandchildren prefer to listen to the grandparents rather than the parents with whom they are unfortunately involved in everyday tussles. The sense of objectivity and the absence of bias lend a sense of credibility to their roles as mediators.

The socialization function of the family has been sustained by the inclusion of grandparents in the household. During the process of socialization, Indian grandparents teach their grandchildren practical abilities and provide them with information about their family and their past (Nalini, 1997). They also provide them with care and support, and act as role models and sources of ideas and reflection about human life. As agents of their grandchildren's socialization, grandparents are significant and contribute to their cognitive, moral and socio-affective development. This creates a close relationship between children's development and the roles played by their grandparents within the web of family relationships. It is been seen in the Indian culture that advice, education and reflection are more frequently attributed to grandfathers while affectionate relationships and care are attributed to grandmothers.

Grandmothers also tend to be more involved and intimate and act as substitute mothers when needed. Regarding developmental stage, while the grandchild is young, the grandparents' main roles are helping with his or her care, developing play behaviors, and stimulating them cognitively and emotionally, thus contributing to their affective, cognitive and social development. (Viguer, Carlos, Sandra, José, and Esperanza, 2010). But as the child grows, grandparents lend new focus to this interaction such as giving them company, advice, being supportive in parent-child relationships, helping when they need it, and mediating any conflicts with the parents. The grandparent role, then, may serve the function of friendship, companionship and solidarity.

In the Indian culture many children see their best friends in their grandparents and can express themselves without any fear of judgment and scolding from them. Such relationship between grandparents and grandchildren in our culture helps in a number of ways. Some of which are:

- Provide an opportunity for both to learn new skills
- Give the child and the older adult a sense of purpose
- Help children to understand and later accept their own aging
- Invigorate and energize older adults
- Help reduce the likelihood of depression in the elderly
- Reduce the isolation of older adults
- Fill a void for children whose parents are working
- Help keep family stories and history alive
- Helping in inculcating family values
- Giving them company, advice, being supportive in parent-child relationships, helping when they need it, and mediating any conflicts with the parents.
- Serve the function of friendship, companionship and solidarity.
- Explain them the importance of values like honesty, solidarity, togetherness, helping behavior with the help of moral stories and by playing role models.
- Making them aware of all the rituals and cultural heritage of India and its past.
- Imbibing in them a sense of proud of being a part of such a diverse cultural heritage.
- Bringing them close to their land by reciting folk songs and telling its meaning and importance in their lives.
- Try to bring in their interest in very small but very peaceful activities like planting seeds, bird watching, walking on grass etc.
- Grandchildren on the other hand try to make their grandparents more aware of the recent technology and its usefulness.

2.2.9 Family and Care of the Elderly

The needs of the elderly has been often taken care by the immediate family members. Personal care, economic and emotional support are provided by the near kith and kin. The task of providing care has traditionally been fulfilled by women in different capacities as spouse, daughter or daughter in law. In contemporary modern urban social set up women are

performing the twin responsibilities of being homemakers as well as professionals beyond the four walls of the household. The potential of the family has been curtailed to support the elderly. The care of the aged is emerging gradually as a major familial issue in the contemporary scenario as the moral and material values are fast changing in the rapid modern urbanized world. The aged find themselves at the cross road of life where neither institutional arrangements are available for them nor family has enough resources and time to provide holistic care and support them. The three important domains where elder's require care are: a) Physical or chronic illnesses b) Social or Retirement c) Psychological.

Ageing process is accompanied by numerous physical changes and ailments such as visual, auditory and other chronic ailments. These ailments not only impair the task of daily living such as eating, bathing, dressing or using the toilet but also require care and assistance from the family members.

The second aspect of elder's care is their social sphere. In a society under transition, respect for the aged is no longer the uniformly adhered norm. "Honour thy father and thy mother" expressed the veneration of the elder's in our scriptures and literatures but with changing social scenario changes are also experienced in the position of elderly too. Retirement from economic life, generation gap has affected the family's role of care giving.

The third set of influences is largely psychological in nature. Elders often experience depression, anxiety and other psychological disorders due to stress and tension of physical and social dependency. It all requires greater care for them by the family members. In the absence of well-developed systems for providing social services for the elderly, the option available is to rely on those with whom they live in close proximity for their social, economic and physical support.

Empirically it has been proved that despite nuclearization of families and changing attitude and outlook of younger generation, no institution or agency is still considered important other than the family by the old people whether residing in nuclear or joint family system. Care of the aged is perceived as the responsibility of family members. To substantiate, Desouza (1982) in a study on the life of the aged persons among urban poor of Delhi, found that although changes have taken place in the family structure due to urbanization and migration but the family is still a source of security to the aged people. After a decade, Shabeen Ara (1994) found in her study that living with children is a preferred living arrangement of the aged slum dwellers. Needs like food, clothing of the aged parents and attending them in sickness was done by the children of the maximum respondents.

In another research study conducted in Delhi by Nasreen, 2009 it was found that during old age, the overall capacity of a person decreases and level of dependency increases. The immediate family has been considered to be of great help for the elderly. The studied sample reported that all the requirements are taken care by the son, daughter, daughter-in-law or spouse. The immediate family provides support for their basic needs and also looks after them during illness. The family is like an umbrella that acts as a safety shield for the aged.

Care by spouse

It is projected that care by spouses or partners is likely to increase considerably in the future, primarily because projected improvements in male mortality are likely to lead to a fall in the number of widows. There are limits to the extent to which care by spouses or other older people can compensate for a shortfall in the supply of care by children.

Care by adult children

The second most important care givers are adult children. Adult children not only provide care themselves, they also increasingly manage care arrangements and ensure that someone looks after their frail parents. Although there has been a steady decline in fertility rates the share of parents in post-war and baby boomer generations is higher than in any generation before or after. Children, therefore, are an important potential care resource to cope with the rising care demand in the next decades. Care of older people by their children and their children's spouses is likely to decline.

There are two main issues around the supply of intergenerational care for older people. The first relates to the future availability of children to provide unpaid care. One factor which it has been suggested might diminish parent-child exchanges is having fewer children. It was also shown that a longer intergenerational gap makes four generation linkages less, because there is a growing tendency towards nuclearization of family with changed values and work pressure is more for which children are not able to spend quality time with their elders.

The second issue relates to the ability or willingness, the propensity, to provide unpaid care. It is argued that a decline in the rate of intergenerational care provision in future will arise from factors such as the decline in co-residence of older people with their children and the continuing rise in labour market participation by mid-life women.

Another potentially discouraging factor is geographical distance between parent and child. Care relationships require geographical proximity. Great distances between parents and children make daily and spontaneous care impossible. Parents who provide more support to their children and received less support in return report the highest levels of life satisfaction. This may however be related to a number of other factors including the level of personal resources.

Marital disruption

Future changes in the marital status of older people will result in a higher proportion living in their own homes: women in each age group will more often grow old living with their partner, and this will also apply, though to a lesser extent, to men aged 85 and over. Both men and women will be less likely to live alone, with people other than a partner, or in institutions. But for men aged 74–84 the likelihood of choosing one or another type of living arrangement will remain remarkably stable in the future. Further, an improvement in health will lead to older people living alone slightly more often, and they will also more often do so in good health.

Marital status and marital disruptions such as the death of a spouse or divorce have a major impact on family relations, especially intergenerational relations, and therefore on support for and from children.

Divorce and separation result in fewer contacts and support from (former) family members and children. Studies for various countries suggest that adult children feel less obligated and are less likely to provide support, e.g. care and financial support, to divorced or remarried parents. Divorced fathers in particular have a higher risk of losing the support of and contact with their children. It is reasonable to assume that the increase in divorce rates will have a lasting effect on the support network of older men in the next 20 years. The reason behind this is that, previously they were dependent on their wives for care and after divorce, they have to rely on formal care systems. Increasing divorce rates will therefore result in higher care demands for professional care.

Trends in marriage, remarriage, divorce and living arrangements will change the role of older people in their families. Marital disruption has a twofold effect on family care. Firstly, partner care is no longer available unless the divorced elderly re-partner or remarry. Secondly, divorced, separated and remarried parents not co-residing with their young children often cannot establish and maintain long-lasting relationships with them. They have fewer contacts with their children and receive less support in old age. The increase in family disruption events will probably result in a higher demand for formal care in the next five decades.

Older people across regions, religion, gender or class distinctions provide assistance in household chores like baby-sitting, marketing for grocery items, kitchen work and voluntary involvement in economic activities. In turn perceives care as the responsibility of family members. Thus, at demographic and societal level changes are taking place.

The population structure and family structure, institution of family are in the process to cope and provide assistance to its members. We have moved along the path of development with regard to lifestyle and longevity. Still, have not yet developed the institutional mechanisms that could address gerontological issues. So, what is required is building the competence of the family at both micro level and macro level. At the micro level, the potential of the individual itself and family need to be strengthened. While at the macro level, the government as well as the NGO's or voluntary organizations can enthuse in the institution of family, a level of confidence and zest for living by creating infrastructure facilities to facilitate older person's rehabilitation and adjustment process in the changed scenario.

2.2.10 Position of the Women:

The position of elderly women in the family needs to be examined as women were always assigned a secondary role in the Indian family. Traditionally, they did not enjoy much social status and in old age with loss of spouse, they would detract further from her position in the family. One of the characteristics of demographic change is that women live longer than men as a result, good proportion of the old women will be widows. Though in joint family, the old women will be automatically taken care of but they may not enjoy high status and respect and even in comparison to male head she receives less care and respect. In the nuclear family, as long as the husband is the de facto head, the wife's position is assured, provided the family is economically viable. If not, the tendency is to ignore, ill-treat and marginalize her. Generally a women may not have any personal income or property in her name during old age. Studies have shown that elderly women have more adjustment problems than elderly men. Jamuna

(1987) reports that the prevalence of a wide gap between the expectation of old women and what they get from their care givers. Much of the problems arises due to unhealthy interpersonal relations between family members of which the attitude and behavior of the daughter-in-law is found to be a critical factor. Since old women's emotional problems seldom go out of the household their problems do not generally catch the public eye and are not understood either in their proper perspective or magnitude.

2.2.11 Situation of Old in Tribal Families

Studies have shown that the family bond is very strong in tribal societies and that this is safeguarded by several rituals and practices. As a matter of fact, the image of elderly as embodiment of rich knowledge and experience finds much acceptance among tribal people even today. However, situation differs from regions to regions and from different tribes. According to Kattakayam (1990) the elderly people in two Kerala tribes command great respect and power and are considered repositories of knowledge. Two studies reported from Odisha (Panda and Samantharaya, 1989 and Acharya and Das, 1989) also confirms the findings made by Kattakayam. A study conducted by Kumar and Saxena (1989) in Madhya Pradesh which accounts for one-fourth of the tribal population of India speaks of the poor economic condition of tribal and consequent misery of the aged population, especially because most tribal have nuclear family system. However, they do not face neglect or desertion. Pati (1989) reports that migrant laborers even take their ill parents to their working place and look after them well.

2.2.12 Impact of Globalization

The globalization has different meaning for different stakeholders. For some globalization bring new opportunities and increase in living standard, for others it may mean loss of jobs and increased migration. The elderly in this context suffer a double burden. Because of globalization, the traditional joint family systems are breaking up as the young in the family migrate for better livelihood options, leaving the elderly to fend for themselves. The existing safety net breaks and in absence of state social and health security system, the aged become more vulnerable.

Some of the important implications of globalization and its impact on the aging population are as under:

1. Breaking up of Safety Net

Earlier, traditional joint family provide care to elders and they were considered as the guardians of family but now, because of the forces of economic liberalization and globalization, the safety net of joint family is under stress. Migration from the villages and towns to cities by young family members for education, employment opportunities and higher prospects resulted in leaving behind the old family members. When they found their jobs, they remained in the cities, causing the first dent in the structure of the traditional joint family system, though they maintained functional joints. Even the joint families in the cities began breaking up into micro units - nuclear families.

The changing socio-cultural trends and increasing economic needs and work pressure on the younger generations has led to a change in their outlook towards life. Money tops at the priority

list, emotions and relationship take back seat. This is leading to an increased danger of marginalization of the geriatric population. Also older people in India do not have access to the same level of income security and health care provisions that their counterparts in the industrialized countries enjoy.

So India is heading towards more and more broken-down families, an increasing number of old age homes, inadequate social support systems and a dearth of effective policies in favour of the aged. As the 60-plus population swells, old age homes have come to be regarded as commercial enterprises and are mushrooming all over the country.

The increasing commercialization and globalization has a direct bearing on the relationships within the families, including lifestyle changes and has an impact on the solidarity within the family. This in turn breaks the safety net for the elders within the family.

2. Increasing Economic Burden

Another impact of the globalization is the increasing economic burden on the elderly as well as youngsters. The cost of living is soaring high, the medical expenses are rising. The proportion of the aged is rising, so as the old age dependency ratios. The private savings are tumbling and the workforce is declining further. Since money and labour is required for running the economy and the viability of pension schemes, the picture can become grave in the years to come. Again, nearly 90 percent of the total workforces are employed in the unorganised sector. They retire from their gainful employment without any financial security like pension and other post-retirement benefits, this makes them further vulnerable to economic insecurity.

Traditionally, Indian population never used to save enough for the future as the children were expected to take care of the elders in the family. Now with these structures breaking up, the Indian workforce comprising mainly of the service class started saving for the years to come. However, the decreasing interest rates on the fixed deposits, investments and provident fund, which formed the core of the savings has put an additional burden on the elderly. Inflating prices and decreasing interest on investments made has impact on the living standards of the aged population.

The upper class - middle class divide is becoming more and more apparent in elderly population. On one hand there is a group of senior citizens from the upper class, who are using the benefits of globalization and are going on world tours on 'special senior citizen travel packages', there is a vast majority of people who are eating into their meager investments to live a decent life due to lack on any viable social security scheme.

3. Privatization of Services

With the advent of globalization process, and the commercialization of services, there has been an appreciable increase in terms of service providers in all sectors, including services for the elderly. For example, private pension schemes and old age homes are now mushrooming in the country. However, traditionally Indian aged have always have faith on the government run schemes especially in the context of economic security. The hassles of private pension and failure of the private pension companies is a constant fear within the minds of those who invest their hard earned money in these schemes. This often leads to an excess baggage of emotional

and economic insecurity. The medical schemes are seen with equal suspicion and wariness. We are yet to see the impact of these schemes and their long term sustainability.

4. Migration implications

When the young migrate, for economic reasons or otherwise, both the young and the old, have to run independent households. Though the household income may not double, but the expenses do add up because of splitting of the household, adding on to the economic burden. However, the young are expected to provide for their immediate family, comprising of the children and spouse. The increasing cost of living in the city adds additional burden. The result is that they can afford to send only a little part of their earning to their aged parents. Apart from the economic implication, the emotional and medical implications add up to pronounce the effect many folds.

5. Gender Concerns

Women are more likely to dependent on others, given lower literacy and higher incidence of widowhood among them. The most vulnerable are those who do not own productive assets have little or no savings or income from investments made earlier. Apart from the token measure that government provides in the form of widow pension, a more holistic approach is needed from the society as well as from the family so that they are able to enjoy a life of dignity and respect. The above factors push women into chronic cycle of poverty from where it becomes difficult to escape.

2.3 Problems of Aged

The situation of the aged in the world in general and in India in particular poses a dilemma. On the one hand, we find that the life expectancy is growing and the proportion of the aged in the population is increasing, which can be regarded as great achievements of modern civilisation. On the other hand, we also find that becoming old is increasingly perceived as a problem, the aged is finding it more and more difficult to adapt themselves to the changing situation. In this unit we shall discuss all these issues pertaining to the aged.

Joshi (1971) has observed that ageing in human beings creates a number of bodily dysfunctions as well as psychological disorder. Seal (1979) has divided the problems of the aged into national, special (community and family) and personal (physical, psychological and socio-economic). The problems of the aged not only differ between younger-old and old-old but also from country to country on the socio-cultural background. Venkoba Rao (1979) has indicated that as to how the prevalent cultural conditions are affecting or contributing to the problems of the aged. Ghosal (1962) has observed that the problems of old age tend to be multiple rather than single. There are various factors responsible for the problems of the old persons.

According to Chowdhry (1992), the following factors are affecting the problems of aged.

1. Bodily changes and depletion of physical and mental strength
2. Modern education and working young couples
3. Urban influence and industrialization
4. Materialistic and individualistic outlook

5. Breaking of joint family system and generation gap
6. High cost of living and lack of social security measures
7. Paucity of accommodation in urban and uncongenial environments
8. Migration of younger generation
9. Employment of women
10. Additional economic responsibility of the elderly- educating sons, marrying daughters etc., in later life; and
11. Sense of loss of job, status, assets, physical strength and social responsibility

2.3.1 Psychological Problems

In order to understand the psychological problems of aged, there is a need to understand perceptions/ images of ageing at two levels—the individual and the societal. We need to know how the wider society perceives the place of older people and the relative status or stigma associated with old age. In addition, we need to know the impact of ageing upon the self-image of the individual. In addition, we need to know how the wider society perceives the place of older people and the relative status or stigma associated with old age. We also consider some of the more commonly held stereotypes about old age and consider how these views are formed and perpetuated. Combining the many stereotypes and images of ageing leads to a very negative view of the experience of old age and the role and potential of older people. Most of the psychological problems of aged are result of these stereotypes that the other people have for aged and the aged have for themselves. Therefore, positive image should be attributed to ageing for solving psychological problems of aged.

Ageing is a progressive and cumulative process of psycho-physical change occurring over time and affected by a variety of factors. To understand the elderly, the three common factors viz., physical, socio-cultural and psychological must be associated.

According to Bhattacharya and Mukherjee, following are the most common and serious psychological hazards:

- The first psychological hazard is acceptance of the traditional beliefs and cultural stereotypes of the aged. Arnhoff et.al. (1964) have reported that ageing is accompanied by many stereotyped belief, which make the old people predominantly negative in outlook, regardless of country involved. Due to this, elderly may feel inadequate and inferior. While both men and women are influenced by the cultural beliefs and stereotypes of ageing, women tend to be more affected than men due to negative judgement by social group as physically unattractive, poor health and widowhood. These all may affect the elderly's personal and social adjustment.
- The second psychological hazard of the elderly is physical changes which prove to be a barrier to communication and social relationship. For example, aged having physical mobility problem cannot interact with their peers which makes them socially inactive and consequently it will lead to depression.
- The third psychological hazard is the realization that mental decline has started already. In this older people face some difficulties like forgetfulness, learning difficulty, withdrawal

from activities, poor adjustment capacity etc. This pattern may be entitled as 'sleep' mentality.

- The fourth psychological problem is known as feeling of guilt about idleness. Many older people of today, who grow up in a more work-oriented society, feel guilty after retirement or after their home responsibilities have diminished. Most of them want to do something useful but may shy away from community activities planned for older citizens because they regard them as form of recreation rather than real work.
- Reduced income is the fifth hazard characteristics for the elderly. After retirement, many elderly people are unable to afford the leisure time activities they consider worthwhile. For women, who had a free access to the husband's purse and was controlling the expenditures of the household, dependence on the son and his family for every need may be painful experience. If she has to ask her daughter-in-law for expenses, she may find it difficult to accept the situation and may develop resentment towards this type of arrangement.
- The sixth and most serious psychological hazard in old age is social disengagement. Studies of members in different voluntary associations or in senior citizen centers have revealed that active participation in these groups contributes greatly to psychological well-being. The elderly who are disengaged, either voluntarily or involuntarily, become socially isolated. This is especially serious if they are widowed or have few family members to turn with their problems.

Other problems are:

- Lack of purpose: This is seen especially among women whose life has been centred on that of the husband. When the husband dies, children start their own family, they lose the motivation to continue living and lose the will for doing anything positive that prolongs their life.
- Feeling of being ignored/depression and loneliness: In traditional joint families there is hierarchy and respect for the elders and their opinions. But in nuclear families, where the older people are looked upon as simply dependents with no useful role, they may not be consulted or included in the family discussions or policy decisions. This gives them a feeling that they are not wanted and are a burden on the children. This leads to depression.
- Feeling of loneliness: In nuclear families, where both spouses are earning members, and the children are going to school, the grandparents are left alone for long times, without much to do at home. Even when they are home, the children and grandchildren are busy with their own work/TV, etc. that they find little time to spend with grandparents. This gives a feeling of loneliness to the elderly. Men may find ways to engage their time by joining clubs and other past time, but women are often confined to the house without much social contact. This complicates their condition and may lead to severe depression.
- Feeling of being exploited: In nuclear families, where both husband and wife are employed earning members, the grandparents may be left to do the household chores and taking care of grandchildren. With declining health, they may find it difficult to do these chores to the satisfaction of the younger members, and, sometimes, the latter may

not appreciate their traditional ways. This can also lead to resentment and also to developing a feeling of being exploited.

- Psychosomatic syndromes: Loneliness, resentment and depression can lead to physical symptoms and the elder persons may develop chronic illnesses like pains and aches, breathlessness, etc. Sometimes these symptoms may be construed by younger members as an attention-seeking tactic and ignored, which can lead to more suffering on the part of the elders.

Cheriboga (1982) has observed that older subjects exhibit more psychosocial distress than do younger subjects and sex difference suggest that males and females have different vulnerabilities. Kay (1959) and Post (1965) have shown that depression in old age is associated with continually increasing losses such as loss of close relatives, intimate friends, status of job.

Depression: Depression is a mood disorder. It affects people of all ages, but is common among older people. Depression encompasses a constellation of affective, cognitive and somatic manifestations in varying from mild to severe. The five D's of depression of the elderly are dementia, decline, disability, diminished quality of life, and demand on caregivers. The accumulation of a lifetime of depressing events, such as bereavement and loss of income etc., coupled with physical illness, place the older adults at risk. Worry, feelings of uselessness, sadness, pessimism, fatigue, inability to sleep, and difficulties getting things done are common symptoms of depression in older adults.

2.3.2 Social Problems

In the early 1980's three prominent issues are identified regarding population and family: 1) the extent to which changes in social norms and responsibilities, driven by the secular process of urbanization and modernization, after traditional family modes of caring for older people; 2) the possible social support burden resulting from reduced economic self-sufficiency of aged people and the likelihood of heightened chronic disease morbidity and functional impairment related to longer life expectancy; 3) the ways in which countries develop funding priorities for public care systems given competing demands for scarce resources.

Inability to cope with changing values and life styles: The traditional people, when relocated to cities find it difficult to understand and adjust with the new milieu. They also find the ways of the younger generation distasteful, e.g. style of dressing, social interactions, parent-children interactions, etc. They may compare the values of their youth with present trends and become overcritical of the freedom and activities of younger people, especially in urban settings.

Inability to mix with people and social isolation: Elderly coming from rural upbringing may find it difficult to intermingle with city-bred generation and feel uncomfortable in the social circle. They may develop an inferiority complex – lack of higher education, unable to communicate and to maintain a conversation, etc. – hence feel socially isolated.

Problems of Social Adjustments: According to Schneider (1965) adjustment is a “process involving both mental and behavioural responses by which an individual strives to cope with inner needs, tensions, frustrations and conflicts and to bring harmony between these inner demands and those imposed upon him by the world in which he lives.” Field (1977) has reported difficult adjustment during old age because of economic insecurity, health problems, fewer

relations and friends, loss of significant roles and loss of status. Anantharaman (1980) has observed that the old subjects with positive self-concept, living with their children and enjoying good health were better adjusted than those who had negative self-concept, were living isolated life and were not enjoying good health respectively.

There are theoretical models- Disengagement theory and Activity theory developed to explain the adjustment problems of the aged.

In the pre-industrial society, the old people use to get enough opportunities to satisfy their various needs. In the society dominated by agricultural and handicraft economy they participated in productive activities as specialists (Simmons, 1960) directly or indirectly, depending on their physical health and remained financially independent. But the present society does not provide opportunities to its aged member to lead a comfortable, respectful and socially useful life. With modernization and industrialization, the roles and status of old people have decreased (Kookey, 1966). The younger generation replaces the aged people in their powerful positions, leaving them in a weakened and functionless situation (Simmond, 1959).

Immigration presented an unusual dilemma before elderly. Those elderly who immigrate with their children to foreign land find it immensely difficult to adjust to the new environment, culture, values, life style, language etc. They feel alienated from their surroundings. Most of them long to return to their native land.

Intergenerational conflict/ Generation gap: Requirements of each generation differs and the members of each generation want to solve their requirements with their own choice. The choice of younger generation is mainly based on the modern way of living which the old generally do not like. Approach towards life differs, thus, arises conflict.

Role diffusion, change in status, disintegration of joint family system, non-participation in decision making, increasing materialism, individual orientation in place of family, urbanization, industrialization, displacement from rural to urban areas, changes in norms, values, culture and acculturation.

Elder abuse: Abuse of elderly has become a problem of ageing and has subsequently developed into a criminal justice concern. The cases of abuse of older people by family members or others known to them, either in their homes or in residential or other institutional settings are taken into consideration. It does not cover other types of violence that may be directed at older people, such as violence by strangers, street crime, gang warfare or military conflict. It is generally agreed that abuse of older people is either an act of commission or of omission (in which case it is usually described as “neglect”), and that it may be either intentional or unintentional. The abuse may be of a physical nature, it may be psychological (involving emotional or verbal aggression), or it may involve financial or other material maltreatment. Regardless of the type of abuse, it will certainly result in unnecessary suffering, injury or pain, the loss or violation of human rights, and a decreased quality of life for the older person. Whether the behaviour is termed abusive, neglectful or exploitative will probably depend on how frequently the mistreatment occurs, its duration, severity and consequences, and above all, the cultural context.

International Network for the Prevention of Elder Abuse states that: "Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person." Such abuse is generally divided into the following categories: Physical abuse – the infliction of pain or injury, physical coercion, or physical or drug-induced restraint. . Psychological or emotional abuse – the infliction of mental anguish. . Financial or material abuse – the illegal or improper exploitation or use of funds or resources of the older person. . Sexual abuse – non-consensual sexual contact of any kind with the older person. . Neglect – the refusal or failure to fulfil a caregiving obligation. This may or may not involve a conscious and intentional attempt to inflict physical or emotional distress on the older person.

Common form of mistreatment was neglect and apathy towards older persons in the family. They were treated as 'piece of old furniture that had outlived its value'. Their emotional, health and other needs were completely overlooked by their 'caregivers'. Older parents were supposed to adjust to the life style of new generation and were excluded from important decisions about the family members and also at times about themselves. This led to extreme mental depression and loneliness in older persons.

Deprivation was another common form of abuse, where the needs of the elderly were overlooked or underplayed. Their dietary, health and other needs are simply ignored in many cases.

Exploitation was another form of abuse that older persons faced in the society. The adult children not only used the services of older persons for managing homes, taking care of grandchildren but also asked the elderly to pay the telephone, electricity and other bills of the household; while they themselves had restricted access to these facilities. Serious economic abuse was acknowledged, especially by way of dispossession of property.

Vulnerability of elderly women to neglect, isolation, deprivation, exploitation and other forms of abuse are very common.

For older people, the consequences of abuse can be especially serious. Older people are physically weaker and more vulnerable than younger adults, their bones are more brittle and convalescence takes longer. Even a relatively minor injury can cause serious and permanent damage. Many older people survive on limited incomes, so that the loss of even a small sum of money can have a significant impact. They may be isolated, lonely or troubled by illness, in which case they are more vulnerable as targets for fraudulent schemes.

Crime against elderly: In this paper, the crime against elders includes crimes committed by outsiders, strangers and non-family members. The increasing incidence of crime against the aged is a matter of serious concern, an ominous trend that is likely to grow with the rising numbers of rapidly ageing citizens. They are the most vulnerable people—defenseless, ignored by their families, and forgotten by the society at large. Rapid industrialization, urbanization and advances in medical technology have brought about major changes in the social structure of Indian society. The centuries-old joint-family system and village community disintegrated, and

with it collapsed the safety net of family support system and thus problems of the uncared aged have been impinging on the welfare agenda of the State. Fractures in the joint family system and commonly owned property, urban migration, shortage of accommodation in cities and alternate individualistic cultural norms have all contributed to sharply eroding family care of the aged which increases the risk of violence against them.

Problems at old age homes:

In recent years, there has been rapid increase in the number of old age homes and they are gradually gaining acceptance, especially by those who see these institutions as a better alternative than living in a son's home where you are not wanted. There is a debate going on in India at present among seniors' organizations, nongovernmental organizations and others about whether this growth should be allowed, supported or curbed. There is a strong feeling that proliferation of old-age homes would make it easier for children to shirk their responsibility for taking care of their aging parents by placing them in institutions. Increasing institutionalization of elderly people would lead to erosion of the desirable traditional family values and may even lead to the breakup of the institution of family itself. While this is the possibility in view of decline in traditional filial obligations among children and lack of an adequate social security safety net, there is also need for various types of institutions to accommodate the increasing number of elderly parents whose children are unable or unwilling to care for their parents.

The major problems the elderly face at old age homes are:

- Adjustment with inmates: Though old age homes are often called "home away from home", there is significant adjustment problems with the other inmates.
- Physical and mental disorders. Elderly are susceptible to a variety of physical and mental disorders at old age homes. These institutions can never take care of elderly as their family members can take and sometimes the elderly feel the warmth of family members is absent in these institutional settings. There is a feeling of isolation because of living away from family and friends and the outside world and this feeling of isolation results in depression. Sometimes elderly show resentment towards strict regulations of institutional homes.

Changing social roles: Sociologically, ageing marks a form of transition from one set of social roles to another, and such roles are difficult. Among all role transformation in the course of ageing, the shift into the new role of the 'old' is one of the most complex and complicated. In an agriculture based traditional society, where children followed their parent's occupation, it was natural that the expertise and knowledge of each generation were passed on to the next, thus affording older persons a useful role in society. However, this is no longer true in modern society, in which improved education, rapid technical change and new forms of organization have often rendered obsolete the knowledge, experience and wisdom of older persons. Once they retire, elderly people find that their children are not seeking advice from them anymore, and society has not much use for them. This realization often results in feeling of loss of status, worthlessness and loneliness. The growth of nuclear families has also meant a need for changes in role relations. Neither having authority in the family, nor being needed, they feel

frustrated and depressed. If the older person is economically dependent on the children, the problem is likely to become even worse.

2.3.3 Political Invisibility of the aged.

Political participation is a mechanism through which needs and preferences of citizens are communicated to political decision makers and by which pressure is brought to bear on them to respond. This can be a platform where aged can raise their voice and let their problems be heard. However, elderly are unable and at times unwilling to participate in the system for various reasons including physical frailty, extreme dependence and ethos. Another way in which issues or concerns get mainstreamed through championing of a certain issue by others and not only the stakeholders i.e. those who are suffering, but, here also the elderly are at a disadvantage because the general view of the upper caste and upper class where family is still providing some kind of support to its elderly and the general concerns of aged belonging to various castes and class are neglected.

Culture plays its role in dissuading elderly to talk openly about the treatment meted out to them. Many of the aged did not want to report about the maltreatment meted out to them by the son or daughter-in-law or the grandchildren, for the simple reason that they were too attached to them! They had the very thought that what society will think of them. Majority parents try to defend the behavior of their children by attributing it to changed culture, pressures of modern life style and other such reasons, many parents blame themselves for maladjustment and consequent conflict. They still want to retain the old values of family honour, underplaying conflict situations and sacrifice for the sake of children's comfort and most important is that they think it as an act of 'maturity' which is manifested in ignoring or forgiving bad behaviour of adult children.

In many cases, if the elderly did not have a choice but to depend on their children for support, then they had no choice and have to hesitate to talk about it in open for the fear of reprisal by the children. This fear is more pronounced in case of elderly women. Most of the women keep quiet about their needs and neglect of their needs by the family for the fear that someone may report it to her son or daughter, then she would be in trouble.

If we look at the organizations that represent the interest of elderly in the country and analyse their composition we will find that they fall in two broad categories: Pensioners' associations and Senior Citizens associations. Their focus is too narrow. The former concentrate on the economic gains of the pensioners, which incidentally form a minority of the total working class in India and the latter organizations cater to the local needs. Another point that goes against developing political consciousness among these associations is the security that is being given to them by the system. Their health, economic and social well-being is guaranteed by virtue of their employment in government sector. The elderly who belong to the poor and chronically poor households lack the time, resources, platform and inclination for political participation to press for their demands.

Elderly women are doubly disadvantaged as women and as elderly and triply disadvantaged if they are widows. So, the question of their political participation does not arise. Surprisingly, even the women's movement in India is not actively taking up issues that concern elderly women. Their exclusive focus is on young girls and women. This could possibly be due to involvement of many elderly women as perpetrator of domestic violence against younger women.

Another important factor in weak participation is lack of consciousness among the elderly of their rights as elderly. Horizontal bonding among them is overshadowed by so many other factors like family, children, class, caste etc. They do not think as elderly and act as a group. It is clear from the facts mentioned above that there is negligible factors pressurizing the system or the government to examine the problems faced by aged in our country .But there is also no pressure from above so to say that can at least lead the way to change.

The political classes do not articulate the concerns of the elderly for the simple reason that elderly are not politically organized. They are scattered and as mentioned earlier not conscious of their common Identity. So, they are electoral insignificant, hence overlooked by the political leaders. At the most governments have adopted a minimalist attitude towards them. If you look at the election manifesto of the national political parties you will know the order of priority these issues are for the leaders.

Ageism in one form or the other works against the elderly occupying the space in the political arena like the other groups of marginalized people. People retire at a certain age not when they want to give up work. This is the biggest example of ageism. Even socially it is acceptable to relive the parents of responsibility and consequent authority in the family that they were exercising till then. They are only considered recipient of welfare and are considered unfit for any productive activity. So, the whole thrust is to give them few concessions and privileges and feel happy that society has done enough to make them comfortable.

2.3.4 Economic Problems

Among the several problems of the elderly in our society, economic problems occupy an important position. Mass poverty is the Indian reality and the vast majority of the families have income far below the level, which would ensure a reasonable standard of living. The Ministry of Social Justice and Empowerment, Government of India (1999) in its document on the National Policy for Older Persons, has relied on the figure of 33 percent of the general population below poverty line and has concluded that one-third of the population in 60 plus age group is also below that level. Though this figure may be understated from the older person's point of view, still accepting this figure, the number of poor older persons comes to about 23 millions. As people live longer and into much advanced age (say 75 years and over), they need more intensive and long term care, which in turn may increase financial stress in the family. Inadequate income is a major problem of elderly in India (Siva Raju, 2002). The most vulnerable are those who do not own productive assets, have little or no savings or income from investments made earlier, have no pension or retirement benefits, and are not taken care of by

their children; or they live in families that have low and uncertain incomes and a large number of dependents

Again, Indian economic development looks at youth and their involvement in the development process. May be this is because young are more informed and expected to participate actively and productively for longer years. Therefore the programs of support and of economic products appear to have been directed to the youth and the adult not for the aged. As the country is ageing, this will affect the economy, because the economic needs of the society will be different in an ageing society. Further, the strength of any economy is its productive human resources in younger age brackets. Thus every aging nation suffers from over dependency and lesser participation of younger human resources in productive processes. Industries suffer from short supply of productive labour. It is felt that the retired ageing populations start using the nation's resources for social security needs, which is estimated to be a big burden on the exchequer of the state.

Thus, the impact of ageing on Indian economy is multi-faceted, which includes production, consumption, labor force and social expenditure on retirement. However short supply of labour has not yet been seen as a big problem due to vast unutilized human resources of the country and still acceptable fertility rates. Coming to the issue of productivity, the older workers are considered to be less productive than their younger counterparts. Researchers believe that absenteeism is more among the older workers due to medical reasons and therefore their productivity tends to decline. With technology advancing faster in every production process, the ageing of the labor force will speed up the obsolescence of human capital. Although retraining of the older workers is suggested to overcome this problem, it is very difficult to motivate older workforce to unlearn and relearn and retrain new techniques and skills. Employers too, prefer to induct youth and fresher from the universities and management institutions at a cheaper cost than re training their older and shortly retiring workers.

The other economic dimension of the ageing of population, although it is not immediately visible in India is, as the ageing work force is retiring; there will be fewer younger workers to replace them. This will create high demand for labour leading to increasing wages. It will reach a situation that the cost of labour will make the production not viable. The developed world has already witnessed this and is looking for options to overcome this problem. Japan has long ago adopted technology driven automated production process to overcome this problem. Other options examined are the business process out sourcing- that is shifting of the production units to developing countries, where young and cheap workers are available- like India. Another option would be to practice a liberal immigration policy to bring in young and trained human resource into the country. This option has social and cultural implications.

Nearly half of the elderly are fully dependent on others, while another 20 percent are partially so (NSSO, 1998). For elders living with their families-still the dominant living arrangement-their economic security and wellbeing are largely contingent on the economic capacity of the family unit. Particularly in rural areas, families suffer from economic crisis, as their occupations do not produce income throughout the year. As the cost of living rises and old people's contribution to

family expenditure decreases, they are considered as burden.

Nearly 90 percent of the total workforces are employed in the unorganised sector. They retire from their gainful employment without any financial security like pension and other post-retirement benefits. The organized sector workforce who includes the employees of the Central and State governments, of local government bodies, and of major enterprises in basic industries (e.g. manufacturing, mining etc.) constitute approximately 30 million workers and nearly one in every 10 members of the total Indian workforce of 314 million (Vijay Kumar, 2000). The work participation rate among the elderly was around 40 percent. More elderly men participate in the economic activities compared to women. The participation is high in rural areas compared to urban areas. The bulk of the 60 plus workers were engaged in agriculture. Nearly half of the elderly are fully dependent on others, while another 20% are partially so (NSSO, 1998).

Again the problem for elders aggravates because of the difficulties they face in arranging suitable part time job to supplement their income for maintaining a standard of living. There is also lack of productive and useful work for them.

Women are more likely to dependent on others, given lower literacy and higher incidence of widowhood among them. The most vulnerable are those who do not own productive assets have little or no savings or income from investments made earlier, have no pension or retirement benefits, and are not taken care of by their children; or they live in families that have low and uncertain incomes and a large number of dependents (Bose, 1996). Vulnerable groups like the disabled, fragile older persons, and those who work outside the organized sector of employment like landless agricultural workers, small and marginal farmers, artisans in the informal sector, unskilled labourers on daily, casual or contract basis, migrant labourers, informal self-employed or wage workers in the urban sector, and domestic workers deserve mention here.

2.3.5 Health Problems:

Health problems are supposed to be the major concern of a society as older people are more prone to suffer from ill health than younger age groups. It is often claimed that ageing is accompanied by multiple illnesses and physical ailments. Besides physical illnesses, the aged are more likely to be victims of poor mental health, which arises from senility, neurosis and extent of life satisfaction. Thus, the health status of the aged should occupy a central place in any study of the elderly population. In most of the primary surveys, health problems and medical care become major concerns among a majority of the elderly. Yet many refrain from seeking medical aid due to various impediments. Some refuse medical attention merely because they have never received such treatment as a rule.

The health related problems of the aged are classified as hereunder:

- General reduction of physical and mental abilities such as feeling less well than unusual, difficulty in working, fatigue, greater need for rest and sleep, forgetfulness and loss of confidence.

- Illness due to cold, cough, fever, headache, body pain, dental problems, digestive complaints, trembling of limbs, weak eye sight and impaired hearing. These are minor health problems that get intensified due to negligence and lack of care.
- Major illness such as tuberculosis, paralysis, asthma, anemia, diabetes, blood pressure, cardiac trouble etc.
- Non adoption of preventive measures
- Lack of health insurance scheme for the aged.

Compared to men, women in India face more health problems. Women suffer from most degenerative diseases such as osteoporosis, arthritis, rheumatism, asthma, depression and cancer which affect women more than aged men.

Andrews and Brocklehurst (1987) summarized health problems into four 'geriatric giants'.

- Immobility
- Instability
- Incontinence and Constipation
- Intellectual decline

Factors affecting health:

Status of health of elderly depends on many factors like age, education, economic status, marital status, perception on living, anxieties and worries, addictions, degree of idleness, type of health center visited, and whether the person is on some kind of medication etc. (Siva Raju, 2002). Health conditions also vary considerably depending on their gender (Siva Raju, 1997). Joshi (1971) opined that environmental and social factors such as diet, addictions, education, family and professional life influenced both physical and mental aspects of differential ageing phenomena. Dilip (2003) found that with increasing age, diseases are more likely to increase with widowhood, divorce and economic dependence. Similarly, in his study of elderly rural females in Rajasthan, Sharma (2003) found that widowhood, economic dependency, lack of proper food and clothing, fear of the future, lack of caring and progressive decline in health made coping with health problems difficult. A study conducted among aged widows in Haryana (Sushma, Vamani & Darshan, 2004) revealed that the majority had multiple health problems. Elderly widows from poor socio-economic families had very poor health status. Adequate financial status, good physical and mental health, active participation in leisure activities, continuation of hobbies, maintenance of daily schedule, retaining social networks and assuming social roles influenced healthy ageing positively (Batra, 2004).



Mortality and morbidity statistics in India are inadequate to draw any definitive conclusions about the health situation of the elderly population. Only a third of the deaths are registered, and the extent of registration varies in different areas of the country. Medical certification of causes of deaths covers the deaths occurring in the districts and teaching hospitals in the country but the coverage is less than ten percent of the registered deaths in most states. The medically certified deaths are recorded for 17 broad cause groups, but regrettably the data are not classified by age groups to enable analysis of causes of deaths among elderly population.

Table 1

Percentage Distribution of Deaths for Persons over 60 years by Cause in Rural India

Cause of Death	India
Bronchitis and Asthma	38.4
Heart Attack	19.6
TB of Lungs	8.7
Pneumonia	1.4
Cancer	10.5
Paralysis	12.5
Anemia	6.2
Vehicular accidents	1.9
Suicide	0.8

Another source of information is the Annual Survey of Causes of Deaths in rural areas carried out by the Registrar General of India. The annual publication provides the distribution of the deaths due to major causes according to age groups.

The First National Sample Survey (NSS) conducted during the second half of 1980s, focused on the elderly and indicated that 45 per cent of the elderly suffered from some chronic illness like pain in the joints and cough. Other diseases noted in the NSS survey included blood pressure, heart disease, urinary problems and diabetes. The major killers among the elderly consisted of respiratory disorders in rural areas and circulatory disorders in urban areas.

Disabilities of the Elderly

According to 2001 Census, there are 3.6 million elderly persons with disabilities, and this is about 5 percent of the population 60 years and above. The NSS probed into five types of disabilities of the elderly. These were visual impairment, hearing problem, difficulty in walking (loco motor problem), problems in speech and senility. Twenty-five percent of the elderly in India suffered from visual impairment, followed by hearing difficulties (14 percent) and locomotor disability and senility (each 11 percent). The prevalence rates of all the five disabilities were higher in rural than in urban areas. Except for visual impairment, women were ahead in all the disabilities compared to males. Between SCs and STs, disabilities among scheduled tribes were high compared to that among scheduled castes. Compared to the general population and scheduled caste, the scheduled tribes reported the highest incidence of disabilities.

About 60 percent of the elderly in India live disability-free lives in old age. The highest proportion of no disability was reported in South India and the lowest in East India.

Despite the adoption of various policies, the existing medical facilities in India are quite inadequate, with no clear strategy or schemes for the development of healthcare for the elderly. Public healthcare utilisation is very low, particularly in remote, rural areas. Poverty, illiteracy, general backwardness and adherence to superstitious beliefs for curing illnesses and diseases may be the cause. Analysing healthcare facilities and its utilisation, Upadhyay had raised doubts as early as 1960 regarding India's ability to afford health services for the elderly population.

According to Sahni (1982), health policy should be an integral part of health services for them.

Public health in our country is under the purview of states with supplementary inputs from the Centre. The healthcare system includes public health facilities like teaching hospitals, secondary level hospitals, first-level referral hospitals (community health centers or rural hospitals), dispensaries, primary health centers, sub-centers, health posts and public facilities for selected occupational groups. Existing public health infrastructure, such as consumables, equipment and essential drugs, is far from satisfactory. The presence of medical and paramedical personnel is often much less than prescribed. Health insurance is limited to only a small section of people in the organized sector, and covers less than 10% of the total population.

Economic consequences of health problems

The decline in fertility and mortality will result in an increase in Elderly Dependency Ratios (EDRs). In India EDR is likely to increase from 6 percent in the year 2000 to 22 percent in 2050. What this implies is that more and more elderly will need public support, since there will be fewer sons and daughters who could support them.

Another aspect of the ageing population is that it is taking place alongside the epidemiological transition in the country as reflected in the changing pattern of causes of death. There will be decline in the share of communicable diseases as we move from nascent stage of ageing to an advanced stage of ageing. The relative share of infectious and parasitic diseases will decline and the relative share of non-communicable diseases will increase. Non-communicable diseases like malignant neoplasm, diabetes, cardiovascular diseases and nutritional and endocrinal disorders will increase with the ageing population. As a result of shift towards chronic and degenerative diseases, there is a greater risk of disabilities among the elderly.

Even as countries like India are struggling with infectious diseases, malnutrition, and complications from childbirth, they are faced with rapid growth of NCDs. The shift from communicable to non-communicable diseases will escalate as the ageing process continues, and by the year 2020, the NCDs will constitute three-fourths of the burden of diseases. This “double burden” of disease is causing great strains to the already scarce resources of the developing countries. The elderly will have to cope with higher health expenditures alongside a fall in productivity. Less than 2% of the older persons in India have old age pension, provident fund or other benefits. Our health care system is unable to cope with even traditional ailments and health insurance system hardly covers a negligible proportions of populations. Geriatric care is lacking in government hospitals and primary health centers, and is available at very high cost in a multi- specialty hospitals. Home and community based programmes for the elderly is practically non-existent in India.

Apart from the general problems faced by the elderly, there are problems related to specific sections.

Women:

Women amongst the aged are the worst victims of apathy and neglect. Today, more of the aged men (82%) as compared to the aged women (47%) are living with their spouses. While men are likely to be cared by their spouses, the same may not be true for women. For women widowhood has greater impact than for men. It makes them dependent on sons, and simultaneously loss of status in family. There are several reports of elderly abuse and especially so of the single and more so of women. Women are known to contribute to family work in many ways but usual invisibility of women in work is also reflected in data for elder women. Being silent sufferers, a large number of the elderly women is likely to face social, economic and psychological problems.

The United Nations Commission on the Status of Women in 1992 reported that older women are seldom part of the development agenda. Their contributions are slighted, discussions on their situations are usually ‘after thoughts’, and remedial actions are seldom taken.

In fact the aged women have been the worst victims of economic development, particularly in the developing countries where they previously used to hold the positions of command and respect both in family and community. Aged women when no longer can carry on their task they are treated as 'burden'.

Childless couples

For them, old age is rather lonely and frightening. Their problems are not very different from couples who have children abroad. These people are at the mercy of strangers, neighbours, watchmen, domestic servants etc. They may have all material comforts but lack family support and care.

2.3.6 Economic Consequences of Ageing:

1. Increase in the dependency ratio. If the retirement age remains fixed, and the life expectancy increases, there will be relatively more people claiming pension benefits and less people working and paying income taxes. The fear is that it will require high tax rates on the current, shrinking workforce.
2. Increased government spending on health care and pensions. Also, those in retirement tend to pay lower income taxes because they are not working. This combination of higher spending commitments and lower tax revenue is a source of concern for Western governments – especially those with existing debt issues and unfunded pension schemes.
3. Those in work may have to pay higher taxes. This could create disincentives to work and disincentives for firms to invest, therefore there could be a fall in productivity and growth.
4. Shortage of workers. An ageing population could lead to a shortage of workers and hence push up wages causing wage inflation. Alternatively, firms may have to respond by encouraging more people to enter the workforce, through offering flexible working practices.
5. Changing sectors within the economy. An increase in the numbers of retired people will create a bigger market for goods and services linked to older people (e.g. retirement homes)
6. Higher savings for pensions may reduce capital investment. If society is putting a higher % of income into pension funds, it could reduce the amount of savings available for more productive investment, leading to lower rates of economic growth.

2.3.7 Potential consequences of population ageing for social development

1. Huge number of older people need to be covered by the newly evolving social security system.

As the proportion of aged in the population will increase because of higher life expectancy, there would be a need for rise in various social security measures. Presently the social security measures do not cover the entire aged population, but, as time will pass the coverage has to be maximum. For providing these security measures, huge amount of money will be needed which will be a burden on the working population.

2. Increasing dependency ratios and challenges to intergenerational solidarity.

As the life expectancy of aged will improve, the chances of their survival for more 5-10 years will increase. However, this may not be accompanied by good health status. Therefore, there will be

an increase in the old age dependency ratio because working population will have to contribute towards social security measures for the elderly. The social security measures may comprise health care benefits, pension schemes, residential benefits etc. Because of all these provisions for elderly, resources which can be used for children and other productive purposes will be diverted and this will act as a hindrance for social development.

3. Challenges to the traditional support system

The challenge emerges strongly of how to share the responsibilities of support for older persons among state, society, family and individuals. Traditionally, this was the responsibility of the family, especially in rural settings. Emotional attachment and mutual support among family members serves as a strong bond. However, population change is exerting an impact on the capacity of families to provide old age support. The most important factor is a considerable decline in fertility, which leads to a reduction in the number of children available to provide support for older persons. As filial responsibility is predicted to be more and more unreliable, it is likely that further legislation may be required to guarantee the rights and benefits of older people. In spite of the scale of socio-economic change, families remain an essential basis for old age support in India and their basic functions will not be replaced by social protection.

4. Demographic ageing demands the establishment and development of community services.

Increasing numbers of older persons, dramatically declining family size and changing living arrangements have resulted in an increasing number of frail older people who are obliged to live alone. India has been facing an increasing need to establish and develop community services to satisfy the needs of community services, the system likely to benefit older persons the most. It is government policy to develop community services to satisfy the needs of community residents. Now the most popular services include nursing services for older persons with diseases, daily life assistance, accompanying services and cultural sports and activities. Efforts have been made to develop the management of the community through organization of volunteer programmes and the utilization of younger older persons to serve older-old person and people with disabilities. In past, the government was the only sponsor responsible for the establishment of nursing homes, hostels and activity centers for older persons. Today, in addition to the government continuing to provide support, society is becoming more involved. Existing community services are provided in line with the increasing needs of older persons based on local conditions.

2.3.8 Recommendations for improvement in overall situation of elderly.

Short term strategies

- Creating more and more cognizance and education among the aged and the community regarding realities of this age group and the role community as well as aged can play to reduce the problems.
- Providing health care facilities for early detection of diseases and prevention from secondary complications. Spreading awareness and sensitizing aged as well as their family members regarding various geriatric diseases.

- All community centres established by government, corporations, municipalities, NGOs, and social and religious institutions should earmark reasonable space for daycare and recreational facilities for senior citizens.
- Mobile medical care unit should be opened.
- Preventive measures should be adopted and physical exercise like yoga etc. should be organized.
- Voluntary organization's services should be encouraged.
- Utilization of senior citizens as a resource of community work.

Long term strategies

- Preparation of psycho social and health profile of the aged of the rural as well as urban areas.
- Development of programmes to improve the status of elderly such as creating adequate opportunities for gainful employment for the capable elders.
- National policy for health of elderly should be formulated.
- Training should be organized for health, para-social work professionals, committed to work with this group.
- Inter-sectoral, multidimensional, mutual functional approach is needed. There is a need to strengthen or establish a national coordinating mechanism on ageing for development and promoting implementation of the national strategy on ageing composed of ministries, councils, departments, committees, advisory groups, representatives of the elderly, political or religious groups and task forces.
- There should be creation of separate geriatric wards as well as department for the elderly with specialist provisions.
- Research activities should be carried out to have more knowledge regarding status, situation, problems and solutions of elderly involving different disciplines.
- Housing should be provided by authorities for aged and there should be reservation of flats up-to some fixed percentage for the aged.
- More travelling concession for aged.
- Tax exemption should be given to those individual as well as organizations who are providing funds to run the programme for aged.
- There should be promotion and expansion of programmes to encourage mutual cooperation, support and exchange between youth and the elderly.
- There should be enforcement of protocols for elderly care providers which should include family, community based settings or institutions such as old age homes etc. to prevent elder abuse and negligence.
- Reports regarding national ageing situation should be produced and widely disseminated.

Family

- Develop and enhance skills whereby elder men and women may fulfill their roles as family leaders, counsellors and care givers.

- Promote, enhance and support family care giving, housing and rental subsidies for multi-generational families, provision of respite care, remuneration for unpaid long term care giving.
- Establishment of support groups for families with special problems and care giving needs such as those having to deal with dementia and physical disabilities.
- Sensitization programmes to make people aware about importance of elderly, their problems etc.

Health:

- Various campaigns should be launched on “Healthy Ageing for all” to stress a holistic approach to health and to decrease the risk of dependency in old age through an emphasis on avoidance of health damaging habits and practices.
- There is a need to establish national indices of health and disability among the aged.
- Establishment of technical aids supply system which will encompass funding and distribution of health accessories and equipment with special attention to eye glasses, hearing aids and teeth prostheses, wheel chairs etc. for prevention and treatment of age related disorders.
- Provide adequate nutrition especially to the elderly at risk including groups such as refugees, victims of disaster and those in isolation.
- To strengthen or establish a public health programme.

Education and Media

- Launching informative and communicative campaigns on ageing to promote positive images of ageing as a subject of general social relevance in which everyone participates.
- Incorporate information on ageing in primary, and secondary curricula, as well as specialized information and courses on ageing in post-secondary level, health, political, religious, economic, planning, architecture and design studies.
- Provide key roles for older persons as voluntary or paid resource persons in literacy programmes, public awareness, and campaigns and in education programmes on cultural tradition and heritage, the environment, abuse etc.
- Provision of schooling or continuing education for older persons.
- Integrate the subject and activities of ageing into national events and meetings.
- Enact legislations to ensure equitable access for older persons to social welfare services.
- To examine and determine the most equitable and efficient mix of public and private incentives which encourage the development and provision of services and opportunities for older persons.
- Recognition to service providers including informal care givers of older persons by providing training, adequate compensation and a positive public image.

Housing and Living Arrangement.

- Provide support for the elderly so that they may continue living in their own homes as long as possible. These supports may include home maintenance, rental assistance etc.

- Provide barrier free community integrated accommodation and public facilities for the elderly in cities, towns, and villages, national housing policies should pay due respect to the requirements of ageing.
- Promote community education on personal security in the home and community which will address accident prevention and security against crime and abuse.
- There should be accessibility and mobility for the elderly to work, provision of social and health services and leisure activities.

Employment

- Suitable measures should be taken to ensure that elderly person get an appropriate minimum income, either in the form of social security benefits or retirement benefits or through some other devices.
- Government should facilitate the participation of elderly persons in the economic life of the society by providing them with suitable employment opportunities.
- Older workers should be provided with satisfactory working condition taking into account their specific characteristics.
- Older workers should be suitably protected against occupational diseases.
- The transition from active working life to retirement should be gradual and not abrupt.

2.3.9 National Policies & Programmes for the Welfare of the Elderly

➤ **Administrative set-up**

The **Ministry of Social Justice & Empowerment**, which is the nodal Ministry for this purpose focuses on policies and programmes for the Senior Citizens in close collaboration with State governments, Non-Governmental Organisations and civil society. The programmes aim at their welfare and maintenance, especially for indigent senior citizens, by supporting old age homes, day care centres, mobile medicare units, etc.

Relevant Constitutional Provisions:

Article 41 of the Constitution provides that the State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want.

Further, **Article 47** provides that the State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties....

Legislations

➤ **The Maintenance and Welfare of Parents and Senior Citizens Act, 2007**

It was enacted in December 2007, to ensure need based maintenance for parents and senior citizens and their welfare. General improvement in the health care facilities over the years is one of the main reasons for continuing increase in proportion of population of senior citizens. Ensuring that they not merely live longer, but lead a secure, dignified and productive life is a major challenge. The Act provides for:-

- Maintenance of Parents/ senior citizens by children/ relatives made obligatory and justiciable through Tribunals
- Revocation of transfer of property by senior citizens in case of negligence by relatives
- Penal provision for abandonment of senior citizens
- Establishment of Old Age Homes for Indigent Senior Citizens
- Adequate medical facilities and security for Senior Citizens

The Act has to be brought into force by individual State Government. As on 3.2.2010, the Act had been notified by 22 States and all UTs. The Act is not applicable to the State of Jammu & Kashmir, while Himachal Pradesh has its own Act for Senior Citizens. The remaining States yet to notify the Act are - Bihar, Meghalaya, Sikkim and Uttar Pradesh.

➤ **National Policy on Older Persons (NPOP), 1999**

The **National Policy on Older Persons (NPOP) was announced in January 1999** to reaffirm the commitment to ensure the well-being of the older persons. The Policy envisages States support to ensure financial and food security, health care, shelter and other needs of older persons, equitable share in development, protection against abuse and exploitation, and availability of services to improve the quality of their lives. The primary objectives are:

- to encourage individuals to make provision for their own as well as their spouse's old age;
- to encourage families to take care of their older family members;
- to enable and support voluntary and non-governmental organizations to supplement the care provided by the family;
- to provide care and protection to the vulnerable elderly people;
- to provide adequate healthcare facility to the elderly;
- to promote research and training facilities to train geriatric care givers and organizers of services for the elderly; and
- to create awareness regarding elderly persons to help them lead productive and independent lives.

The Implementation Strategy adopted for operationalisation of National Policy envisages the following:

- Preparation of Plan of Action for operationalisation of the National policy.
- Setting up of separate Bureau for Older Persons in Ministry of Social Justice & Empowerment.
- Setting up of Directorates of Older Persons in the States.
- Three Yearly Public Review of implementation of policy.
- Setting up of a National Council for Older Persons headed by Ministry of Social Justice &

Empowerment from Central Ministry, states, Non-Official members representing NGOs, Academic bodies, Media and experts as members

- Establishment of Autonomous National Association of Older Persons
- Encouraging the participation of local self-government

➤ **National Council for Older Persons**

In pursuance of the NPOP, a **National Council for Older Persons (NCOP) was constituted in 1999 under the Chairpersonship of the Minister for Social Justice and Empowerment** to oversee implementation of the Policy. The NCOP is the highest body to advise the Government in the formulation and implementation of policy and programmes for the aged. The **Council was re-constituted in 2005** with members comprising Central and State governments representatives, representatives of NGOs, citizen's groups, retired person's associations, and experts in the field of law, social welfare, and medicine.

➤ **Inter-Ministerial Committee on Older Persons**

An **Inter-Ministerial Committee on Older Persons comprising** twenty-two Ministries/ Departments, and headed by the Secretary, Ministry of Social Justice & Empowerment is another coordination mechanism in implementation of the NPOP. Action Plan on ageing issues for implementation by various Ministries/ Departments concerned is considered from time to time by the Committee.

➤ **Central Sector Scheme of Integrated Programme for Older Persons (IPOP)**

An Integrated Programme for Older Persons (IPOP) is being implemented since 1992 with the objective of improving the quality of life of senior citizens by providing basic amenities like shelter, food, medical care and entertainment opportunities and by encouraging productive and active ageing through providing support for capacity building of Government/ Non Governmental

Organizations/ Panchayati Raj Institutions/ local bodies and the Community at large. Under the Scheme, financial assistance up to 90% of the project cost is provided to non-governmental organizations for establishing and maintaining old age homes, day care centres and mobile medicare units.

The Scheme has been made flexible so as to meet the diverse needs of older persons including reinforcement and strengthening of the family, awareness generation on issues pertaining to older persons, popularization of the concept of lifelong preparation for old age, facilitating productive ageing, etc. The Scheme has been revised with effect from 1.4.2008. Besides increase in amount of financial assistance for existing projects, several innovative projects have been added as being eligible for assistance under the Scheme.

Some of these are:

- Maintenance of Respite Care Homes and Continuous Care Homes;
- Running of Day Care Centres for Alzheimer's Disease/ Dementia Patients,

- Physiotherapy Clinics for older persons;
- Help-lines and Counseling Centres for older persons;
- Sensitizing programmes for children particularly in Schools and Colleges;
- Regional Resource and Training Centres of Caregivers to the older persons;
- Awareness Generation Programmes for Older Persons and Care Givers;
- Formation of Senior Citizens Associations etc.

The eligibility criteria for beneficiaries of some important activities/ projects supported under the Scheme are:

- Old Age Homes - for destitute older persons
- Mobile Medicare Units - for older persons living in slums, rural and inaccessible areas where proper health facilities are not available.
- Respite Care Homes and Continuous Care Homes - for older person's seriously ill requiring continuous nursing care and respite

During 2007-08, Government has spent more than 16 crores of rupees for assisting 660 such programmes around the country which covered around fifty thousand beneficiaries.

➤ **Assistance for Construction of Old Age Homes**

A Non-Plan Scheme of Assistance to Panchayati Raj Institutions/ Voluntary Organisations/ Self Help Groups for Construction of Old Age Homes/ Multi Service Centres for Older Persons was started in 1996-97. Grant-in-aid to the extent of 50% of the construction cost subject to a maximum of Rs.15 lakhs was given under the Scheme. However, the Scheme was not found attractive by implementing agencies and was discontinued at the end of the X Plan (2006-07). Section 19 of the Maintenance & Welfare of Parents & Senior Citizens Act 2007 envisages a provision of at least old age home for indigent senior citizens with 150 capacities in every district of the country. A new Scheme for giving assistance for Establishment of Old Age Homes for Indigent Senior Citizens in pursuance of the said provision is under formulation.

➤ **International Day of Older Persons**

The International Day of Older Persons is celebrated every year on 1st October. On 1.10.2009, the Hon'ble Minister of Social Justice & Empowerment flagged off "Walkathon" at Rajpath, India Gate, to promote inter-generational bonding. More than 3000 senior citizens from across Delhi, NGOs working in the field of elderly issues, and school children from different schools participated. Helpage India, New Delhi collaborated with the Ministry in organizing the event of the day.

Schemes of Other Ministries

I. Ministry of Health & Family Welfare

The Ministry of Health and Family Welfare provides the following facilities for senior citizens of:

- Separate queues for older persons in government hospitals.
- Two National Institutes on Ageing at Delhi and Chennai have been set up
- Geriatric Departments in 25 medical colleges have been set up.

II. Ministry of Rural Development

The Ministry of Rural Development has implemented the National Old-age Pension Scheme (NOAPS) – for persons above 65 years belonging to a household below poverty line, Central assistance is given towards pension @ Rs.200/- per month, which is meant to be supplemented by at least an equal contribution by the States so that each beneficiary gets at least Rs.400/- per month as pension.

III. Ministry of Railways

The Ministry of Railways provides the following facilities to senior citizens:

- Separate ticket counters for senior citizens of age 60 years and above at various (Passenger Reservation System)

PRS centres if the average demand per shift is more than 120 tickets;

- 30% and 50% concession in rail fare for male and female senior citizens respectively of 60 years and above respectively.

IV. Ministry of Finance

Some of the facilities for senior citizens provided by the Ministry of Finance are:

- Income tax exemption for senior citizen of 65 years and above up to Rs. 2.40 lakh per annum.
- Deduction of Rs 20,000 under Section 80D is allowed to an individual who pays medical insurance premium for his/ her parent or parents, who is a senior citizens of 65 years and above.
- An individual is eligible for a deduction of the amount spent or Rs 60,000, whichever is less for medical treatment (specified diseases in Rule 11DD of the Income Tax Rules) of a dependent senior citizen of 65 years and above.

V. Department of Pensions and Pensioner Grievances

A Pension Portal has been set up to enable senior citizens to get information regarding the status of their application, the amount of pension, documents required, if any, etc. The Portal also provides for lodging of grievances. As per recommendation of the Sixth Pay Commission, additional pension are to be provided as per details given below to older persons:As per recommendation of the Sixth Pay Commission, additional pension to be provided to older persons:

Age Group	% pension to be added
80+	20
85+	30
90+	40
95+	50
100+	100

VI.Ministry of Civil Aviation

The National Carrier, Air India, provides concession up to 50% for male senior citizens of 65 years and above, and female senior citizens of 63 years and above in air fares.

There is an urgent need to mainstream issues concerning the aged and ageing in India. The needs and requirements of the elderly should not be overlooked by society. We need to fight ageism that is so deeply ingrained in the societal psyche and reinforced very powerfully by the media. Elderly should not be considered a spent force and consigned to the history books but seen as active members of the society contributing to its wellbeing. Society and government should be sensitized to the fact that old age is also another phase of life with its special characteristics and needs just like childhood and youth. Though the losses in this phase of life are more than in any other phase in life but still all is not lost. The younger people should get to know how the world appears to the elderly; because that is the future of the youth. Most importantly, the elderly should be encouraged to get out of this 'retirement mentality' and think about old age as an opportunity to complete so many unfinished tasks and may be expand their horizon and look beyond the self and the family and work for community. Active participation is the mantra for being ensuring independence, dignity, and self-fulfillment and then become entitled for care. But, until that happens on a mass scale NGOs should take the lead in mobilizing elderly to take up their case in various forums and also articulate their interest in various policy forums. Once awareness is spread to considerable sections in society and elderly are mobilised they will form their own groups to struggle for their rights. These are ways of empowering the elderly to participate in the democratic process and once that happens then democratic channels of participation should facilitate participation of this group of people in governance.

2.4References

Andrews, G.R. (1992) : Ageing in South East Asia. A five country study : Cross National Epidemiological and Social Study. *Adelaide : The Centre for Ageing Studies. The Flinders University of South Australia.*

Anttila, S., Takala, J., Takala, A., Ollila, O.P., Vierimaa, E., Koski, M. (1985) : Health status and social conditions of the elderly in remote districts. *Scand J Soc Med*, Vol. 13 : 119-26.

Bhattacharyya, S and Birla, B. (2006). Impact of Globalization on Elderly: Issues and Implications. *Journal of Gerontology*. Vol. 20, No. 3. pp 273-284

Bose, A.B. 1996: Economic and Social Conditions of the Elderly, with a Special Focus on Women: Needs and Capabilities of the Elderly. Implications of Asia's population future for older people in the family (ESCAP Asian Population Studies Series # 145). Bangkok: ESCAP, cited in Vijay Kumar, S. 2003: "Economic Security for the Elderly in

India: An Overview", An Aging India: Perspectives, Prospects and Policies, The Haworth Press p.45-65, New York.

Government of India 1999 National Policy on Older Persons. Ministry of Social Justice and Empowerment, New Delhi.

Irudaya Rajan, S. (2001, February 24): Social Assistance for Poor Elderly: How Effective? Economic and Political Weekly, 613-617.

National Sample Survey Organisation 1998 Morbidity and Treatment of Ailments July, 1995- June, 1996 (NSS 52nd Round) Report No. 441, New Delhi, Government of India.

Vijay Kumar, S. 2003: "Economic Security for the Elderly in India: An Overview", An Aging India: Perspectives, Prospects and Policies, The Haworth Press p.45-65, New York.

Chacko, A., Joseph, A. (1990): Health problems of the elderly in rural South India. *Indian Journal of Community Medicine*, Vol. XV (2): 70-3.

Chadha, N.K., Chao, D., Mir, U.A. and Bhatia, H (2005) Structure of Social Network of the Elderly in Delhi. pp 307 – 326

Datta, A. (2006). Greying Citizenship: The Situation of the Older Persons in India. *Journal of Gerontology*. Vol. 20, No. 3. pp 285-298

Devi, U.P. (2005). Aging and Gerontology in the Context of Women in India. *Indian Journal of Gerontology*. Vol. 19, No. 3. pp 350 – 355

Dilip, T.R. (2001) : The Burden of Ill Health among Elderly in Kerala. *Research and Development Journal*, Vol. **7(2)**: 7-15.

Elango, S., (1998) : A study of health and health related social problems in the geriatrics population in a rural area of Tamil Nadu. *Indian Journal of Public Health*, Vol. **42 (1)**: 7-8.

Government of India. *National Policy on older persons*: Ministry of Social Justice and Empowerment, Shastri Bhawan, New Delhi, Jan. 1999.

Grover, V., Aggarwal, O.P., Tiwari, R.S., Markandey, N. (2000) : Prevalence of health problems among the elderly in Rural Areas of Delhi. *Indian J Prev. Soc. Med.*, Vol. **31 (3&4)** : 47-51.

Gupta, I., Dasgupta, P., Sawhney, M. (2000) : *Health of the Elderly in India : Some Aspects of Vulnerability*. Institute of Economic Growth, New Delhi.

Hunt, R.J., Beck, J.D., Lemke, J.H., Kohot, F.J., Wallace, R.B. Oct. (1985) : Edentulism and Oral Health Problems among elderly rural Lowans: The Iowa 65+ Rural Health Study. *AJPH*, Vol. **75 (10)** : 1177-81.

Kishore, S., Garg, B.S. (1997) : Socio-medical Problems of Aged Population in Rural Area of Wardha District. *Indian Journal of Public Health*, Vol. **41 (2)** : 43-8.

Lal, S., Mohan, B., Punia, M.S. (1997) : Health and Social Status of Senior Citizens in Rural Areas. *The Indian Journal of community Medicine*, Vol. **9 (3)** : 10-17.

Mallick, A. (2005). Crime and Older People in Kolkata. Journal of Gerontology. Vol. 19, No. 3. pp 356 – 367

Nasreen, A. 2010. Family in Transition and Challenges for Elderly Persons. *Indian Journal of Gerontology*. Vol. 24, No. 4. pp. 501-508

National Sample Survey Organisation. “*The Aged in India. A Socio-Economic Profile*” (52rd round (July 1995-June 1996) Report No. 446, New Delhi. Department of statistics, 1998b.

National Sample Survey Organisation. *Socio-economic profile of the aged person*. 2nd Round (July 1986-June 1987) No. 367. Revised Report, New Delhi : Department of statistics, September 1989.

Nayar, P.K.B. : The Ageing scenario in Kerala : A Holistic Perspective. *Research & Development Journal*, Vol. **6 (2)** : 5-13, Feb-May 2000.

O’Connor, M. (1992) : The Self-Perceived Health Needs of the Rural Elderly who Live Alone. *I.J.M.S.*, Vol. **161(4)** : 108-111.

Pareek, U. (1981) : *Manual of the Socio-Economic Status Scale (Rural)*, Delhi : Manasayan, 1981.

Purohit, C.K., Sharma, R. (1976) : A Study of General Health Status of Persons Aged 60 years and above in the Rural Health Training Centre Area, Naila. *Indian J Med Res*, **64 (2)** : 202-09.

Raj, B. (1971) : A medico-social study of aged persons in certain villages. *Indian Med Gaz*, Vol. **10** : 25-31, 1971.

Registrar General of India (1986). *Report of the technical group on population projection* constituted by the plannign commission. Office of Registrar General, India.

Registrar General of India (1991). *Report of the technical group on population*. Census Office of the Registrar General, India : 1991.

Shettar, S.C. (2013). Problems of Aged in Changing Indian Scenario. Retrieved from Yojna Archives.

Singh, C. Mathur J.S., Mishra, V.N., Singh J.V., Singh R.B., Garg, B.S. (1990) : *A study of health status of aged among rural population of Meerut* [M.D. dissertation]. Meerut : University of Meerut.

Singh, M.M., Murthy, G.V.S., Venkataramen, R., Rao, S.P., Nayar, S. (1997) : A Study of Ocular Morbidity among Elderly population in a rural area of central India. *Indian J Ophthalmol*, **45** : 61-65, 1997.

Siva Raju, S. 2000: "Ageing in India: An Overview", in 'Gerontological Social Work in India', Murli Desai and Siva Raju (Eds.), Delhi, B. R. Publishing Co.

Siva Raju, S. 2002: "Health Status of the Urban Elderly: A Medico-Social Study", Delhi, B. R. Publishing Co.

Siva Raju, S. 2002: "Meeting the Needs of the Poor and Excluded in India", Situation and Voices, The Older Poor and Excluded in South Africa and India, UNFPA, Population and Development Strategies, No. 2, 93-110.

Siva Raju, S. 2004: "Profile of Elderly and Organisations Working for their Care: A Study in Mumbai", Family Welfare Agency, Mumbai (Mimeo) Vijay Kumar, S. 2000: "Social Security in Indian Context", cited in Vijay Kumar, S. 2003: "Economic Security for the Elderly in India: An Overview", An Aging India: Perspectives, Prospects and Policies, The Haworth Press p.45-65, New York.

Swaddiwudhipong, W., Koonchote, S., Nguntra, P., Chaovakiratipong, C. (Sept. 1991) : Assessment of Socio-Economic, Functional and medical problems among the elderly in one rural community of Thailand. *South East Asian J Trop Med. public Health*, Vol. **22** (3) : 299-306.

Swaddiwudhipong, W., Lerdlukanavongse, P., Chaovakiratipong, C. *et al.* (1996). Screening assessment of the elderly in Rural Thailand by a mobile unit. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, Vol. **90** : 223-27.

Swain, P and Sherin Raj, T.P (2005). **Demography of Ageing in India: State and District level Analysis. Indian Journal of Gerontology. Vol. 19, No. 3.pp 327 – 342**

UN Population Division (1996). *Sex and Age Distribution of the World Populations* : The 1996 Revision and World Population Projection to 2150. Department of Economic and Social Affairs, New York, United Nations : UN Population Division, pp. 1-119.

Verma, S.K. and Satyanarayana, A. (2012). Patterns of Intergenerational Relations in Indian Family. *Indian Journal of Gerontology*. Vol. 26, No. 3, pp. 367–385

Weinberg, L.E., Strain, L.A. (Oct. 1995) : “Community-Dwelling Older adults’ Attributions about Falls. *Arch Phy Med. Rehabil*, Vol. **76** : 955-60.

World Health Organisation (2000). *Noncommunicable Disease Prevention and Health Promotion*; Retrieved June 2003.

World Health Organisation. (2001). *Health and Ageing: A Discussion Paper*. Department of Health Promotion, Non-Communicable Disease Prevention and Surveillance. Retrieved June 2003.

Yassin, Z., Terry, R.D. (1990) : Health characteristics of rural elderly Malay females in selected villages in Negeri Sembilan. *Med. J. Malaysia*, Vol. **45 (4)** : 310-18.

2.5. Questions

Long type:

1. What factors are responsible for population ageing?
2. What are the various problems of elderly?
3. Changing family structure has created problems for elderly. Elaborate.
4. What factors are responsible for changing family scenario for elderly?

Short Types:

1. What are the stages of demographic transition?
2. What is the impact of globalization on elderly?
3. Elaborate the economic problems of aged.
4. What long term strategies can be taken for welfare of elderly?
5. What are the consequences of population ageing for social development?
6. What are the various schemes by different ministries for the aged?

UNIT- III

Theoretical Approaches

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- 3.0 Approaches to sociology of ageing
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3.0

This unit revolves around the key theoretical frameworks for understanding ageing.

Social gerontology is multidisciplinary because it involves the social sciences and arts and humanities in the study of the social context of ageing. It also includes insights gained from research, policy and practice. Given the variety of disciplinary perspectives involved in social gerontology, and its comparative emergence as an academic discipline, it is hardly surprising that the development of theory within gerontology remains limited. Indeed socialgerontology does not possess an extensive theoretical framework in its own right.

Frequently, researchers have limited themselves to describe aspects of behaviour in later life, or the characteristics of various subgroups of the older population, without trying to organise the findings into a coherent theory of social ageing. The focus in much social gerontological investigation has been upon identifying, classifying and describing the experience of later life rather than understanding and theorising.

Much of the explanation of this largely a theoretical nature of much gerontological work derives from the essentially applied and/or policy related nature of much gerontological research. This dominance is encapsulated by the still relevant comments of Fisher (1978), who wrote: Social gerontology has not succeeded in creating a body of theory. However, in this unit we will try to encapsulate various theories in sociology of ageing.

3.1 Objectives

After studying this unit, students will be able to conceptualize

- The various theoretical approaches to ageing
- Course of development of various theoretical approaches
- Loopholes in each approach

3.2 Introduction

Gerontology, like sociology, operates at both macro- and micro levels of investigation, which adds to the complexity of our subject. Gerontology is interested in questions of micro level individual adaptation to the experience of ageing such as 'how do individuals adjust to widowhood?' or decide when to consult their doctor. At the macro-level social gerontologists are concerned with questions such as the implications for the health care system of population ageing or the economic purpose of retirement (Phillipson, 1982), or with how factors such as class and gender influence the

experience of ageing (Arber et al., 2003). In attempting to evaluate and understand theoretical perspectives and frameworks upon social ageing we need to establish at which level the theoretical proposition is operating at—micro or macro. In reality, of course, the distinction between these two perspectives is much less clear cut than the dichotomy described here—it reflects a continuum rather than a clear division. It is not that one perspective is superior to the other. They both contribute different, but complementary, approaches to our understanding of the experience of old age and serve to enrich our subject.

3.3 Old age as a social problem

While not a specific theory as such, the consideration of old age and later life as a social problem is a framework which is carried out in Britain. This perspective focuses upon the problematic nature of ageing, both for individuals and societies. This framework is an approach that operates at both micro-and macrolevels of analysis as it can investigate both the problems of ageing individuals and ageing societies. This type of approach has been applied frequently in social gerontology and relies heavily upon the biological model of ageing with its emphasis upon decline and deterioration in function.

In using this perspective the definition of which aspects of ageing are defined as 'problematic' is crucial.

At the most obvious level social problems are what people think they are. If conditions are not defined as social problems by the people involved in them, then they are not problems to those people although they may be problems to policy makers or to scientists. Hence there is an issue of power and ownership at the heart of the 'social' problem approach to the study of ageing. Problems may be defined as being perceived either by the individual or by society at large. In this tradition, who defines which 'problematic' aspects of ageing are worthwhile researching is of key importance. Additionally we must consider why the identified problems, for example loneliness or isolation, are seen to be problematic for older people but not to other segments of the population. The essence of this approach is that it is concerned with the problematic and difficult aspects of ageing and the knowledge so generated is concerned with these areas, thus this approach will yield very little evidence as to the 'non-problematic' or 'normal' aspects of ageing.

At the macrolevel older people emerged as a specific 'problem group' for which specific social policies were required in the late nineteenth century (Thane, 2000; MacIntyre, 1977). Prior to this older people were not differentiated from the rest of the pauper classes: old age per se was not seen as a social problem; rather destitution, irrespective of age, was the issue. What prompted the emergence of older people as a specific problem group in the late nineteenth century? Demographic changes are an insufficient

explanation because the major period of growth in the absolute and relative number of older people in the population did not occur until the early part of the twentieth century.

Thane (2000) demonstrates how the awareness of older people as a particular problem group arose from three interrelated factors: a growing awareness of the complexity of the causes of poverty (of which old age was one), the difficulties of older workers remaining in the labour force, and the concentrations of older people, especially in rural areas, brought about by the outward migration of the young. A variety of interlinking social trends combined to increase the social and physical visibility of older people within society and drew attention to the problems of old age for both the individual and society as a whole. There was not, however, the same impetus to examine the 'non-problematic' aspects of the newly visible population of elders.

There are two distinct forms of the 'old age as a social problem' perspective—the humanitarian and the organisational—and these two approaches reflect the macro and micro level approaches towards the study of ageing (MacIntyre, 1977).

The humanitarian perspective emphasizes an interest in the problems of old age and ageing for the individual while the organisation approach is concerned with the problems for society of an ageing population. Again while for the purpose of discussion and description these two approaches are presented as distinct dichotomies, in reality such sharp divisions are less clear cut and a specific piece of research may be addressing both aspects of this perspective.

From another perspective, the focus of attention is upon the individual older person and the problems which old age by implication 'inevitably' brings. Old age is implicitly conceptualised as a time of declines in physical, mental and social functioning and not as a time of life characterised by new opportunities or challenges. Research in this framework has focused upon five main areas: morbidity, quality of life, social relationships, use of services and employment.

Where issues other than these have been addressed, the focus has been on describing the differences between older people and other age groups, rather than looking at either continuities between age groups or differences within the older age groups. Old age is segregated or separated from earlier phases in the life course and is not often seen as representing a continuation and development of previous phases of life. Few of the investigations carried out considered the contributions made by older people. Research undertaken from this 'social problem' perspective often, by the very nature of the questions they are seeking to answer, portray a very one-sided picture which often focuses upon the negative aspects of ageing and which is of only limited generalizability. While undertaken for the best of reasons, social problem-focused research has contributed, in part at least, to perpetuation of negative attitudes towards

old and older people and has not looked at the positive aspects of how older people organise and manage their daily lives.

The second manifestation of the 'old age as a social problem' perspective is as an organisational problem for society and is a macro level approach to the 'problems' of ageing. This tradition emphasises the ideology that old age is a 'burden' for society, especially for those people who are in employment and who will have to shoulder the 'burden' of paying to support the legions of pensioners.

Despite the recent interest in the notion of 'intergenerational conflict' resultant from the burden which younger people are going to face in supporting future cohorts of elders, this is not a particularly new approach.

This concern about the burden of population ageing has been termed 'moral panic' by Jefferys (1983) or the 'elderly avalanche' by Russell (1990).

3.4 Developing theory in social gerontology

There are a number of different explicit theoretical frameworks concerned with the study of ageing. Psychological and physiological perspectives upon ageing focus upon the changes which happen to individuals. However, when focusing upon the social context within which ageing occurs, both for groups and individuals, then theories derived from sociological perspectives are most pertinent. As noted earlier, a concern with examining and understanding the social context of ageing involves studies which look at questions concerned with the adaptation of individuals (a microscale approach) and of questions posed at the macroscale (i.e. concerns with the impact of ageing upon social structures and vice versa).

Social theories of ageing are characterised both by the level of explanation at which they operate and by the assumptions and ideologies that underpin them. Aroni and Minichiello (1992) developed a typology of theories including both the level of analysis (micro versus macro theories) and nature (interpretist contrasted with normative theories such as role theory).

3.5 Functionalist theories and ageing

Functionalist perspectives have been highly influential in the development of theoretical frameworks in social gerontology. Theories such as disengagement, activity theory, and continuity theory, the thesis of modernisation and age stratification theories of ageing all developed from the structural-functionalist premises.

❖ **Let us remember:**

Structural functionalism is a macro level theoretical stance that is concerned with analysing elements of society (social institutions and structures) in order to elucidate how society is maintained and developed. The appropriate analogy here is with the body. In order to understand how the body works you need to understand how each organ works, how the organs are interrelated and how they relate to the body as a whole. Functionalists adopt a similar approach to understanding and theorising about society and are concerned with identifying the functions that particular social arrangements fulfil for any given society. This approach views the elements of society as being functionally interdependent, with the individual and society always seeking to maintain a state of equilibrium between them.

3.5.1 Disengagement theory

This is a theory which links both micro and macro approaches to the study of ageing. Disengagement was the first explicit social theory that was concerned with ageing and was originally formulated in *Growing Old* by Cumming and Henry (1961). This theory posits that, independent of other factors such as poor health or poverty, ageing involves a gradual but inevitable withdrawal or disengagement from interaction between the individual and her/his social context and that this process is mutually beneficial. Thus disengagement would be seen as functional or useful, because it facilitates a smooth transfer of power from the old to the young. From this perspective, retirement is seen as a mechanism by which companies can predetermine levels of employee turnover, gives the individual a 'graceful' exit from the pressures of employment and creates employment opportunities for younger workers. Hence disengagement, as illustrated by retirement, is a mechanism for ensuring equilibrium within society and the transition of social power across generations. By disengaging from activity, either employment or social, individuals prepare themselves for death. At the same time, society also prepares the individual for the later phases of life, by withdrawing the pressure to interact and facilitating the entry of younger cohorts into the social world and the disruption caused by the death of the individual is minimised.

Disengagement therefore implies a triple loss for the individual:

- loss of roles,
- restriction of social contacts and relationships and
- reduced commitment to social mores and values.

Successful ageing, from the viewpoint of disengagement theory, implies a reduction in activity levels and a decrease in involvement, until the individual withdraws from all previous activities and becomes preoccupied with the ultimate withdrawal of death. Central to this theory is the assumption that both the individual and the wider society benefit from the process. Withdrawal for the individual may mean a release from social pressures that stress productivity, competition and continued achievement. For society, the withdrawal of older members permits younger, more energetic individuals to take over the roles that need to be filled. Disengagement therefore is seen as a way of permitting an orderly transfer of power between generations. The mutual withdrawal of the individual and society from each other is presented as a necessary condition for both successful ageing and the orderly continuation of society. This involves a triple loss—of social roles validated by society, restricted social contact and a reduced commitment to social mores.

Disengagement theory had a profound influence upon the development of gerontological research partly because it was the first major theory and thereby generated considerable debate and discussion within the gerontological world. It has also been influential because it appeared to indicate the pathway to 'successful' ageing. In this case the way to age 'successfully' was to reduce social involvement and social interaction. Although it is a negative pathway to the successful ageing, it is not conceptually different from other ways to a successful old age such as dietary adaptations (such as eating yoghurt) or religious or physical activity. It was also highly influential at a time when the negative effects of demography were being heard and it clearly resonated with the negative concerns which were linked with population ageing.

The empirical evaluation of disengagement as a theory of ageing must address three core aspects of the theory.

First, disengagement is a life-long process; for most individuals, it takes place over a period of time rather than suddenly. Throughout the life course the individual is continually acquiring and dropping particular social roles. Hence it is problematic to design a research study which could easily incorporate this 'lifelong' perspective.

Second, there is an implicit statement that disengagement is inevitable because death and biological decline are inevitable, although the nature and timing of disengagement will vary between individuals, historically and culturally. Again to establish the inevitability of reduced social engagement poses methodological challenges. How can 'inevitable' disengagement be differentiated from reduced levels of social participation resultant from ill health or poverty?

Third, disengagement is seen as adaptive for both society and the individual. Reduced social engagement is seen as being beneficial.

There is some empirical evidence to support disengagement theory in that older people do experience a loss of roles with ageing, whether through retirement, the death of a spouse or the departure of older children from home. However, older people, like other groups within the population, use strategies of substitution and compensation to offset for losses of role. The widowed may remarry, or older people may replace a widespread and loose-knit pattern of interaction with more intense, locally based networks. While empirical data may demonstrate reduced social activity with increasing age, the inevitability, universality and essentially adaptive nature of these changes remains unproven. Indeed the veracity of disengagement theory is further compromised because of the involuntary nature of many disengagements, such as mandatory retirement and the failure for disengagement to be demonstrated universally (for example there are some societies where social roles increase in later life). However, Daatland (2002) has suggested that disengagement theory was an important stage in the development of gerontology because it identified old age as distinct and important phase of life and because it was an essentially multidisciplinary perspective.

Criticism:

Several commentators argue that disengagement theory has had profound negative impact upon older people because of its influence within social and health policy formulation. Blau (1973) argues that disengagement theory has been used to avoid confronting and dealing with the issue of older people's marginality in American society and to condone indifference towards the problems of older people. Estes et al. (1982) and Estes (2001) consider that the popularity of disengagement theory has had a marked influence upon the formulation of policy for older people in the United States. They argue that this concept of old age prescribes either no policy response to ageing or interventions that achieve the separation of the older person from society. Similar arguments could be for India, where many services for older people are often discrete or separate from the mainstream (the argument being that specialist services offer better services by concentrating expertise). Such separations may be spatial as well as conceptual with, for example, health services for older people located off main hospital sites, in former workhouse premises or symbolically in the oldest hospital buildings.

Disengagement theory has implicitly formed the justification and intellectual basis for age-segregated policies and the separation of older people from other forms of welfare development. The notion of disengagement has been used to legitimise policies that have sought to exclude older people from social arenas and services and enabled professionals dealing with older people to rationalise their often negative stereotypes. This theory has further created 'barriers' between older people and other social groups and the professionals dealing with them, with the inevitable consequence of poor quality

services and inadequate education and training for the staff working within them (Biggs,1993,1999). It has also provided the theoretical justification for a culture of indifference for both the problems experienced by older people and the policy formulations developed in response to these. Poor quality services, low pensions and inadequate standards of care can be justified by theorizing that old age is a time of disengagement and that older people are no longer to be evaluated against current social mores. Hence it is perfectly acceptable to provide them with marginal or substandard care and concern.

3.5.2 The response to disengagement: activity theory

The presumed inevitability of the process of disengagement, with its basis in the biomedical and sickness model of ageing, has also been subject to extensive academic criticism. While disengagement theory has been highly influential in the development of social gerontology, empirical testing and debate have exposed its essential loopholes. It has, however, had an important impact in stimulating the development of counter-theories of which activity and continuity theories are the most significant. These two theories are concerned with the ageing of individuals although, again, approached from a macro level theoretical perspective. However, it still remains within the structural functionalist paradigm in that it is concerned with the maintenance of equilibrium within society. The focus is upon adaptation and integration into the social system and, again, it is prescribing a route to successful ageing.

Diametrically opposed to the notion of disengagement is activity theory. Developed by Havighurst (1963) this perspective maintains that normal and successful ageing involves preserving, for as long as possible, the attitudes and activities of middle age. Here mid-life is conceptualised as the 'success' to which we are always looking back and always trying to regain. To compensate for the activities and roles that the individual surrenders with ageing, substitutes must be found. Upon retirement from paid employment the retiree must find other roles, such as voluntary work, to compensate for this loss. It is assumed that any type of activity can be substituted for the lost role. The assumption is made that the meaning and value attached to different activities are the same and that all members of society share these meanings. Both these assumptions may be unfounded. Activity theory is a prescriptive view of ageing which argues that activity and engagement offer the path to successful ageing. This is a socially based manifestation of the 'use it or lose it' conceptualization of successful ageing and is the mirror image of disengagement but is equally judgmental and prescriptive.

There are two central assumptions of activity theory.

First, that morale and life satisfaction are positively related to social integration and high involvement with social networks: those with high levels of activity and integration are more satisfied.

Second, role losses such as widowhood or retirement are inversely correlated with life satisfaction and such losses need to be compensated for by the substitution of compensatory activities.

Criticism:

However, it could equally well be argued that satisfaction with life causes activity or that some other confounding (or intervening variable) such as health or income influences both activity and satisfaction. Furthermore, research has demonstrated that individuals can maintain high levels of satisfaction and quality of life with both declining levels of activity and with low levels of activity. Again, one may question the value judgements inherent in the theory that interaction and activity in old age is a 'good thing'. The social policy implications of this perspective are rather more positive than disengagement theory, for at least it argues for the integration of older people as full members of society.

3.5.3 The Continuity theory

Continuity theory holds that, in the course of growing older, the individual will attempt to maintain stability in the lifestyle he/she has developed over the years. Continuity theory suggests that in the process of ageing, the person will strive to preserve the habits, preferences and lifestyle acquired over a lifetime; that there will be a process of evolution of activities as the individual grows older (Atchley, 1999).

Both disengagement and activity theory suggest that successful ageing is achieved by movement in a single direction. Continuity theory, in contrast, starts from the premise that the individual will try to preserve the favoured lifestyle for as long as possible. It then suggests that adaptation may occur in several directions according to how the individual perceives her/his changing status. The theory is rather less dogmatic in that it does not assert that one must disengage, or become active, in order to cope with the ageing. Rather the decision regarding which roles are to be disregarded and which maintained will be determined by the individual's past and preferred lifestyle and potentially by structural factors such as income and health. Unlike activity theory, this approach does not assume that lost roles need to be replaced. Continuity theory,

therefore, has the advantage of offering a variety of patterns of successful ageing from which the individual can choose.

Building a generally applicable theory from this basis is, therefore, difficult. From a research and policy perspective, it stresses the need to understand the biography and life course of the individual in attempting to understand her/his experience of later life. As such it is a more person-centered approach and stresses the links between 'old age' and earlier phases of life.

Criticism:

The disadvantage is the problem of trying to test this theory empirically. Each individual's pattern of adjustment in old age or retirement becomes a case study in which the researcher attempts to determine how successfully the individual was able to continue in her/his previous lifestyle.

3.5.4 The importance of social roles in functionalist theory

Both disengagement and activity theory embrace the structural-functionalist concept of social roles. Disengagement, activity and continuity theory are all, to a lesser or greater degree, concerned with how older people adjust to changes and losses in social roles. However, such concerns are also evident in other phases of the lifecycle—role loss is not exclusive to old age. All three theories offer a profoundly negative view of old age in which all role changes are the result of loss. There is little reference to new positive roles such as becoming (great) grandparents.

Social role theory assumes the existence of a set of rules, regulations and roles and that as an individual ages there will be a change (adaptation) in the number of social roles an individual has and how these are executed. Here roles are conceptualised in the Parsonian sense and are defined in terms of both expectations of the role and orientation of the role. Roles are part of the normative order of society and are powerful determinants of behaviour as there are sanctions for deviation from 'social expectations'. Put at its most straight forward a social role can be conceptualised as a pattern of behavior expected from an individual who holds a particular social status (defined in terms of social position) —in our examples that of an older person. However, the social world is a complex entity and any individual has a multitude of roles to play simultaneously. An individual could be involved in the roles of spouse, parent, sibling or employee at the same time. All of these roles stress different aspects of the individual's persona.

In the broadest sense, competing social roles differ in three main ways.

First, roles will emphasise varying qualities. Some roles are defined in terms of the task undertaken, such as the worker role, while others are defined more in terms of emotional content, such as wife or husband.

Second, social roles vary in the type of reward offered, such as money, prestige, status, emotional support or satisfaction.

Third, roles are evaluated according to the values of the society. For example, in capitalist societies strongly imbued with the Protestant work ethic, the role of the retired person or the mother staying at home looking after small children may be ascribed little value. Similarly, the retired person may be ascribed little status in a society, which places its major emphasis upon economic activity and financial independence.

The notion of social roles is complex and a dynamic area of social world which not all theories acknowledge. In attempting to understand later life we clearly need to be able to integrate our understanding of the different roles that older people play and how they make sense of them.

3.5.5 Age stratification theory

This is another good example of a theory which is concerned with the adaption of groups, rather than of individual older people. Again the concern is with examining social integration but from the basis of age-based groups and it flows out of the consensus approach. Society is often conceptualised as being stratified, or divided, along a number of dimensions such as social class or ethnic status and these factors are used to allocate social roles. Age stratification theory uses chronological age as the defining and role allocation variable (Riley, 1971; Riley et al., 1973; Riley, 1987).

Three basic issues dominate age stratification theory:

First, the meaning of age and the position of age groups within any particular social context,

Second, the transitions which individuals experience over the lifecycle because of these social definitions of age, and

Third, the mechanisms for the allocation of roles between individuals.

Riley (1971) argues that each age group (young, mid-life and old) can be analysed in terms of the roles that members of that group play within society and how these are valued. For example within the employment field, workers may be classified as 'older' and 'younger' and the latter valued more highly because of their perceived greater productivity, innovation and vitality. The use of chronological age in guiding the allocation of social roles is probably universal to all cultures, but the precise nature of

these age norms reflect the culture, history, values and structure of specific societies. For example, over the twentieth century there have been substantial variations in some aspects of the lifecycle. Childbearing and child-rearing are now confined to a much shorter period than previously when women were 'reproductively active' for twenty-five to thirty years. This has been matched by the creation and increase in the duration of the 'empty nest' phase of the lifecycle. Similarly, within specific societies the size, composition and history of particular cohorts influence both the timing and order of the major life events. The existence of compulsory national service will 'delay' the major life transitions such as marriage, going to university or starting a career.

These age norms in behaviour may originate in tradition, factual regularity or negotiation. Whatever the origin, they are based upon assumptions, either explicit or implicit, about age-related abilities and limitations. These norms may, however, vary with social class, ethnicity or sex, historically or culturally. For example, members of the working class traditionally marry at an earlier age than members of the professional classes. Similarly, age at first marriage is usually older for males than for females. Because of these variations, age norms have different realities and meanings for varying social groups. Despite this, age is a universal criterion for role allocation. The age grading of roles within an age stratification system creates age differences and inequalities. Each age group is evaluated, both by itself and others in the society, in terms of the dominant social values. This differential evaluation of roles will produce an unequal distribution of power and prestige across the age groups. Thus when societies value the accumulated experience and wisdom of the old, and allow them to undertake roles that capitalise upon this experience, then the aged will be accorded a position of respect.

Riley and Riley (1994a) have developed the notion of structural lag as a way of responding to the observation that individual lives, in relation to age-graded roles, change more rapidly than social norms or institutions. They argue that social institutions lag behind major social changes such as the institutionalisation of formal retirement. Now people can anticipate fifteen or twenty years of retirement without the development of social opportunities and clear roles. Similarly a policy of 'lifelong learning' does not fit easily with the completion of formal education for most people between 18 and 25 years. This approach can be used to argue for a review of our formalised age norms, such as retirement, which can lead to the loss of the potential contribution of older people across the life course.

The value of this approach is that it allows the gerontologist to look at any age group in terms of its demographic characteristics and its relationships with other groups. The system of age stratification in any society is complex and dynamic and linked in with

other systems of stratification such as class or ethnicity. The task of understanding the effects of age stratification is complicated by these interactions. Furthermore the usefulness of this approach is weakened by the use of chronological age rather than 'actual' ageing to define cohort membership; the 'meaning' attached to particular ages is both historically and culturally specific.

Riley et al. (1999) developed the ageing and society paradigm to address the static nature of age stratification. This new paradigm distinguished the notions of changing lives and changing structures as two interrelated sets of processes. However, this remains an essentially functionalist stance which emphasises balance, integration and norms and one in which factors such as class and gender are conspicuously absent.

Criticism:

This is very much a macro scale approach to the study of ageing for, while it tells us about the attributes of different cohorts, it is of limited value in explaining individual behaviour. This approach can often be seen as being deterministic and allowing little freedom of action for the individual social actor because of the themes' macro level orientation and of being an essentially static theory which neglected political processes (Quadagno and Reid, 1999).

3.5.6 Modernisation theory

The position of older people in pre-industrial society is usually described as one of respect and authority. Typically, pre-industrial society is depicted as the 'golden age' of ageing and older people, although every stage in history seems to look back to its own 'golden age'. This stereotypical view of the past is usually contrasted with their position in modern society where older people are thought to be worse off because they are consigned to meaningless retirement, neglected by their family and ignored by the prevailing youth culture.

The basic thesis of modernisation theory is that as society moves from rural to industrial, the position of older people deteriorates as urbanisation and industrialization combine to undermine the extended family and replace it with the nuclear family as the primary unit of society and isolate older people from both society and the family.

Cowgill and Holmes (1972) developed these ideas further.

The process of modernisation was defined by four parameters:

- Improvements in medical technology,
- The application to the economy of science and technology,
- Urbanisation and
- Mass education.

Cowgill and Holmes (1972) argued that improvements in health care led to an ageing of the population. The decrease in the potency of death results in an ageing of the working population and a decrease in job opportunities for the young. Thus intergenerational tensions are created by the competition for jobs. Retirement then becomes a social substitute for death and creates job opportunities for the young. However, the dominance of the prevailing work ethic results in a 'devaluing' of retirement. Additionally economic and technological developments devalue the employment skills of the old. Urbanisation attracts young people from the rural areas, resulting in a break-up of the extended family. Finally, the development of mass education reduces the hold that older people have over younger people. Changes in these four factors contributed, it was argued, to a decrease in the status of the older people in modern society.

In such developing social settings, youth and progress are extolled while the traditions and experience of the old are developed and seen as irrelevant and their reduced power and prestige places them at a disadvantage. The old become socially and physically abandoned and live a marginal existence on the fringes of society.

Basic Postulates:

First, implicit within this theory is the notion that preindustrial societies are uniform and are characterized by a positive attitude towards older people.

Second, it assumes there has been a before-and-after situation within societies with regard to the position of older people and that there has been a smooth, uniform, linear translation from one type of society to another.

Third, and perhaps most important, there is now a significant body of empirical research which indicates that the presence of an extended family does not guarantee the status and care of older people (Thane, 2000).

Again preindustrial societies illustrate a degree of diversity in the attributes displayed towards older people and it is unwise to presume a homogeneity that is more fable than fact.

3.5.7 Overall critique of Functionalist Theories.

Before considering the major gerontological theories that have developed out of functionalism it is necessary to outline the meta critiques which have been made of this approach. The implicit emphasis within functionalism is upon social order, equilibrium and the maintenance of the status quo rather than upon possible change and conflict. Hence the functionalist perspectives, and resulting theories of ageing, are seen as being essentially conservative. In reading functionalist theories, with their stress upon determined nature of many social actions, the power of individuals to influence their social environment is highly limited. Individuals are seen as little more than passive social actors or 'cultural dopes' (Aroni and Minchello, 1992). Furthermore society is conceptualised almost as a separate entity, with its own set of needs and desires, and an existence separate from the individual members. However, despite these critiques, functionalism has been important in gerontology given that much of the emphasis in our area has been towards investigating and understanding personal and social adjustment to old age, changes in social roles which often accompany later life and life satisfaction. Given these concerns it is, perhaps, hardly surprising that functionalism has been so important to the development of theory in gerontology. Hence we consider the major functionalist theories which have influenced gerontological thinking and have had a very profound influence upon the types of research questions posed and the development of our knowledge base.

3.6 Conflict theory and ageing

As its name suggests, conflict theorists take a rather different view of the organisation of society than functionalists who stress the values that different social groups have in common. In contrast conflict theory, which derives from neo-Marxist and neo-Weberian views of society, stresses discord and conflict.

❖ Let us Remember

In conflict theory, social groups are conceptualised as having opposing views and are seen as being in conflict over control and access to social resources. However, this is still a macrolevel group of theories in that the concern is with society overall rather than individuals. Society is conceptualised as being stratified into specific groups and classes and society is seen as the result of the conflict between these different groups. The neo-Marxists explain this conflict as a result of economic inequalities resulting from the concentration of economic power within specific groups (which then seek to retain control of them). Neo-Weberians take a more expansive view of the

roots of social conflict, which include not only economic power but also social status and ideology.

Gerontological applications of this theoretical perspective are much less common than theories from the functionalist perspective but include the highly influential structured dependency theory and political economy approach to ageing. This perspective upon ageing became very important in the development of the 'radical' dimension of British gerontological developments and has key protagonists in the United States (Estes, 2001) and Europe. Such themes were not, however, unique to the field of ageing but demonstrated a wider resonance across the social sciences (Estes et al., 2001).

3.6.1 Structured dependency and the political economy approach

The approach to old age from a conflict theory perspective emphasises the continuity into later life of the inequalities that characterise the earlier phases of the lifecycle. To oversimplify the case, those who were poor in mid-life will be poor in old age (perhaps even poorer) while those who were rich and powerful remain so. A good example of this was Queen Elizabeth, the Queen Mother. Although she lived to be a centenarian her wealth, power and prestige were not compromised by her experience of ageing.

The structured dependency theory was initially proposed by Townsend (1981) and then enthusiastically taken up by others such as Estes (1979), Walker (1980, 1981), Myles (1984) and Pampel (1998). Structured dependency theory has been especially influential in British gerontology during the latter part of the twentieth century while in the United States similar views were described as political economy.

Political economy is concerned with the interaction between the state, the economy and various socially defined groups, in this case older people, and in particular with the way 'social goods' are distributed between groups and the mechanisms by which they are allocated. Those working in the broad field of political economy were informed by four main areas: conflict theory, critical theory, feminism and cultural theory. What both political economy and structured dependency are concerned with is the proposition that the dependent social position of older people and the problems they experience are socially constructed and derive from conceptions of ageing and health. This approach to the study of old age is essentially structural and macro level in nature although Estes

(2001) now claims that it can be used to study micro- and meso-level (organisational) aspects of ageing.

This perspective offers a sharp contrast to the potentially 'victim blaming' and 'biomedical' philosophy of old age as a time of loss and decline which was at the heart of some manifestations of structuralist theories. Political economy theorists argued strongly against these assumptions and developed a theoretical framework in which age is conceptualised as a social rather than biological construct and one which is located within the explicit study of capitalism. Social policies, which shape old age, are seen as the product of economic, social political and cultural forces.

The political economy approach, as exemplified by Estes (1979), Walker (1981) and Olson (1982), argues that old age is defined neither by chronology nor by biology but by the relationship between older people and the means of production in general and social policy in particular. The organisation of production, social and political institutions, social processes and the social policies pursued explicitly (or implicitly) by society is seen to be, in this approach, the key relationships. It assumes a structural relationship between older people and the rest of society, with society constructing the institutions and rules within which old age is defined and the experience of ageing contextualised.

Estes (2001) argues for the importance of the state in defining and experience of old age because (a) the state is important in the distribution of power and resources, (b) it intervenes to mediate relationships between different social groups, and (c) it intervenes to ameliorate conditions which threaten the overall stability of society. From this perspective, older people are seen not as a group separate from the wider social context, but as an integral, if marginalised, part of society. Capitalism and the state combine to marginalise and dominate older people (Walker, 1999). However, in this perspective older people cannot be analysed in isolation from the society within which they are located.

Central to this perspective is the notion of structured dependency (Townsend, 1981). This approach argues that in order to understand the dependent situation of groups such as older people we need to understand the essentially 'socially constructed' nature of this status. Dependency is viewed as a socially constructed entity best understood in terms of relationships between the dependent groups, in this case older people, capitalism and the state. Policies for social security, retirement and pensions assume particular importance in this perspective because they determine the duration of the working life and assign dependent status to specific phases such as retirement (or child-rearing) or to groups such as the long term sick or to handicapped people. This dependency is enhanced and reinforced by the exclusion of older people (or young mothers) from employment, the major means of economic status in advanced capitalist societies.

As a result of this socially constructed exclusion from the labour market, and their reliance upon welfare and pensions for their source of income, older people experience wider social exclusion such as poverty, reduced community involvement, institutionalization and marginalisation. This exclusion of older people from the social mainstream could, therefore, be overcome by changes in social policy, most notably a major increase in the level of the state pension.

The political economy and structured dependency approaches have several positive aspects.

First, it has offered a powerful set of counter-arguments against the demographic 'doom and gloom' analysts who portray the increasing numbers of older people as an inevitable social and economic catastrophe. This perspective has important new questions for research and has done much to overturn the assumption that the experience of old age is homogeneous and that those factors such as class, gender and ethnicity do not matter. This perspective has also been instrumental in raising questions about the nature and quality of services offered to older people.

Second, structured dependency has, at its heart, a focus upon the full integration of older people into society and, as such, offers a sharp contrast to the notions of disengagement so characteristic of earlier gerontological studies. It has certainly been one of the most influential gerontological theories and excited a whole generation of scholars.

Criticism:

There are drawbacks to this approach which are well summarised by Gilleard and Higgs (2000). Conceptually it is a macro level theoretical framework concerned, as it is, with the analysis and explanations of the workings of the social system and its problems. The key concept of structured dependency is rather deterministic and fails to address the issue of the power of individuals to challenge such classification and control mechanisms. By focusing upon relationships with the labour market and issues of retirement, which for current generations of elders largely concerns men only, this perspective has failed adequately to deal with issues of gender. Perhaps most importantly this approach has largely ignored questions concerning the meaning and purpose of the experience of ageing. Its focus upon structure has led to the relative neglect of the experiences of older people and the ways that they make sense of old

age, although this is now changing. By focusing upon a 'mass' solution to the key problem of poverty in old age, structured dependency theorists end up homogenising older people by proposing a simple 'one size fits all' policy solution. This has been somewhat undermined by the discovery of significant variations among the current cohort of elders in terms of class and gender.

Phillipson (1998) responds to this challenge by developing a dichotomy in the history of old age (Gilleard and Higgs, 2000); up to the 1970s the welfare state and retirement were central to the development of a 'secure' old age, while after this period the institutions of the welfare state were radically transformed by recession and the rupture of the consensus on the role of the welfare. This, combined with increasing diversity of the older population, has led Phillipson (1998) to argue for the creation of 'critical gerontology', which marries the political economy perspective with its recognition of the importance of class, gender and biography to provide a more rounded perspective upon old age and later life.

Estes (2001) has significantly developed this approach by developing a complex multilevel analytical framework that incorporates (a) financial/postindustrial capitalism and globalisation, (b) the state, (c) sex/gender system, (d) citizen/public and (e) the ageing enterprise/ medical industrial complex.

These are located within the interlocking systems of oppression—class, race, gender and ideology. Despite the refinements, it remains a theory which is problematic at the micro level of analysis.

3.6.2 Cumulative Inequality Theory

Inequality is present in all societies, with some persons having more resources, opportunities, and influence than others. Although some viewpoints regard inequality as the result largely of personal action (human agency), we conceptualize the major antecedents of inequality as systematically structured.

People make choices that influence inequality, but the choices available throughout the world are quite varied, signifying that human agency is "always constrained by the opportunities structured by social institutions and culture" (Elder, Johnson, & Crosnoe, 2003, p.8). There is a need to recognize the primacy of how inequality is systematically generated and, thereby, difficult to eliminate (Bourdieu, 1996). Although many scholars recognize the existence of structural determinants of inequality, what Cumulative Inequality theory adds is greater articulation of how these determinants are manifested through *demographic* and *developmental* processes.

For this chapter, demographic processes refer to cohort-linked stimuli, events, and experiences. Developmental processes refer to age-linked stimuli, events, and

experiences that can be observed in individuals. What may not be readily apparent, however, is that scores of scholars interpret these two sets of processes from a single indicator: age. Although gerontologists have long recognized that age is a crude indicator that is often confounded with period or cohort (the age–period–cohort [APC] confound), this fact often escapes the view of many studying how inequality accumulates over the life course.

As noted previously, inequality is systematically generated, and the cohort is a fundamental unit of social organization (Easterlin, 1987; Elder, 1974, 1998b).

Not only do cohorts reflect the ages of persons who share a time of birth, but cohort membership marks population processes such as how large is the cohort into which a person is born and migration patterns. Cohorts also provide the context for development; they structure access to opportunity. Aging is highly dependent on social context, reflecting gene pools and social organization at that point in history.

Recognizing the demographic/developmental dialectic, Cumulative Inequality theory holds that childhood conditions are important to adulthood. Based on research during the past decade, we now have compelling evidence that childhood conditions structure the life course. This is not just in terms of personality formation and stability but also in terms of achievement and well-being. Scholars have long seen the interconnectedness of life stages, but what has been most stimulating to this area of inquiry is whether early insults have long-term consequences.

Are later-life outcomes dependent on childhood experiences? Does gestational health influence health in later life? The answers to these questions appear to be affirmative, but isolating the mechanisms for these long-term connections remains a matter of continuing inquiry (Barker, 2003; Holland et al., 2000; Irving & Ferraro, 2006).

Beyond childhood as a life stage, we assert that gerontologists would be wise to recognize that reproduction is a fulcrum for defining the life course trajectories and population aging. Puberty is widely accepted as a key biological step in the transition to adulthood, and reproduction is a marker for adulthood in many societies. But what follows reproduction? When we think of aging as a life stage of “growing older,” we are probably referring to the *post reproductive* stage of life. There may be some arbitrariness to such demarcations of growing older, and the reproductive schedules of men and women are distinct. The point is that gerontologists would profit from greater attention to conceptualizing the reproductive period as a pivotal life phase (Waters, 2007), one that leads to nonlinearities in accumulation processes. In addition, Cumulative Inequality theory privileges gender differences in the accumulation of inequality by noting the distinct processes for men and women that lead to inequality.

Inequality exists *between* the sexes in part because of biology but *within* each sex because the accumulation processes are often distinct.

Biologists often refer to the postreproductive period as senescence. For instance, Spence (1989) describes senescence as “a term used to describe the group of deleterious effects that lead to a decrease in the efficient functioning of an organism with increasing age, and leads to an increased probability of death” (p.8).

This decrease in efficient functioning is most often attributed to an increase in molecular disorder (Hayflick, 1998). We think of defining the life course with more fluid boundaries but nonetheless feel that gerontologists should give greater attention to how the pre- and post-reproductive stages of life sandwich the time during which individuals are able to reproduce.

As noted earlier, a major distinction of cumulative inequality theory is that it gives explicit attention to the intergenerational nature of inequality; family lineage is a major source of inequality (Pearlin, Schieman, Fazio, & Meersman, 2005; Wickrama, Conger, & Abraham, 2005). Despite the legacy of sociological research on the intergenerational transmission of inequality, we have not been able to identify systematic coverage of this topic. Angela O’Rand (2006), another major contributor to the theory recently discussed “intergenerational flows of resources from older to younger members of the population” (p. 147), but we assert that the intergenerational nature of inequality is an *essential* element of how inequality is reproduced.

Family lineage may influence the accumulation of inequality in many ways, but we identify four primary mechanisms: biological, social psychological, economic, and ecological. Biological processes are manifested via genetic and nutritional factors, social psychological via modeling and norms, economic via finances and wealth, and ecological via environmental and spatial arrangements. Any one of these mechanisms may be used to identify the influence of family lineage, but they frequently combine together. Regardless of genetic background, ecology remains an important axis on which to advance the study of cumulative inequality.

Ecological context is important as a mechanism for family lineage (e.g., shared environmental exposure), but this mechanism also unfolds over the life course. Moreover, status hierarchies are often correlated with spatial arrangements. For instance, poverty as a form of social disadvantage is often concentrated in geographic

areas. Individuals of lower socioeconomic status tend to live in impoverished neighborhoods or rural areas that struggle to provide residents with social and economic resources, such as formal services or employment opportunities. Beyond the individual-level attribute of low income, there is the contextual effect of concentrated poverty that makes upward mobility more difficult to achieve.

1.7 Interpretative theory and ageing

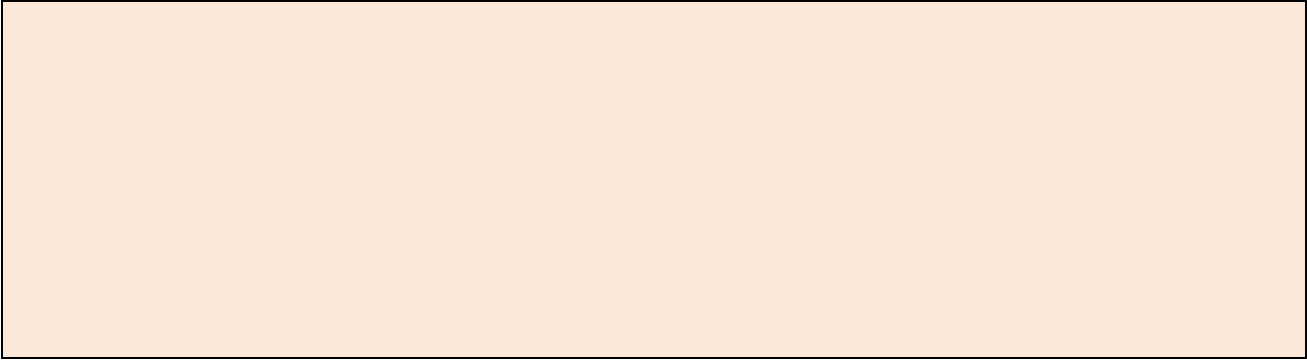
In contrast to the macrolevel theories of ageing are those developed from the interpretative tradition in social science and which have a micro level focus where the individual is the key focus of theoretical attention. As noted in the development of Phillipson's (1998) notion of critical gerontology, there are now explicit attempts to link these different theoretical approaches in a more integrated fashion. At the heart of the differing manifestations of the interactionist perspective is the notion that we should understand those we study and that we can do this best by trying to view and understand the world as they do.

These approaches, with their emphasis upon individuals, offer a very different way of theorising about social phenomena from the structuralist perspectives. In a structuralist theory individual actions are framed within a broad social system which governs social interactions and is understood within a specified top-down framework. In contrast interactionism has a very different individual-based focus. From this perspective social life, social action and social processes derive from the bottom-up and out of the cumulative actions of lots of individuals rather than being 'prescribed' by external factors. Society and social life does not take on the autonomous, independent characteristics attributed to it by structuralists. Society is not seen as a rigid external structure but as a series of loosely overlapping groups and is seen as coming from within: society is not conceptualised as an external force.

1.8 Symbolic interactionism

❖ Let us Remember

Symbolic interactionism was developed by Mead (1956) and is a key sociological theory. Proponents of this view argue that communication with others is a means of both transmitting and receiving cultural norms and values. It is via the communication of symbols that we learn vast numbers of social meanings and ways of acting and this perspective implies that most adult behaviour is learnt from symbolic communication with others. In the process of social interaction, the individual is both an actor and a reactor. Essential to the interactionist perspective is the view that individuals construct realities or social worlds in a process of interaction with others. Meanings are socially defined but the social actor defines the social world as well as being defined by it.



The symbolic interactionist perspective on ageing is concerned with the reciprocal relationship between the individual and her/his social environment. Old people, like other social actors, construct their own social reality. Consequently this approach sees ageing as a dynamic process that is responsive to both structural and normative contexts and individual capacities and perceptions. This perspective is essentially a micro scale approach to the study of ageing for it stresses the need to understand the nature and impact of ageing at the individual level. Thus an understanding of the impact of ageing requires an understanding of the meaning and interpretation of the events which accompany old age and which are articulated and defined by older people.

Sarah Matthews's (1979) research on the management of self-identity among old women is an exemplary study from a symbolic interactionist perspective. Her point of departure is Erving Goffman's (1959) concept of stigma, from which she argues that the category of old is likewise devalued in contemporary society. The old women she interviewed are continuously subjected to the stereotypic associations of this stigma, which include images of infirmity, senility, and worthlessness.

Matthews (1979) uses a grounded theory approach to uncover the strategies used by a sample of old women to sustain positive identities. Some of the strategies are rhetorical: the older woman assembles her identity to present herself to others in a positive light, contrasting who she is with what many in her social category discredit. One strategy used by the women is to "suppress evidence" of age. One respondent replied "People don't think I'm as old as I am, so I don't go around blabbing' it" (p. 74). Another strategy is to argue for different definitions of age, separating the age category that masks of aging assign from what inner definitions convey. One woman put it this way, "In the old vintage, eighty was the little black bonnet affair and that sort of thing. I don't think we should think of age chronologically at all. It's your outlook more than anything else" (p.

75). The use of others' testaments to one's age are a third strategy, such as suggesting that "other reputable people do not think of me as old."

1.8.1 Labelling theory

It has been suggested that old age may usefully be conceptualised within the framework of the labelling theory of deviance. Labelling theory (Berger et al., 1976) suggests that other groups attribute social status to individuals and/or groups by the successful application to them of negative `labels' to confer stigma or deviant status. In a youth- and health-conscious society, old age may be defined, or labelled, as a deviant and stigmatising condition. Indeed, those who work with older people may also attain this damaged or spoilt identity by contamination with the stigmatised group. Coming into contact with the `deviant' group is sufficient to compromise the status and professional identity of individuals as well as the older people themselves.

The basic assumption of labelling theory is that

The concept of self is derived from interaction with others in our social environment: we get our sense of worth and identity from how others react and interact with us. Thus the behaviour of older people is seen to depend largely on the reactions of significant others in their immediate social world, which depend upon how they define, classify and value older people.

Such interactions may communicate a stereotypical image of older people as useless, dependent and marginal. The individual who accepts this negative labelling is inducted into the dependent negative position, learning to act as older people are supposed to and losing previous skills, confidence and independence; finally the external label is accepted and the person defines her/himself as inadequate, thereby creating a vicious circle. Thus once people are `labelled' as old because they are retired, they have to play the role of a `retiree' and accept their pension and not seek gainful employment. Similarly the failure of older people to consult their doctor for specific symptoms because they think they are `due to old age' rather than interpreting them as signs of disease is another negative way that social labelling may affect older people. Although

the example here is of a negative image of old age, it is clear that from this theoretical perspective the adoption of positive labelling could have the opposite effect; attempts to rebadge old age as a positive and rewarding phase of life have met with little success to date.

Criticism:

Two of these related theories concentrate upon the detail of human behaviour and interaction without locating this within some notion of the structural impact of society as a whole. There is no link with the macrolevel of analysis which may be defining the overall social context. As such this contrasts markedly with the structural theories considered earlier. Some critics argue that interactionist perspectives find it problematic to deal with large-scale structures and social processes. Like the structural theories, however, this approach is also ahistorical in that it neglects the influence of life experiences and lacks a biographical or lifecourse perspective and does not address issues of class or gender in any detail.

1.8.2 Lifecourse perspectives on ageing

Age is an important organising factor within society and is used to allocate social roles and to determine entry into specific social activities. Most countries have laws regarding age of entry into formal education, driving, voting, purchase and consumption of alcohol or tobacco, and marriage. The precise ages that are used to determine entry into these different social activities vary both between different societies and historically. The 'formal' age-related roles are supplemented by a series (and obviously fluid) set of informal social norms and expectations. These combine to form what Neugarten (1974) termed a 'social clock' that is now more commonly referred to as the 'lifecourse'.

What is the life course?

The notion of the life course is one of the oldest and most enduring of all our conceptual frameworks concerning ageing and has been important in the development of gerontological theorising and frameworks for analysis. At its most straightforward the lifecourse consists of a series of stages (or social roles) which all individuals pass through as they age; this idea is not new or confined to the erudite discourse of gerontologists.

The notion that the pattern of life is divided into distinct phases is prevalent across cultures and throughout different historical time points. Most of us are familiar with Shakespeare's seven ages of man. There are various different models as to the number of 'stages' which constitute the life course. The lifecourse has become increasingly differentiated into smaller segments with the emergence of subgroups of 'adolescence', 'preschool' and 'middle age' as distinct phases, and more recently 'empty nesters'. The distinction between the 'young' old (those aged between 65 and 74 years) and the 'old' old (those aged over 75 years) is now often described as the third and fourth ages.

An idea that has held considerable currency is the notion that the later phase of life may be divided between the 'third age' and the 'fourth age' (Laslett, 1989).

Laslett advanced the thesis that it is possible to differentiate a 'third age' characterised by a time of opportunity and leisure for the increasingly affluent older person freed from the necessities of paid employment and dependence upon the state. In contrast the fourth age is a time of decrepitude, dependence and ill health before death. The seductive image of the 'third age' lifestyle is clearly evident. It celebrates the agency of older people as it recognises the less rigid post-work world that requires active planning by older people in the construction of a 'third age' post-work identity. However, it neglects to take into account the broader social context of ageing and the way that factors such as class and gender impact upon our ability to enjoy a post-work lifestyle.

The lifecourse is not a single entity but consists of several different spheres such as education, occupation and family dimensions.

In understanding the lifecourse we need to distinguish and interrelate three different types of time: historical, biological and social. Historical time refers to the precise historical context, biological time links the physiological and biological timetable to life stages such as infancy, adolescence and maturity, while social time relates to the definition, expectation and meaning that is attributed to the different stages of life. These different dimensions interrelate to produce a pattern of life stages that is historically and culturally distinct. The (fairly) recent emergence of stages such as childhood, adolescence and retirement demonstrates the essentially dynamic and fluid nature of the lifecourse concept and its location within specific cultural and historical contexts. There is nothing inevitable or universal about this way of thinking about the process of ageing: it is a dynamic and constantly evolving framework.

Although the lifecycle is often perceived as a simple universal progression from one well-defined set of social roles to another, it is in reality a highly complex concept consisting of several interrelated trajectories. We need to distinguish between the different arenas within which we can identify different stages of development and how these different stages overlap and sometimes are in conflict. For example, the family lifecycle element may involve numerous transitions including courtship, newly married, new parents, parents of teenagers, 'empty nesters', retirement and widowhood.

Importantly not everyone will experience all these phases of the family cycle; there may also be enormous variations, between cultures and different historical time points, in the ages at which individuals experience these transitions. The primary focus of lifecourse research remains, however, at the individual level of analysis.

In using a lifecourse perspective, to describe someone as old (or juvenile) we are locating them within a specific social environment, which expects particular roles and provides differing opportunities, rights, privileges and barriers. Chronological age serves as the basis for proscribing or permitting admission to various social roles and behaviours. The entry into, and exit from, specific social roles such as adolescent or retiree is influenced by the existence of 'age norms'. All cultures have rules (either explicit or implicit) which define what appropriate (and inappropriate) forms of behaviour are for people of particular ages. These rules are generally referred to as norms and allow us to predict the behaviour of others in specific situations, as well as allowing others to predict our behaviour. For example, in British culture the norm, or expected behaviour, upon being introduced to someone for the first time is to extend our hand and shake hands. This seems perfectly natural to British people but in some cultures it would be interpreted as a gesture of hostility, not friendship, or an indication of extreme rudeness.

Age norms are concerned with the linking of specific chronological ages to expected (and inappropriate) behaviours. Three features characterise age norms: they identify appropriate and inappropriate behaviours, they are shared by particular social groups (ranging from entire societies to specific subgroups) and they imply some element of social control and social sanction for transgression. At the formal level there are established age norms concerning voting, driving, alcohol consumption or school attendance. There are also informal norms concerning the appropriateness of behaviours for different age groups (and not just older people).

For example we are not surprised, but might be embarrassed, to see a young child having a tantrum if her mother refuses to buy her some sweets. However, we would consider it most surprising if a teenager behaved in the same way. Similarly we expect certain behaviours and attitudes from older people such as lack of interest in sex or romantic involvement and to thinking and dressing in a conservative fashion. Neither are they expected to engage in heavy manual labour. Informal behaviour rules also provide suggestions about appropriate behaviour towards older people. We are expected to help old ladies across the street, give them our seat on crowded buses and trains, and carry their shopping or luggage. Similarly, older adults have social obligations such as showing an interest in their (great) grandchildren. The erring or uninterested grandparent would be subject to considerable social sanction and gossip, both from within the family and from the wider social environment. The classic studies of Neugarten (1974) identified empirically that noninstitutionalized age norms are well recognized by the population, and appropriate behaviours are ascribed to them. Five dimensions defined progression from one stage to the next: health, career, family responsibilities, and psychological and social factors.

Clearly the notion of the lifecourse is a very powerful organising concept within gerontological theory and research. It is, however, problematic for many of the reasons already outlined. Operationalising this concept is problematic because of lack of consensus as to the number of stages involved and in defining entry or exit points to the different stages. There are also problems in determining the universality of the concept because of cultural and historical variations in the 'meaning' ascribed to different ages. However, it remains a powerful idea because of the way that it seeks to locate the understanding and explanation of the behaviour of individuals and societies within a temporal perspective. Individuals and societies are not simply 'old'; rather they are ageing with a past (and with a future) and it is this dynamic perspective which a lifecourse approach to ageing emphasises.

1.9 Phenomenological approach to ageing

Social phenomenologists have criticized theories of aging for taking the existential status of age for granted. While the theories look at variations in the meaning of age and aging behavior along, for example, historical, cohort, and exchange lines, the variations are accepted as background factors or outside forces operating upon older people. Thus, the interpretation of the so-called forces and their subsequent reinterpretation, in the ongoing practice of everyday life, is ignored. The social phenomenologists, on the other hand, focus attention on the process by which age,

agedness, and age-related "facts" are produced and reproduced in the first place. Their concern lies with the issue of how the objects of and ideas about aging are understood by people who experience them, and how these experiences serve to produce and reproduce themselves along certain lines.

The social phenomenological analysis reveals that the potential realities assigned to the aging experience are the products of an ongoing process of social construction, descriptively organized by prevailing stocks of knowledge (Schutz). Even so, the issue of power is never fully addressed by this perspective. The reason is that while the approach generates important data about the process of social production, at the same time it tends to ignore its structure. That is, it tends to conclude its analysis when the human products of the process have been produced, considering the product not as a configuration of social conditions independent of and perhaps confronting members, but rather in terms of its interpretive resources and production and reproduction—a concern for structuration rather than structure as such (Giddens).

❖ Let us Remember

What Is Phenomenology?

Alfred Schutz (1932) describes how we construct the objects and our knowledge of these objects that we take for granted in our everyday lives. The basic act of consciousness is a first-order typification: bringing together typical and enduring elements in the stream of experience, building up typical models of things and people, and thereby building a shared social world.

Schutz talks about sociology as creating a world of rational puppets that we then manipulate to discover how people might act in the real world. Schutz's legacy led to a growing body of knowledge that can be called interpretive sociology (May & Powell, 2008).

The Lineage of Phenomenology: From Husserl to Schutz

Phenomenology was first developed by the German philosopher Edmund Husserl in the final decade of the 19th century. It involves the systematic investigation of consciousness, or, as he called it, the “science” of consciousness. Consciousness as an intentional process is composed of thinking, perceiving, feeling, remembering, imagining, and anticipating directed toward the world (Husserl, 1931). The objects of consciousness, these intentional acts, are the sources of all social realities (Sibeon, 2004).

Phenomenology and Aging

Within social theory phenomenology is an established mainstream paradigm. It guides most qualitative research focused on everyday life in the social sciences today (Gubrium & Holstein, 1995). Within gerontology, however, it has had a very limited impact. The social construction of ageing has been concretely demonstrated in an analysis of the Alzheimer's disease experience (Gubrium, 1986; Gubrium and Lynott, 1985; Lynott). The study examined the social organization of two types of discourse—aging and disease—by which to reference, describe, and explain the “symptoms” of aging. It was clear that those affected by the variety of conditions experienced considerable suffering.

For example, in the support groups for caregivers of Alzheimer's patients, the condition of a patient could be interpreted as a sign of a given stage of the disease against a background of certain comparisons with others. That “same” condition could shift, with a change in framework, to an interpretation of old age when lamenting the lack of any “rhyme or reason” to the course of illness. In this respect, there were no straightforward facts concerning any aspect of the disease experience; rather, the facts entered into ongoing practical experiences as more or less useful ways to understand the condition and related experiences under consideration.

They explored two contexts:

- the body under the medical gaze and
- the body as a basis of identity.

Aging and the Biomedical Gaze

Before taking up the discussion, it is necessary to understand the biomedical model which is understood to have four components:

- (a) The mind and body are essentially different, and medicine is restricted to considerations related to the body;
- (b) The body can be understood as analogous to a machine;
- (c) Medical answers are thought to be more reliable when they are founded on the basic sciences; and
- (d) Thus biophysical answers are preferred to all others (Longino & Murphy, 1995).

This model is reductionistic, and by focusing almost entirely on the body, it ignores the person that animates the body and the lifeworld that contextualizes the person. The biomedical model has dominated the perceptions of old age in gerontology. As Powell and Longino (2002) pointed out, the medicalization of old age is not an objective scientific process but rather a series of policy struggles at local, national, and international levels. These struggles to define the nature of aging are between several *provinces of meaning*, such as old and potentially old people, their network of informal caregivers, the helping professionals of different types, entrepreneurs from family-run care homes to pharmaceutical companies of global reach, and finally the institutions of the state and the organization and distribution of resources through policy spaces (Biggs & Powell, 2001). The biomedical model has consistently problematized “truths” about the declining viability of adult aging.

As Arthur Frank (1990) notes, the biomedical model is a dominant force in popular culture: *Medicine does . . . occupy a paramount place among those institutions and practices by which the body is conceptualized, represented and responded to. At present our capacity to experience the body directly, or theorize it indirectly, is inextricably medicalized. (pp. 135–136).* The somewhat hegemonic dominance of the biomedical model goes beyond negative discourses pertaining to aging; it has sought to reinvent itself as the “savior” of biological aging via the biotechnological advancements that foster reconstruction of the “body” to prevent, hide, or halt the aging process (Powell & Wahidin, 2007).

As Biggs and Powell (2001) point out, *Established and emerging master narratives of biological decline on the one hand, and consumer agelessness on the other co-exist, talking to different populations and promoting contradictory, yet interrelated, narratives by which to age. They are contradictory in their relation to notions of autonomy and*

independence, and dependency on others, yet [they are] linked through the importance of techniques for maintenance, either via medicalized bodily control or through the adoption of "golden-age" lifestyles. (p.97). Because of the reluctance of socially trained gerontologists to deal directly with the body and their tendency to hand off the subject matter to the health scientists and clinicians, the social study of age and the aging body has gained theoretical momentum only recently, in the past 20 years, on both sides of the Atlantic (Phillipson, 1998; Powell, 2006).

The body in its material form has been taken for granted, absented, or forgotten in gerontological literature (Powell & Wahidin, 2007) until the body begins to mechanically break down. Thus, the role of the body in gerontology has for some time focused on the failing body and the political response to that aging body. In those parts of the medical establishment where care rather than regimen and control is most emphasized, particularly in nursing, there seems to be a deeper focus on the provision of care based on a rigorous emphasis on the patient's subjective experience (Benner, 1995). In these patient care contexts, substantial attention has been devoted to the ethical implications of various disease definitions. Specifically, the discussion also focuses on how language shapes the response to illness and how disease definitions and paradigmatic models impact communication between health professionals and patients (Rosenberg & Golden, 1992). Significant work on the phenomenology of disability has demonstrated how the *lived body* is experienced in altered form and how taken-for granted routines are disrupted, invoking new action recipes (Toombs, 1995). Nonconventional healing practices have also been examined. In this context, embodiment and the actor's subjective orientation reflexively interrelate with cultural imagery and discourse to transfigure the self (Csordas, 1997). Further, phenomenological work has suggested that emotions are best analyzed as interpretive processes embedded within experiential contexts (Ritzer, 1996). The focus on the lived body is a central concern for phenomenological gerontology.

Thus, phenomenological gerontology seeks to offer a corrective to the seeming dominant emphasis on biomedical conceptualizations of aging; it excavates how we problematize aging at a surface level by digging underneath such surfaces to reveal meanings and a subjective sense of self that have been historically silenced by rigid biomedical models of aging and body. Hence, phenomenology presents theoretical techniques and qualitative methods that illuminate the human meanings of social life that brings to life issues associated with understanding the body.

Aging and Identity

Only in the past two decades has there been any sustained attempt to fuse together phenomenological concerns about aging bodies in order to foster a deeper understanding of aging identity (Gubrium & Holstein, 1995). Gubrium (1992) has investigated how aging is constituted in the consciousness of persons. The struggle for meaning when accompanied by chronic pain may be facilitated or impaired by constructs that permit the smoother processing of the experiences. Biggs (1999) makes the point that phenomenological work encourages caregivers of older people to gain empathic appreciation of their clients' lifeworlds. Enhanced affiliation with them through the use of biographical narratives highlight their individuality and humanity. Where does the story of the human body begin? What is in fact meant by the "body"? One can simply argue that the body is "present," "lived," "real," and "experienced." The body, in terms of its biology, is always in the process of becoming. Cells die, mutate, and regenerate. It can be argued from this proposition, then, that the body never finally becomes but is left as an unfinished project, in a state of transition. In reality, however, typifications of old bodies intertwine with masculinity, femininity, sexual orientation, and race, which serve to regulate and define the spaces that older people use.

Writing about phenomenology and the aging body poses a series of theoretical challenges relating to the issue of human embodiment, the body, and body image (Featherstone & Hepworth, 1993). The body, like parchment, is written on, inscribed by variables such as gender, age, sexual orientation, and ethnicity and by a series of inscriptions that are dependent on types of spaces and places. However, as Shilling (1993) argues, the more we know about our bodies, the more we are able to govern, modify, and question gender norms highlighting how gendered and ageist discourses serve to confine and define old bodies. Although social gerontologists have only recently begun to conceptualize the body, old people themselves are clearly concerned about their changed physical appearance and how to come to terms with the changing conditions of their identity and lived bodies.

Morris (1998) argues that consumer culture promotes this concern and then exploits it; consumer culture is preoccupied with perfect bodies as presented by the glamorous images of advertising. Consumer culture's emphasis on youthfulness and the body beautiful increasingly marginalizes the identity of older people in later life. Such images, therefore, do not help old people to see themselves as able actors within the world. This discontinuity between the experience of living in an aging body and images of aging has

been identified as an issue. One may feel oneself to be a different age than one looks, as though one is wearing a mask. Featherstone and Hepworth (1993) maintain that old age can be a mask that “conceals the essential identity of the person beneath” (p. 314). A person’s appearance may change with age, and one’s identity may not. It is thus possible to be surprised by one’s own image. As counterpoint to the notion of the mask of old age, Biggs (1999) argues that people derive their sense of self-identity in old age from the achievements of the past and what remains to be accomplished in the future rather than from a set of stereotypical images of old age.

Unless they are ill, older people do not necessarily feel old. Researchers can study, without reflecting the experienced reality of aging, whether the subjects’ lived bodies are ignored. Aging is an embodied and meaningful process. Bryan Turner (1995) emphasizes several key processes that work on and within the body across time and space. The body has to be contextualized within its polymorphous state of positions within and between a numbers of different discourses: the biological and the social, the collective and the individual, and that of structure and agency. The next section advances a phenomenology of aging by incisively stating that we need to capture the use of biography in order to appreciate and understand individuals and cohort groups across the life course.

Toward a Phenomenology of Aging: Biography and the Life Course

The notion of biography is central to understanding people’s meanings and experiences of mind and body relevant to the life course. Schutz employed the life course as a second-order analytical construct to understand different classes of experience from early to later life. Individuals make their own biographical histories across the life course. From the earliest age to old age, individuals create biographical narratives to create a sense of coherence and self-identity. The social worlds that individuals create are put together by categorized experiences. Categories take on an existence of their own for interpreting and constructing meaning. Both natural and social objects are interpretively constituted and as such are evolving “stocks of knowledge” (Schutz, 1972), the cornerstone of common frameworks for making sense of experiences.

The interior mental processes of individuals and their self-identities dynamically collide and interact with social forces to produce and reproduce the forms of

experience. Schutz's notion of "biographical work" (Starr, 1983) is the means of embracing this dynamic interplay of subjective and objective social processes. By tracing an individual's life career trajectory, the concept of biography allows us to document the development of their unique configuration of personal powers, skills, and emotional-cognitive capacities as they emerge out of the interplay of social involvements and constraints. This is because the concept of biography refers to tracing specific individual's experiential trajectories across the life course and the unique social configurations in which they are enmeshed. Birth cohorts, who move through their life courses together, may have an overlap in their stocks of knowledge that is contextualized by their shared historical experience. Intersubjectivity based on birth cohort is therefore possible. However, as Passuth and Bengtson (1988) remind us, a phenomenological understanding of cohort is not the same as that used by demographers. Lives are linked through education, work, consumption, and family in everyday life, and these linkages give cohort membership and their related stocks of knowledge special significance (Davila & Pearson 1994; Gubrium, 1992).

For example, phenomenological work with young children at one end of the life course examines how both family interactions and the practices of everyday life are related to the social construction of childhood (Davila & Pearson, 1994). It is revealed how the children's elemental typifications of family life and common sense are actualized through ordinary social interaction. Penetrating the inner world of children requires a level of sensitivity among researchers of aging that would allow them to view the subjects in their own terms, from the level and viewpoints of children themselves (Shehan, 1999). Such theoretical interrogation transcends scientific perspectives and seeks to give voice to the children's experience of their own worlds and relationships with others. In this sense, children's communicative and interactive competencies are respected and are not diminished by the drive toward just listening to adults (Shehan, 1999). One could apply this example just as well to the other end of the life course.

According to Encandela (1997), when we look at aging and the social construction of "pain," we can see the use of a phenomenological perspective. Encandela investigated the interrelationship of aging and trauma and found that it was constituted in the consciousness of members and helping agents. The struggle for meaning accompanied by chronic pain may be facilitated or constrained by the availability of constructs that permit the processing of the experiences. Members of cultures that stock typifications and recipes for skillfully managing pain may well be more likely than others to construct beneficial interpretations in the face of these challenges (Encandela, 1997). Phenomenology in this context encourages the professionals who work in the field of

pain management with older people to gain an empathic appreciation of their clients' lifeworlds and enhanced affiliation with them through the use of biographical narratives that highlight their individuality and subjective sense of self (Biggs, 1999). Subjective experience, in this sense, is an amalgam of several, often seemingly diverse sensitivities and operations. Such experiences impinge on the fluidity of the life course. Settersten (1999) suggests that the study of the life course teaches us that it is open to historical contingency.

Distinctive changes for subgroups in the life course cannot be understood without reference to biographical contexts. At the same time, Settersten claims that there has been scarce study of inter- and intra-cohort variation in the ways that sociohistorical circumstances relate to particular lives. Members of cohort groups react in unpredictable ways to historical contexts. The timing into expectable social roles can influence the ways in which they are experienced and alter expectable role entrances and exits in life zones such as work and employment. Similarly, subgroups of individuals may hold basic values of their generational cohort but hold a different outlook to their larger cohort, a process of "self-identity." Understanding the aging self in such terms enables us to appreciate the power and control dimensions of human conduct, especially as they apply to individual self-identity that is linked to the social world. Because individuals vary in terms of their biographically produced personal powers and capacities across age cohorts, it is important to recognize how these differences feed into and in turn are influenced by other social domains. There is a long-standing tendency to reduce the social dimension of aging to a set of normative "stages" across the life course that are said to determine the experience of old age. Such approaches present old age as primarily a private experience of adaptation to inevitable physical and mental decline and preparation for death.

This common understanding of aging is quite alienating, and people logically flee from this image of senility. A fixed standpoint of stages openly contradicts the phenomenological challenge set by Schutz. At the same time, life course theory has begun to emphasize that old age is part of a lifelong developmental process. Life course ideas coalesced as atheoretical orientation on aging during the 1960s and 1970s. Bernice Neugarten (1974) wrote an influential essay marking a distinction between what has since become more commonly referred to as the "third age" and the "fourth age," the youthful years of retirement and the older ones, respectively. She referred to persons in these stages of later adult development as the young-old and the old-old. The young-old are like late middle-aged persons. They generally have good health, and

they are about as active as they want to be. The old-old, however, tend to be widowed and are much more likely to be living dependently.

Consequently, the concept of old age, with its attending miseries, was only pushed later into life by this reconceptualization. The first decade after workers retire seems like a second middle age, but the declining body remains an issue in the fourth age (Gilleard & Higgs, 2000; Laslett, 1991). During the 1980s and 1990s, life course theory increased in sophistication as proponents addressed variations in the process of aging and recognized that the individual's life course is embedded in relationships with others (Elder, 2001).

Phenomenology is a movement in social science that illuminates an understanding of the relationship between states of individual consciousness and social life. As an approach within social gerontology, phenomenology seeks to reveal how human aging awareness is implicated in the production of social action, social situations, and social worlds. Phenomenology asks of us to note the misleading substantiality of social products and to avoid the pitfalls of reification. It is inadequate for gerontologists to view older people only as "objects." Older people are "subjects" with sentient experience. Phenomenology focuses on the investigation of social products as humanly meaningful acts. The "meaning contexts" applied by the social gerontologist explicate the points of view of older actors. It also expresses their lifeworld. Phenomenological gerontology strives to reveal how actors construe themselves, all the while recognizing that they themselves are actors construing their subjects and themselves.

1.10 Ethno methodological theories

Ethno methodological theories are not conceived as causal explanations of the social world but instead focus attention on problems of meaning in everyday life.

As analytic perspectives, not theories, they provide broadly sensitizing orientations to the socially constructed features of experience, including aging. Empirically, this results in analytic descriptions of how the social categories and forms of age enter into everyday life, how they are managed, and how they are socially organized.

1.10.1 Identity Management

One of the most extensive areas of research in aging is the social construction of identity. From traditional studies of role definition (Marshall, 1986) to deconstructions of aging and identity (Gubrium, Holstein, & Buckholdt, 1994; Hazan, 1994; Katz, 1996), the leading questions here are, who is the aged person and how are answers to the question managed in everyday life? Symbolic interactionists are apt to focus on identity management within a particular context of meaning such as age, whereas ethnomethodologists emphasize how various defining contexts, including the category of age, are used to designate applicable identities in particular social situations.

1.10.2 Narratives of Aging

A variety of commentators have noted that experience is not just lived but is continually shaped by how it is conveyed (Gubrium & Holstein, 1998). Narrative analysis is a very popular way of approaching experience through the examination of personal stories and storytelling. A number of gerontological researchers has shown that the personal story and other forms of individual narrative construct and reconstruct lifelong experiences in relation to ongoing developments in people's daily living (Birren, Kenyon, Ruth, Schroots, & Svensson, 1996).

From diverse quarters, we are now being empirically convinced that the personal past has not simply gone by but is continually lived out in new terms as its storytellers speak of life. The present and the future, too, are implicated, as a narrative unpacks and designs experience in relation to time as a whole. The subjective is clearly at hand here.

The difference in emphasis results in deeply personalized narratives on the one hand and detailed subjective accounts of historical events on the other. Context varies accordingly. Those constructionists who emphasize the introspective skills of the storyteller can produce highly idiosyncratic contexts for telling lives. In contrast, constructionists who link storytelling to social forces tend to formulate overly typified historical contexts for the experiences in question.

We have chosen Sharon Kaufman's (1986) book *The Ageless Self* to exemplify narrative analysis in gerontology. Although she is concerned with how people's lives, especially the aging experience, are subjectively assembled, and she explicitly addresses

the issue of contextual emphasis. As Kaufman explains, "I wanted to look at the meaning of aging to elderly people themselves, as it emerges in their personal reflections on growing old" (p. 5). Kaufman finds that her respondents construct and fashion their own accounts of aging, separate from the varied contexts that embed them in history. As Kaufman emphasizes, "The old Americans I studied do not perceive meaning in aging itself; rather, they perceive meaning in being themselves in old age" (p. 6). Kaufman (1986) asks two questions in analyzing her data: What thematizes the life stories of these older Americans and from what do they draw meaning to construct their accounts? Sixty people participated in the opened interviews, important elements of which were organized around the life story.

1.10.3 Using Age to Construct Context

If Kaufman (1986) shows how the elderly select from contexts other than old age to thematize their stories, author Jim Holstein's (1990) ethnomethodological study of involuntary mental commitment hearings illustrates how age is applied to create locally useful contexts for interpreting conduct. Holstein's subjects are the judges, attorneys, consultants, witnesses, and candidate patients who use various features of the patient's life, including age, to give meaning to his or her conduct in relation to a commitment decision. An important question is how age is used in building a case for or against involuntary commitment.

Holstein (1990) reverses the typical research concern with age, not treating it as a background variable affecting the likelihood of involuntary commitment but rather as a condition that is selectively applied to construct a background or context for decision making. Emphasis is on the local management of age as an interpretive context. We are shown how standard background factors serve to assemble explanations, not to explain life events in their own right.

Holstein's (1990) empirical material is especially relevant for illustrating how an ethnomethodological perspective orients to theories of aging. He draws from the material to show how members of everyday social settings, such as an involuntary mental commitment hearing, themselves theorize old age. As Gubrium and Wallace (1990) have argued, gerontological theorizing is not exclusively gerontologists' stock-in-trade but is part and parcel of folk explanations of aging. Holstein illustrates how vernacular versions of disengagement and activity theories, for example, are used by judges in two different hearings as accounts or explanatory contexts for their decisions.

As the following extracts from these hearings show, the theories in use are ways of constructing a context for action, rather than being the researcher's explanation for the causes or consequences of aging.

Early ethnomethodological work stressed the artful but methodical ways in which social order is constructed (Garfinkel, 1967). This was empirically realized in two ways. Some ethnomethodologists applied methods of participant observation to document the "ethnomethods" that members of social situations used to establish a sense of order in everyday life. Conversation analysts focused more on talk and interaction, examining their empirical material to show how the sequential machinery of talk served to systematically construct social reality in its own right. The most recent work in the area increasingly attends to the "external" institutional mediations of talk and interaction (Drew & Heritage, 1992). In between are other promising developments. The analysis of personal stories is a burgeoning area of interest. No longer are stories considered to more or less present the experiences they convey; it is increasingly recognized that the process of storytelling itself works to construct lives, which otherwise remain untold.

The subjective here is also center stage, as researchers uncover the various ways that narrative works to construct experience. Still, the emphasis on narrative composition may now be excessive, overshadowing the local and practical conditioning of storytelling (Gubrium & Holstein, 1998). Other important developments that variously locate themselves along the continuum are feminist contributions (Harding 1987; Hekman, 1990), what has come to be called "queer theory" (Seidman, 1996), and African-American and ethnic perspectives (see, e.g., Collins, 1989). All aim to broaden significantly the working horizons of what it means to socially construct reality.

As constructionist perspectives continue to develop across this continuum, the heart of the orientation to everyday life has been and will continue to be focused on the question of how social categories and social forms develop and enter into experience. In a word, to construct is to produce, to work at the constitution of the world we live in, including aging as a set of categorical features of that world. The 21st century will move constructionism in various directions along the continuum we have described, but it will remain centered on the various processes by which the categories and structures of people's lives are assembled, managed, and sustained.

Some Constructionist analytics will increasingly offer modes of explanation focused on how the interplay between reality-constituting activities and variable conditions of possibility (Foucault, 1975) provide for the meaningful organization of everyday realities (see Gubrium & Holstein, 1997). As constructionist perspectives, they will stop short, however, of formulating causal models or predictive theories. Newly emerging skeptical postmodernist insights (Rosenau 1992) might also move some constructionist perspectives in the direction of obviating broad theoretical formulations altogether as they continue to question the very possibility of both "theory" and "the empirical" itself. This presents constructionist researchers on aging with an extraordinarily broad horizon of choices regarding their analytic projects, methodological approaches, and end results.

3.11 Feminist Theory

Despite growth in the study of old men and masculinities (e.g., Calasanti, 2004; Calasanti & King, 2005, 2007; Davidson, Daly, & Arber, 2003; Russell, 2004), feminist gerontology continues to be seen as a specialized approach within gerontology overall, unable to contribute to knowledge about aging in general. Feminist gerontology is inclusive in that it theorizes gender relations and thus the experiences of both women and men. Further, a focus on intersecting inequalities is critical to understanding those experiences of aging and that feminist gerontology is uniquely able to offer scholars a lens through which to view these intersections.

Feminist Gerontology: A Brief Overview

Spurred by the 1970s women's movement, in the 1980s, some scholars of aging began to question the lack of explicit attention paid to aging women. For instance, women were routinely excluded from retirement research (Gratton & Haug, 1983). The presumed split between private and public spheres fostered a belief that paid labor was central only to men's identities and that, especially for married women, "retirement is usually irrelevant" (Bixby & Irelan, 1969, p. 144). Initial calls to address women's omission from aging research often led simply to adding women to samples and placing them into models and theories derived from men's experiences. Conceptually, gender remained an individual attribute within such models, and, as Gibson (1996) notes, scholars tended to discuss gender differences in old age in ways that treat men as the implicit standard against which women are assessed. As a result, scholars noted differences between men's and women's labor force participation histories and women's subsequent lower retirement benefits but failed to ask why women's work histories were more intermittent, why Social Security rewards stable participation, why dependent-spouse benefits amount to only half of the retired worker benefit, or whether women and men garner similar workplace returns for similar human capital attributes.

Feminist gerontology emerged in the 1990s, partly in response to this failure to theorize the relations of inequality that underlie gender differences. It examined women's experiences from their own standpoints, but it has allowed scholars to reformulate methods and derive theories that incorporate men's experiences as well. Its critical approach to gender inequality has led some feminist gerontologists to theorize the larger system of intersecting relations of inequality, a project shared with other groups of scholars, driven by overlapping social movements (e.g., labor, civil rights, gay/lesbian, and Gay Panthers).

In its theories of such systems of inequality, feminist gerontology recognizes that both women and men have gender and that their experiences are structured by *gender relations*: dynamic, constructed, institutionalized processes by which people orient their behaviors to ideals of manhood and womanhood, influencing life chances as they do so. Because men's privileges are intimately tied to women's disadvantages, the situation of one group cannot be understood without at least implicit reference to the position of the other. For instance, beginning with women's experiences of retirement has revealed the ways in which men's and women's experiences of this transition are related.

To be sure, women's responsibility for domestic labor shapes their retirement by lowering their potential income; it also means that when they leave the labor force, they relinquish only their paid labor and maintain their unpaid work. In this sense, the meaning of "freedom" in retirement for women includes continued labor, even though they may be happy with this time in their lives. The contribution of feminist theory was to move beyond simply noting women's deviations from the model of retirement built for male breadwinners and to theorize the ways in which collective efforts to see that women lived up to ideals of gendered labor shaped their work lives.

Divisions of domestic and paid labor also influence men's lives—both their greater retirement income potential and their relative freedom. That is, husbands' abilities to enjoy successful careers and financial security in old age or the choice of what work (if any) to perform in retirement rest on the domestic labor of their wives (Calasanti & Slevin, 2001).

Theories of such gender relations explain what might otherwise appear anomalous, such as the ways in which subordinate status can result in strengths while privilege can be harmful. For instance, women's immersion in the work of daily life, including kin keeping, provide them resources in later life that men may not enjoy at that stage. Not only do such networks offer social support in old age; for those with fewer material resources, such networks may also ensure a decent quality of life. Because men are not responsible for domestic life, they often access social networks through their wives.

Thus, some men can be highly dependent on their wives for social and material resources, and men who are not married often have smaller networks (Barker, Morrow, & Mitteness 1998; Davidson et al., 2003).

Intersecting Inequalities

For many gerontologists with ties to liberatory social movements that demand attention to inequality, the picture of retirement painted here would be inadequate without a sense of its place in a larger system of *intersecting inequalities*. Recent feminist gerontologists have argued that just as gender shapes aging, so do other hierarchies influence both gender and aging (e.g., Calasanti, 2004; Calasanti & Slevin, 2001; Connidis, 2001; McMullin, 2000).

Thus, while feminist gerontologists may focus on gender at points in their analyses, they recognize that old men and women do not exist apart from their racial and ethnic, sexual, and class-based locations. For instance, if we look only at gender, we see a much higher incidence of poverty among old women. But when we look at intersections with race, we find that Blacks—men and women—have higher poverty rates than do White women (Social Security Administration, 2006).

By way of theorizing intersecting inequalities, such feminist theorists as Young (1990) have given us criteria by which we can assess systems of privilege and oppression. Based on these criteria, we might define a group as oppressed to the extent that they experience economic marginalization, powerlessness and a lack of authority and status, and stigmatization. Those who are privileged use their greater resources to control those who are disadvantaged and justify these inequalities through ideologies that deem them to be “natural” and thus beyond dispute or based on social necessity or the will of a higher power (Calasanti & Slevin, 2006; King, 2006). Recently, feminist gerontologists have used these criteria to theorize old age itself as a social location, part of a system of age relations that intersects with other forms of inequality.

3.12 Conclusion

The early theories of ageing were very proscribed and prescriptive as to how individuals should age. Successful ageing was to be achieved variously by remaining active, prescribing a middle-aged lifestyle and reducing engagements.

Theoretical formulations which offer the path of successful ageing re-emerged in the 1990s with the proposal of Rowe and Kahn (1997). They suggest that successful ageing, which is never really defined, is to be achieved by the promotion of three factors: low probability of disease, high functional and cognitive ability, and active engagement with life. These formulations take little account of the influence of wider structural factors upon the experience of ageing nor do they fully take into account the

influence of race, gender and class in predicting the experience of age. As with so many theoretical formulations the notion of 'successful ageing' assumes a homogeneous population and does not acknowledge the existence and importance of the existing inequalities with which cohorts enter old age. Encompassing the diversity that the older age groups demonstrate remains a challenge to all those who theorise about this aspect of life.

Given the complexity of social gerontology, it seems unlikely that a single perspective will adequately explain the experience of ageing. It seems probable that a composite theory of ageing will develop using aspects of a number of these different viewpoints. Before we are able to formulate a composite theory of social ageing, these competing approaches require much more empirical investigation to test their explanatory power. In particular we need to develop cross-cultural and cross-national perspectives in order to test the veracity of our theoretical formulations. In addition, as Bytheway (1997) argues, we need, as gerontologists, to recognise the ageist assumptions which underpin many of our theoretical perspectives upon ageing. He argues that we need to develop a theoretical base, which breaks free from the ageism implicit within popular culture, if we are ever to be able to understand how people manage and experience age and to be able to evaluate the social context within which this takes place.

3.13 Key Words

Bio-medical, Cohort, Continuity, Dependency, Disengagement, Gaze, Gerontology, Identity, Inequality, Narratives, Stratification etc.

3.14 Review Exercise

Long type questions

1. Critically analyze functionalist approach to ageing.
2. Describe two dominant conflict theories of ageing
3. "The symbolic interactionist approach to ageing has not gained prominence". Explain.
4. Elucidate phenomenological and ethno methodological approaches to ageing.

Short type questions

1. Write a short note on Disengagement theory.
2. "Old age is a social problem." Explain
3. "Activity theory is a response to disengagement theory". Explain
4. Critically examine age stratification theory.

5. Write a note on feminist approach to ageing.

3.15References

Aroni, R. and Minichiello, V. (1992) Sociological aspects of ageing. In Minichiello, V., Alexander, L. and Jones, D. (eds) *Gerontology: A Multi-disciplinary Approach*. Prentice Hall, Sydney.

Bengtson, V. L., Silverstein, M., Putney N. M. and Gans, D. (2009). *Handbook of Theories of Ageing*. Springer. New York.

Bernard, M. (2000) *Promoting Health in Old Age*. Open University Press, Buckingham.

Bernard, M. and Meade, K. (eds) (1993) *Women Come of Age: Perspectives on the Lives of Older Women*. Edward Arnold, London.

Beveridge Report (1942) *Social Insurance and Allied Services*. HMSO, London.

Biggs, S. (1993) *Understanding Ageing*. Open University Press, Buckingham.

Biggs, S. (1999) *The Mature Imagination*. Open University Press, Buckingham.

Blakemore, K. and Boneham, M. (1994) *Age, Race and Ethnicity*. Open University Press, Buckingham.

Blau, Z.A. (1973) *Old Age in a Changing Society*. Franklin Watts, New York.

Brody, E. (1981) Women in the middle. *The Gerontologist*, 21, 5, 471–479.

Brody, E.M. (1990) *Women in the Middle: Their Parent Care Years*. Springer, New York.

Cornwell, J. (1984) *Hard Earned Lives*. Tavistock, London.

Costa, P.T. and McCrae, R.R. (1988) Personality in adulthood. *Journal of Personality and Social Psychology*. 54, 853–863.

Cowgill, D.O. and Holmes, L.D. (eds) (1972) *Aging and Modernisation*. Appleton, New York.

Crow, G. (2004) Social networks and social exclusion: an overview of the debate. In Phillipson, C., Allan, G. and Morgan, D. (eds) *Social Networks and Social Exclusion*. Ashgate, Aldershot.

Davidson, K., Daly, T. and Arber, S. (2003) Exploring the social worlds of older men. In Arber, S., Davidson, K. and Ginn, J. (eds) *Gender and Ageing*. Open University Press, Maidenhead.

Falkingham, J. and Victor, C.R. (1991). The myth of the Woopie. *Ageing Society*, 11, 4,471–493.

Featherstone, M. and Hepworth, M. (1989) Ageing and old age: reflections on the postmodernlifecourse. In Bytheway, W. (ed.) *Becoming and Being Old*. Sage, London.

Featherstone, M. and Hepworth, M. (1995) Images of positive ageing. In Featherstone, M. and Wernick, A. (eds) *Images of Ageing*. Routledge, London.

Finch, J. (1989a) *Family Obligations and Social Change*. Polity Press, Cambridge.

Victor, C.R. (2005). *The social context of ageing*. Routledge. New York.

Unit-IV

Adjustments in Later Life:

4.0.Objectives

4.1. The Informal Support and Its relevance in Later Life.

4.1.1 Defining 'care'

4.1.2 Who provides care? The informal/formal care distinction

4.1.3 Why the Growing Interest in Informal Care of the Elderly?

4.1.4 Characteristics of Informal Supporters

4.2. Elderly and the Caregivers.

2.1 The Effect of Caregiving

4.3. Living Arrangements of Elderly.

4.4. Ageing & Retirement.

4.6. References

4.5. Questions

4.0. Objectives

After studying this unit you will be able to understand

- The informal support needed for the elderly
- The relevance of informal support in later life
- The effects of care giving
- The role played by the care givers
- Living arrangements of the elderly

4.1. The Informal Support and Its relevance in Later Life.

A society as large and complex as India needs to explore the contemporary society to work out an extensive plan for the care and well-being of the elderly. The plan would vary from those in the more developed countries due to the different stages of urbanisation and differences in the cultural and familial systems in India. The diversity that has emerged in the ageing process necessitates that research efforts focus on different ageing issues in society. This in turn is expected to promote the development of effective age-related policies and programmes. The heterogeneity among the elderly population cannot and should not be ignored, while framing various models of care for the elderly in our society.

4.1.1 Defining 'care'

Clearly, the term 'care' is multifaceted, as it relates to both health (medical/paramedical) and social care. Medical care, despite its complexities, is nonetheless reasonably easily defined as attempts to cure or alleviate physical or mental illness. The OECD (2005: 10) defines long term care as:

. . . a range of services for persons who are dependent on help with basic activities of daily living (ADL) over an extended period of time. Such activities include bathing, dressing, eating, getting in and out of bed or chair, moving around and using the bathroom. These long term care needs are due to long-standing chronic conditions causing physical or mental disability.

The term 'social or long term care' can also be used in a wider sense to denote assistance not only activities of daily living (ADL) as specified above, but also assistance with instrumental activities of daily living (IADL), in other words, domestic work such as cleaning and cooking, and other basic day to day 'life management' tasks such as paying bills, shopping, running errands, and so on. The definition of long term care can also include 'light touch' services such as supervision (for instance of a person with dementia who is liable to wander and put him/herself at a risk that is deemed unacceptably high) or purely 'social' aspects such as companionship.

4.1.2 Who provides care? The informal/formal care distinction

Informal care refers to the care given to dependent persons, such as the sick and elderly, outside the framework of organized, paid, professional work. Attention to the importance of informal care has increased with the adoption of community care policies which place increasing reliance on care provided by family, relatives, and friends, often women.

Long term care is received in many different settings, and is carried out by a wide range of carers ranging from medical 'professionals' to 'formal' (paid) carers to 'informal' or family carers (who in most cases are not paid). Informal care can also be referred to as family or unpaid care, denoting the fact that it is delivered by family members, neighbours or friends, typically in the recipient's or carer's home, usually without any financial recompense. Formal or paid care, on the other hand, can be provided either in the community (in the older person's home or in a public community setting such as a daycare centre) or in a residential institution.

A complex 'care mix' exists in many countries that have both formal and informal care services operating in parallel (of course, many countries continue to rely exclusively, or almost exclusively, on informal care and have not developed the formal care services sector).

However, in country like India mostly aged are given informal care and the roots of formal care have not spread their tentacles yet because 67% of the population reside in

rural areas where we stick to the tradition of taking care of our elders either to avoid sarcasm or as a part of respect and obligation.

For social and familial relations of the elderly, there appears to be a steady change in care-giving from the traditionally secure joint family care of the elderly to extended family care in which care by adult children forms a major part. Scholars cite that if the present trend continues, there will likely be a decrease in elder care by adult children in the future, which will create more demand for old-age homes. India is at a crossroads and has to decide whether to go the family care way or the institutional/community care way.

4.1.3 Why the Growing Interest in Informal Care of the Elderly?

In recent years, policymakers and service planners have become more interested in finding ways to support informal care providers, for several reasons:

- Most of the care for the elderly is provided by informal caregivers, most of whom are family. Studies conducted in India and elsewhere among disabled elderly reveal that informal care has remained extensive despite the accelerated development of the formal service system. Informal support is provided in a range of areas, such as activities of daily living (ADL, e.g., washing and dressing); household management (IADL; e.g., preparing meals and shopping); and emotional and social support. Moreover, family members now often provide support in areas that were, until recently, the domain of professional caregivers. For example, due to the shortening of hospital stays, families now care for the elderly during their convalescence from an acute illness, sometimes even when the elderly still require acute treatment. Furthermore, as life expectancy increases, care providers are increasingly called upon to confront end-of-life care at home. The care provided by informal caregivers has thus become more complex, requiring them to have understanding, knowledge and skills in a broad range of areas.
- Recent demographic, epidemiological and social changes also challenge the informal care system. For example, the aging of the population, changes in family structure, and the entry of increasing numbers of women into the labor market all affect the ability of a family to cope with the aging of a relative. In addition, for the first time in history, due to rising life expectancy and dropping birth rates, the average married couple may have more parents than children. While family care of sick and disabled relatives is by no means a new phenomenon, and has indeed typified most societies throughout history, it is now being provided for longer periods. Furthermore, it is increasingly likely that most individuals will at some time play the role of caregiver; thus, caring for disabled and sick elderly relatives is relevant to all.
- There is consensus that extensive informal help enables many elderly to remain in the community, thereby postponing or averting institutionalization. Not only do most elderly prefer to remain at home, and most professionals believe that this is important to maintaining their quality of life, but also provision of care at home saves public resources.

- Professional caregivers are increasingly aware of the advantage of training family to provide care (which they are providing in any case), so as to improve its effectiveness and quality.
- Research findings have raised the awareness of professionals to the fact that burnout and the heavy burden on the families may lead to aggressive behaviors toward the elderly and even to physical and mental abuse. To prevent these phenomena, it is necessary to support family caregivers.
- Evidence is increasing of the negative implications of the burden resulting from caregiving on the family. Professionals are becoming more aware that caring for an elderly relative can significantly undermine the quality of life, as well as the physical and mental health, of the caregiver.
- Liebig and Rajan state that for a country like India, the State cannot enter as a major player in elder care in view of the high (prohibitive) cost to the exchequer and the low national priority to elder care. The need to develop models of home or family care may be supplemented by suitably adapting them to a variety of respite services while at the same time suitably adapting them to Indian conditions (Phoebe S. Liebig and IrudayaRajan, 2005). For these reasons, policymakers, service planners and professionals view informal care of the elderly as extremely important, and wish to preserve it as a social resource.

4.1.4 Characteristics of Informal Supporters

As noted, the system of informal support for the elderly is composed primarily of relatives. Even when the family is a large one, one member usually takes on more responsibility than the others.

Most of the literature focuses on this person, known as the "primary caregiver". An examination of primary caregivers in India shows diversity in their characteristics and needs.

- In most cases, the primary caregiver is either the spouse or a child of the elderly person.
- Most primary caregivers live with, or in proximity to, their elderly relative.
- Most (two-thirds) primary caregivers are women.
- Caregivers' health affects the level of support they can provide and their ability to cope with burden and stress. It should be noted that caregiving itself may adversely affect health.

4.2. Elderly and the Caregivers.

Variations in models for the care of the elderly would be influenced by factors such as whether the place of residence is urban or rural, social class differences and gender dynamics to name a few. The issues upon which different models for the care of the

elderly may be developed and the same required to be tested for their efficiency and potential replication are outlined in the following section.

Rural Elderly

In traditional Indian society, the informal support systems of family, kinship and community are considered strong enough to provide social security to its members, including older people. Urbanisation, industrialisation and the ongoing phenomenon of globalisation have cast their shadow on the traditional values and norms within the society. Gradual nuclearisation of the joint family, erosion of morality in economy, changes in the value system, migration of youth to urban areas for jobs or work and increasing participation of women in the workforce are important factors responsible for the marginalisation of older people in rural India. As a result, the elderly depend on 'money-order economy' and their intimacy with their children is only from a distance (Vijaykumar, 1999). The rural poor, who mostly work in the informal or unorganised sector face insecure employment, insufficient income, lack access to any form of social security and good quality or reasonably priced health care and generally have to pay a large percentage of their income for even the most basic healthcare services. As the interrelation of health and economic status continues throughout one's life, it is of special importance to the elderly whose livelihood depends on their physical ability and who do not have any provisions for economic security. Social security pensions, though meager in amount, create a sense of financial security for the elderly, who benefit through schemes such as old age pension, widow's pension, agricultural pension and pension for informal sector workers. However, the proportions of the elderly who benefit from these schemes have to be improved significantly.

Urban Poor Elderly

Due to industrialisation and urbanisation and the changing trends in the society, it is the urban elderly who are more likely to face the consequences of this transition as the infrastructure often cannot meet their needs. Lack of suitable housing forces people to live in slums which are characterised by poor physical condition, low income levels, high proportion of rural immigrants, high rates of unemployment and underemployment, rising personal and social problems such as crime, alcoholism, mental illness, etc. along with total or partial lack of public and community facilities such as drinking water, sanitation, planned streets, drainage systems and access to affordable healthcare services. With the increasing prevalence of slum dwellers that come to urban areas in search of better opportunities, a significant proportion of them would constitute the elderly.

Urban Middle Income and Well-to-do Elderly

While awareness regarding the process of ageing and its changes is of prime importance in utilization of services among the poor, the middle income and well-to-do largely require scope and opportunities to improve their later life in all aspects— health conditions, financial prospects, physical environment, family relationships and

community participation. The awareness of improving the quality of later life has led to the emergence of a section of the elderly who are healthy and active and therefore, refuse to sit placidly contemplating the sunset when they can lead a productive and purposeful later life well into their 80s and 90s. The healthy elderly have to be acknowledged as a resource and the notion that they are social and economic burdens has to be discarded. While rural India continues to provide the support of the family in old age, the impact of urbanisation has touched many a life leading to migration of children to cities or abroad. Many elderly are well-off due to their prosperous children but are left alone to take care of themselves.

Female Elderly

Gender-related differences show that women worldwide typically live longer than men, leading to a process called the 'feminisation of later life'. The female elderly are more likely to be widowed, have low economic security, lower educational attainment, less labour force experience and more caregiving responsibilities than their male counterparts. Traditional gender roles stressing the woman's place within the home with little decision-making power, lack of opportunities for education and earning a living may affect their social and economic status. The absence of gender-specific health services, poor health due to child bearing, less nutrition and their priority role as the providers of care for the young and the elderly combined with economic deprivation throughout their lives, often make the female elderly face a greater risk of ill-health in later life. Considering the demographic, cultural and income differences between genders, ageing means more challenges for women than for men. As most women outlive their male counterparts, they are more likely to be taking care of their husbands in their later years. The burden of care giving often leads to deteriorating health and mental stress among older women. Nowadays, with the increase in longevity, the older woman also takes care of her very old parents or in-laws. Moreover, if those women are employed, they face a dilemma between the responsibilities of their jobs and their caregiving obligations, especially seen among the rural and urban poor who cannot source external help/staff. There are several situations that women face in their young age which have implications in their old age. Malnourishment in girls, low educational standards, limited job opportunities - all these make them dependent both in their active life and in old age. For instance, in a study conducted by Wason and Jain in Jodhpur (2011), it was observed that the risk of malnutrition was more among females (42.2 per cent) than among males (32.9 per cent). Today, even if the urban setting provides better scope to earn a living, their status within the family continues to be dependent on their husband and they sometimes have little or no say in the aspect of financial saving for old age. The loss of status at the death of their husband only increases the situation of dependency in old age. This dependency can become more complex as the woman grows older, given the situation that she has no source of income or right to property as seen in traditional families, where her relationship with her son and daughter-in-law decides her fate in old age.

4.2.1 The Effect of Caregiving

Although the burden on informal caregivers has been studied since the early 1980s, investigation has intensified in recent years, and includes a broader examination of the whole range of aspects involved in caregiving and of its effects on the employment, personal, family and social life, and health of primary caregivers. A significant part of the literature is based on sociological and psychological models of stress. Many studies have thus examined the negative aspects of care provision, to identify caregivers who are at risk and develop models linking the causes of stress to the characteristics that engender them. Recently, however, attention has also begun to be paid to the positive aspects of providing support, including the caregivers' feelings that they are of help to their relative, that they are needed, and that caregiving adds a new facet to their life.

- There is a sense of burden on the primary care givers. According to various studies, more than two-thirdsof caregivers report having physical difficulties (caregiving requires too great aphysical effort and adversely affects their health); more than two-thirds report that theirsocial and leisure activities have suffered (caregiving leaves the caregivers little time forthemselves or their family); over 90% of caregivers report emotional stress (caregivingincreases tension in the caregiver's own home, or the relative's condition worries and upsetsthe caregiver).
- The following have been found to affect a caregiver's sense of burden: the elderly person'scharacteristics and level of disability or illness; the characteristics of the caregiver himself(age, gender, relation to the elderly person, marital status and employment); the existence of a support network (e.g., whether there are other caregivers); and the existence of a formalsupport system.
- The burden on spouses who serve as caregivers is greater than that on children. Not only arespouses themselves older, and in some cases suffer from poor health or physical difficultiesthat make it hard for them to provide care, but also their sense of commitment seems to bedeeper; and their physical proximity to the elderly person means they are more exposed tohis need for assistance. Some studies have also found that when the primary caregiver is thespouse, other family members are less involved in caregiving.
- Shared living affects primary caregivers even if they are not the spouse: Caregivers who livewith a disabled relative tend to report a greater sense of burden. One reason for this may bethat assistance is not time-bound, such that the caregiver may have particular difficultyfinding time for other roles.
- When other informal caregivers are involved, the primary caregiver tends to report a lessersense of burden. This is particularly true when another relative can replace the primarycaregiver during a vacation or illness.
- Most of the informal care is provided by women. This has two implications: first, if the lady is not working then her household responsibility increases; second, if the lady is working then she has triple responsibility i.e. her work, her family and the aged. Now, if the elderly is disabled or sick to a greater extent than that hampers her career prospectus because most of the time she has to take leave in case of any serious health issue of the elderly and she is bound to suffer physically and emotionally and would be psychologically stressed.

4.3. Living Arrangements of Elderly.

Living arrangement of senior citizens in India is of increasing concern in view of the expanding cohort of older ages resulting from increasing longevity. Moreover, with the rapid decline in fertility, there is substantial reduction in the number of children to take care of the elderly. The increasing number of the elderly has been of concern in the developed world for many years, both from the individual and social policy perspectives and for effectively responding to the increasing costs of providing care. In developing countries like India, where social pensions are meagre and access to health insurance is still very limited, the traditional support systems from family and community becomes important to uphold the Indian tradition of respect and care of the elderly. As a result, elderly members of the family have normally been taken care of within the family itself. The family and social networks provided an appropriate environment in which the elderly spent their lives, engaging in religious activities, participating in the rearing of grandchildren, and following other pursuits. This way, the institution of family fulfilled the needs of the elderly in providing social, psychological and economic security. In addition, the family took care of the physical welfare as well as the psychological well-being of the older family members, and in turn, the elderly contributed by dispensing their acquired wisdom and prudence, distributing their wealth and belongings, and maintaining family harmony resulting in symbiosis and reciprocity (Siva Raju 2011).

The most crucial aspect of living arrangements of the elderly is co-residence with adult children in extended families or multi-generational households, where kin provide income, personal care and emotional support to the elderly (Nandal 1987, Rajan and Kumar 2003). Scholars and policy makers working in this area view the living arrangements of the elderly as a measure of their wellbeing. It has been a common assumption that co-residence with children and grandchildren in multi-generational households benefit the elderly, and that the elderly who live with at least one adult child are better off and better provided for than those who live alone or with non-relatives (Teng 2007). Thus, Cogwill (1986) concludes that co-residence of the elderly and young has been in the spirit of "life time reciprocity". Though co-residence is an important criterion for the well-being of the elderly, Chan (1997) and Irudaya Rajan et al (1999) argue that it may not always ensure a healthy relationship between successive generations and economic, emotional, and social support from the younger generation can still be provided even without co-residence. However, they believe that the level of social and economic development becomes an important determining factor. Further, it is said the co-residence does not always indicate flow of support from the younger to the older generation; co-residence may also imply child-care or help in household chores by the elderly.

The Indian economy, demography and society are in a major transition. The economic development gains are not equitably shared across different geographical regions and sections of the society. These social and economic changes have brought in cultural changes as well as changes in individual characteristics. With the demographic transition under way, there are only a few children to take care of the elderly. They are now more educated, mobile, aspire for a higher standard of living, and as such, changes in their individual behaviour and attitude are observed. These, in turn, are

expected to bring changes in the living arrangements of the elderly with implications for their well-being.

In terms of interaction and familial support, there are interesting patterns of Note, that elders in urban areas do not have familial support by means of communication and meeting is not surprising, given that support networks tend to be stronger in rural areas. Female children have differential patterns of familial support than male children, with females indulging in more by way of communication and meeting, while male children are more likely to assist monetarily. Health and functionality are important indicators of interaction: those in worse health are more likely to receive monetary support, while those in better health are more likely to send transfers to their children. Pensions do not seem to protect elderly in terms of living arrangements, instead, compound familial support: elderly who receive pensions are also more likely to receive monetary support from their children. This could also mean that these are the most vulnerable elderly who need both public and private transfers. Interaction terms in the multivariate models are needed.

It is possible then, that India is moving toward a more western system of living arrangement, where highly educated, functional elderly in good health are more likely to live independently of familial structures by choice rather than compulsion. There is however the fact that widows and women are the most vulnerable of the survey group , who need better safety nets by way of governmental schemes behind the backdrop of changing household structures in India.

4.4. Ageing & Retirement.

Old age is a crucial stage in one's life. One is lucky enough if have a smooth sailing from middle age into the old age and is not confronted with variety of bewildering problems. But in case of people who lead an active life in service, the change is drastic. From an active life one is thrown suddenly into inactive life of retirement. Retirement is a major turning point in adult development since it is the social milestone marking the shift from the middle years to the later years of life. According to Carp (1960), "Retirement is a relatively new phase in human development. In the past, retirement often suggested disability. Most adults worked until they died, retirement from life not work.

The impact of retirement is tremendous as it results in loss of role, status, power and an occupational identity. Therefore, at this stage a major reorganization of one's life activities is required. There can be considerable degree of social isolation ie new activities are not found to replace work related activities. The implication that the individual is no longer able to carry out the work role is especially problematic. Retirement can lead to low morale, decreased level of satisfaction, depression and feelings of loneliness and helplessness.

Retirement has numerous dimensions and consequently can be defined in several ways. The most inclusive definition of a retired person is, "an individual who is not full

time annually and who receives some kind of retirement pension from previous years of job service". (Epstein and Murray,(1968).

- i. Retirement as an event,where the retirement is an occasion that makes the transition from middle age to the later years of adulthood. For some individuals, it may also mark the end of period of work and the beginning of a period of relative leisure.
- ii. Retirement as a position where the individuals move into a relatively new social position with the accompanying expectations and roles. There is major characteristic decline in the standard of living and a reduction in the number of roles played.
- iii. Retirement as a process which involves working through the conflicts and concerns inherent in a major transition. These concerns have to work with factors such as the individual's health whether retirement is mandatory or voluntary and the meaning the individual personally attributes to retirement.

A popular opinion is that emergence of problems after retirement is due to ambiguity and non-availability of roles for old persons. Our socialization process does not adequately prepare even fully mature adults for the trauma of retirement. It ultimately leads to problems of ill health, psychological maladjustment, economic hardship, disturbed relationship within family and improper utilization of leisure time. Cushing(1952) suggested four essentials of successfully meeting the problems of retirement: financial security, a time consuming interest, a gradual tapering of work, companionship of one's own co-peers.

Influence of Age on Mental Health

Elderly period of life is more prone to mania, depression, anxiety, schizophrenia and personality disorders(Beckman, 1995). Anxiety disorders are less common in the elderly than in younger adults. Generalised anxiety disorders and phobias account for most anxiety in later life (Flint,1994). The physiological, psychological as well as the socio-economic changes with age may be the cause of greater severity of mental health problems in later life period. An older person faces numerous very real fears and insecurities that may not be the characteristics of earlier life periods, like that produced by retirement. Many people depend greatly on their work for status, for self identity, for satisfying inter personal relationship and for the meaning of their lives. Retirement often does not meet those needs and may leads to severe stress like reduction in income which further augments the older person's adjustive burden. As the individual grows older, he is faced with the inevitable loss of loved ones, friend and contemporaries. The death of the mate with whom one may have shared many years of close companionship often poses certain particularly difficult adjustment problems. Defiance by son or disturbances in sleep and lack of control over emotions may also be the causes of mental health problems in old age people.

Ageing and the Family

Traditionally family has been the key institution that provided psychological, social and economic support to the individual at different stages of life. Elderly in the family enjoyed undisputed authority and power. They were treated as knowledge banks and resource persons for the younger. Their advice is accepted as law; their words are respected as words of god. However the structure of family has undergone changes differently at different stages of human history in India. Intergenerational relationship and the role of women in the family are changing that affect the care of the aged in the family. Industrialization and urbanization have brought changes to family structure in India to a great extent. The extended family that existed in the society has changed to a nuclear family. This has affected the position of the elderly in the family as well as the family's capacity to take care of the aged. However, in India the older people are still cared for by the younger relations. As keeping parents in old age homes draws criticism from social networks and community at large, living in old age homes is not popular in India. The strong cultural pressure makes the families to take care of the elderly.

Traditionally the aged felt that the money spent on their offspring was an investment that could enjoy the returns when they became old. They derived psychological and economic support from the younger generations. In the recent times individualism, independence, and achieved position in the family are becoming part of family culture in India. The aged would now prefer to live independently as long as possible and the children do not feel guilt of being away from the parents. Nevertheless there is no total societal acceptance to deserting parents by their children. Living arrangements for the elderly are influenced by several factors such as gender, health status, disability, socio economic status, societal tradition and cultural heritage.

Ageing and family relationships have been central forces shaping individual lives throughout history. While family may in some sense be a safe heaven from harsh realities of life, studies have found that close personal bonds can also serve to express and apply ageism.(Butler and Dowd, 1980).

When a person is in service, he may be the head of the family and all the important decisions are usually taken after consultation with him. But after retirement, he may have to be satisfied with a secondary position. And at times he may only be nominally informed about some of the important family matters. Most of the elderly people state that there has been a change in family relations towards them after retirement. Majumdar (1985) stated that there is loss of status accompanied by a sense of alienation and hopelessness among the elderly after retirement caused by economic dependence, physical weakness and domestic event. Elderly people staying with other younger members may have to face problems of adjustment too. With change in economic status, it is conceivable that the behavior of other members towards elderly people may also change. More non-pensioners feels that there is a change in the attitude of their sons, daughters and relatives. This is because the children who were dependent on him for financial support may have become earners themselves and may not respect the respondents to that extent.

4.6. References

1. Achenbaum, W Andrew (1995): *Crossing Frontiers — Gerontology Emerges as a Science*. Cambridge: University Press.
2. Alam, Moneer, 2006, 'Ageing in India: Socio-Economic and Health Dimensions', Academic Foundation, New Delhi.
3. Bhattacharyya, S and Birla, B. (2006). Impact of Globalization on Elderly: Issues and Implications. *Journal of Gerontology*. Vol. 20, No. 3. pp 273-284
4. Chacko, A., Joseph, A. (1990): Health problems of the elderly in rural South India. *Indian Journal of Community Medicine*, Vol. XV (2): 70-3.
5. Government of India. *National Policy on older persons*: Ministry of Social Justice and Empowerment, Shastri Bhawan, New Delhi, Jan. 1999.
6. Kishore, S., Garg, B.S. (1997) : Socio-medical Problems of Aged Population in Rural Area of Wardha District. *Indian Journal of Public Health*, Vol. 41 (2) : 43-8.
7. Lal, S., Mohan, B., Punia, M.S. (1997) : Health and Social Status of Senior Citizens in Rural Areas. *The Indian Journal of community Medicine*, Vol. 9 (3) : 10-17.
8. Nayar, P.K.B. : The Ageing scenario in Kerala : A Holistic Perspective. *Research & Development Journal*, Vol. 6 (2) : 5-13, Feb-May 2000.
9. Registrar General of India (1986). *Report of the technical group on population projection* constituted by the plannign commission. Office of Registrar General, India.
10. Registrar General of India (1991). *Report of the technical group on population*. Census Office of the Registrar General, India : 1991.

4.5. Questions

Long type questions

1. Discuss the social and psychological impact of ageing.
2. Critically examine the informal means of support that are available for senior citizens of India.
3. Explain the role of family in supporting aged.
4. Make a comparison between rural and urban family in this respect.

Short type questions

1. write a note on social impact of retirement.
2. Discuss the socio-economic conditions of elderly female.
3. Issues and challenges in supporting older poor in India. Discuss.
4. Rural elderly and urban elderly.

UNIT- V

The State and the Elderly

5.0. Objectives

5.1. Role of State-Policies and Programmers for the Aged in India

5.2. Role of NGOS

5.3. NGOs working for Elderly people

5.4. National Policy on Aged

5.5. References

5.6. Questions

5.0. Objectives

In this unit we have discussed

- State policies and programmes for the elderly
- Role played by the NGOs.
- Concessions facilities available for elderly in India
- List of national NGOs for elderly

5.1. Role of State-Policies and Programmers for the Aged in India

PRESENT CONCESSIONS AND FACILITIES AVAILABLE

The Ministry of Railways provides the following facilities to senior citizens:

- Separate ticket counters for senior citizens at various (Passenger Reservation System) PRS centres if the average demand per shift is more than 120 tickets;
- Provision of lower berth to male passengers of 60 years and above and female passengers of 45 years and above.
- 40% and 50% concession in rail fare for male passengers aged 60 years and above and female passengers aged 58 years and above respectively.
- Wheel chairs at stations for old age passengers.

Ministry of Health & Family Welfare

Central Government Health Scheme provides pensioners of central government offices the facility to obtain medicines for chronic ailments up to three months at a stretch. More details on Central government Health Scheme.

The Ministry of Health and Family Welfare provides for (i) separate queues for older persons in government hospitals and (ii) geriatric clinic in several government hospitals.

The Ministry has taken a new initiative called the National Programme for the Health Care for the Elderly (NPHCE) in the Eleventh Five Year Plan. The programme has been implemented from the year 2010-11 with an approved outlay of ` 288 crore for the remaining period of the 11th Five Year Plan (i.e for 2010-11 and 2011-12). The objectives of the programme are to:

- Provide preventive, curative and rehabilitative services to the elderly persons at various level of health care delivery system of the country
- Strengthen referral system
- Develop specialized man power and
- Promote research in the field of diseases related to old age.

The basic strategies of the programme are to:

- Strengthening of 8 Regional Geriatric Centres
- Dedicated facilities at district hospital including 10 bedded wards
- Dedicated services at PHC/ CHC level
- Primary health care approach.

The major components of the programme are:

- To establish geriatric department in all the existing 8 Regional Geriatrics Centres
- Strengthening healthcare facilities for elderly at various levels of 100 identified districts in 21 States of the country.
- Regional Institutions to provide technical support to geriatric units coordinate the activities down below at CHC, PHC and sub-centres.

Physical targets set for achievement till March 2012

- Establishment of Geriatric Department at the 8 Regional Geriatric Centres
- To cover 30 districts in 2010-11 and another 70 districts in 2011-12 from 21 identified States:
 - Establishment of Geriatric Units at the district hospitals
 - Establishment of Rehabilitation Units at CHCs
 - Establishment of Weekly Geriatric Clinic at PHCs

Initiative taken and progress in 2010-11

- Programme initiated in 30 districts of 21 identified States.
- Rs.32.61 crore has been released to 19 States (covering 27 districts). Fund sanctioned for 3 districts of Jharkhand (Bokaro) and Uttar Pradesh (Raibareilly and Sultanpur) could not be released due to non-receipt of Bank Account details.
- Rs. 8.59 crore have also been released to 4 Regional Geriatric Centres (S N Medical College, Jodhpur; Banaras Hindu University,UP; Guwahati Medical College, Assam; and Trivandrum Medical College.

Initiative taken and progress in 2011-12

- Programme to be initiated in another 70 districts of 21 identified States.

- Funds have been released to 7 States (Bihar, HP, Karnataka, Kerala, Sikkim, Punjab and Rajasthan) to take up 21 new districts.
- Funds for Haryana and Chhattisgarh are being released.
- Funds have also been released to 2 Regional Geriatric Centres (Madras Medical College and Grants Medical College, Mumbai). Fund is being released to Sher-i-Kashmir Institute of Medical Sciences, J&K.
- Non Communicable Diseases (NCD) Cells at the Centre, State and District will implement and monitor the NPHCE. The National NCD Cell has been established at the Centre.

National Mental Health Programme focuses on the needs of senior citizens who are affected with Alzheimer's and other old age problems like dementia, Parkinson's disease, depression and psycho geriatric disorders.

Tax Exemption on Interest: Senior citizens enjoy additional benefits in terms of saving schemes and interest earned on them. Interest is levied on the amount of money deposited for a particular time period. The rate of interest varies for different durations and is liable to change from year to year. Most banks provide a higher rate of interest to senior citizens than the rate available to the general public. The Reserve Bank of India has permitted higher rates of interest on saving schemes of senior citizens. Other than higher interest rates on deposits, senior citizens also enjoy exemptions on penalty rates for premature withdrawal of term deposits. Fixed deposits are sometimes withdrawn to tide over emergencies like sudden medical expenses and hospitalization. In this case, senior citizens are either exempted completely or charged a meagre percentage rate of their deposits.

A Senior Citizens Savings Scheme has been introduced by the Government through Post Offices in India which offers higher rate of interest on the deposits made by the senior citizen in post offices.

(i) Ministry of Finance

The Ministry provides the following facilities for senior citizens:

- Income tax exemption for Senior Citizens of 60 years and above up to Rs. 2.50 lakh per annum.
- Income tax exemption for Senior Citizens of 80 years and above up to Rs. 5.0 lakh per annum.
- Deduction of Rs. 20,000 under Section 80D is allowed to an individual who pays medical insurance premium for his/ her parent or parents, who is a senior citizen.
- An individual is eligible for a deduction of the amount spent or Rs. 60,000, whichever is less for medical treatment of a dependent senior citizen.

Insurance Regulatory Development Authority (IRDA)

IRDA vide letter dated 25.5.2009 issued instructions on health insurance for senior citizens to CEOs of all General Health Insurance Companies which inter-alia includes:

- Allowing entry into health insurance scheme till 65 years of age,
- Transparency in the premium charged
- Reasons to be recorded for denial of any proposals etc. on all health insurance products catering to the needs of senior citizens. Likewise the insurance companies cannot deny renewability without specific reasons.

Department of Pensions

The Department has set up a Pension Portal to enable senior citizens to get information regarding the status of their application, the amount of pension, documents required, if any, etc. The Portal also provides for lodging of grievances. As per recommendation of the Sixth Pay Commission, additional pension will be provided as per details given below to older persons:

Age Group	% of Pension to be added
80+	20
85+	30
90+	40
95+	50
100+	100

Ministry of Civil Aviation

The National Carrier, Air India, under the Ministry of Civil Aviation provides air fare concession up to 50% for male passenger aged 65 years and above and female passenger aged 63 years and above on the date of commencement of journey and on production of proof of age (Photo- ID) and nationality.

Ministry of Road Transport and Highways

The Ministry of Road Transport and Highways has taken initiatives for providing reservation of two seats for senior citizens in front row of the buses of the State Road Transport Undertakings. Some State Governments are giving fare concession to senior citizens in the State Road Transport Undertaking buses and are introducing Bus Models, which are convenient to the elderly.

National Old Age Pension (NOAP) Scheme

Under National Old Age Pension Scheme, in 1994 Central Assistance was available on fulfillment of the following criteria:-

- The age of the applicant (male or female) should be 65 years or more.

- The applicant must be a destitute in the sense that he/she has no regular means of subsistence from his/her own source of income or through financial support from family members or other sources.

The amount of old age pension varies in the different States as per their share to this scheme. This scheme is implemented in the State and Union Territories through Panchayats and Municipalities. Both Panchayats and Municipalities are encouraged to involve voluntary agencies as much as possible in benefiting the destitute elderly for whom this scheme is intended.

The Ministry is now administering the Indira Gandhi National Old Age Pension Scheme (IGNOAPS) under which Central assistance is given towards pension @ ` 200/- per month to persons above 65 years belonging to a household below poverty line, which is meant to be supplemented by at least an equal contribution by the States so that each beneficiary gets at least ` 400/- per month as pension.

As on 31.3.2011, the number of beneficiaries receiving central assistance was 171 lakh.

The Ministry has lowered the age limit from the existing 65 years to 60 years and the pension amount for senior citizens of 80 years and above has also been enhanced from ` 200/- to ` 500/- per month with effect from 1.4.2011. It is estimated that there are about 72.29 lakh additional persons living below the poverty line, who would become eligible to receive central assistance under IGNOAPS in the age group of 60-64 years and there are 26.33 lakh persons above the age of 80 years living below the poverty line, who would become eligible to receive enhanced central assistance @ 500 per month. The number of beneficiaries is expected to increase from 171 lakh to 243 lakh.

The decision of the Government of India regarding lowering the age limit from 65 to 60 years along with the revised guidelines have been issued to all States/ UTs vide letter no.J-11015/1/2011-NSAP dated 30th June 2011.

The Maintenance and Welfare of Parents and Senior Citizen Act, 2007 Legislative Framework

The Maintenance and Welfare of Parents and Senior Citizens Act, 2007 was enacted in December 2007, to ensure need based maintenance for parents and senior citizens and their welfare. The Act provides for:-

- Maintenance of Parents/ senior citizens by children/ relatives made obligatory and justiciable through Tribunals
- Revocation of transfer of property by senior citizens in case of negligence by relatives
- Penal provision for abandonment of senior citizens
- Establishment of Old Age Homes for Indigent Senior Citizens
- Adequate medical facilities and security for Senior Citizens

The Act has to be brought into force by individual State Governments. As on 31.3.2011, the Act had been notified by 22 States and all UTs. The Act is not applicable to the State of Jammu & Kashmir, while Himachal Pradesh has its own Act for Senior Citizens. The remaining States yet to notify the Act are – Bihar, Meghalaya, Sikkim and Uttar Pradesh.

States/ UTs which have notified the Act are required to take the following measures/steps for effective implementation of the Act:

- Frame Rules under the Act;
- Appoint Maintenance Officers;
- Constitute Maintenance and Appellate Tribunals.

The Act was enacted on 31st December 2007. It accords prime responsibility for the maintenance of parents on their children, grand children or even relatives who may possibly inherit the property of a Senior Citizen. It also calls upon the State to provide facilities for poor and destitute older persons.

Provisions of the Act

- Parents who are unable to maintain themselves through their own earnings or out of their own property may apply for maintenance from their adult children. This maintenance includes the provision of proper food, shelter, clothing and medical treatment.
- Parents include biological, adoptive and step mothers and fathers, whether senior citizens or not.
- A childless Senior Citizen who is sixty years and above, can also claim maintenance from relatives who are in possession of or are likely to inherit their property.
- This application for maintenance may be made by Senior Citizens themselves or they may authorize a person or voluntary organization to do so. The Tribunal may also take action on its own.
- Tribunals on receiving these applications may hold an enquiry or order the children/relatives to pay an interim monthly allowance for the maintenance of their Parents or Senior Citizen.
- If the Tribunal is satisfied that children or relatives have neglected or refused to take care of their parents or Senior Citizen, it shall order them to provide a monthly maintenance amount, up to a maximum of ₹ 10,000 per month.
- The State Government is required to set up one or more tribunals in every sub-division. It shall also set up Appellate Tribunals in every district to hear the appeals of Senior Citizens against the decision of the Tribunals.
- No legal practitioner is required or permitted for this process.
- Erring persons are punishable with imprisonment up to three months or a fine of up to rupees five thousand or with both.

- State Governments should set up at least one Old Age Home for every 150 beneficiaries in a district. These homes are to provide Senior Citizens with minimum facilities such as food, clothing and recreational activities.
- All Government hospitals or those funded by the Government must provide beds for Senior Citizens as far as possible. Also, special queues to access medical facilities should be arranged for them.

Rights of Older Persons: International Scenario

Beginning with the Universal Declaration of Human Rights, going on to the many International Instruments - including the Covenants on Economic Social and Cultural Rights, on Civil and Political Rights as well as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) - there are many references to the Rights of all. The Declaration on Social Progress and Development in 1969, for the first time specifically mentions old age in Article 11.

The UN adopted the 1st International Plan of Action on Ageing in Vienna in 1982, and it took until 1991 for the General Assembly to adopt the UN Principles for Older Persons (Resolution 46/91) and its 4 main themes independence, participation, care, self-fulfillment and dignity.

The Committee on Economic, Social and Culture Rights adopted the General comment no 6 on the Economic and Social, and Cultural Rights of Older Persons (Document E/1996/22, Annex IV) in the year 1995.

In 1999, with the International Year of Older Persons (Document A/50/114), came the Conceptual Framework based on the Plan and Principles with 4 priority areas: (a) The situation of older persons, (b) individual lifelong development, (c) the relationship between generations, (d) the interrelationship of population, ageing and development. Finally, in Madrid in 2002, 20 years after, the 2nd World Assembly on Ageing (WAA) adopted unanimously a Political Declaration and an International Strategic Plan of Action on Ageing.

Both the documents include clear objectives and related actions to be taken: (i) to ensure the Rights of older persons, (ii) to protect older persons from “neglect, abuse and violence” in all situations addressed by the UN as well as (iii) to recognize “their role and contribution to society”.

The 2002 Madrid Plan of Action goes into great details on the situation of older persons and the Commission for Social Development was given the charge of implementation.

However, it is obvious that these precedents are not enough to give older persons their Rights as well as recognition of their contribution to society. Older persons are not only unrecognized but more and more excluded from their role in society, just to cite a few examples:

- Migration of younger generations from developing countries or countries in transition with little or no welfare leaves behind older persons with no social, economic and care support, thus increasing their vulnerability, isolation, poverty, discrimination and lack of health care;
- The galloping technological development increases the generation divide: in a 4 to 5 generation society, the 2-3 older generations are too often excluded and affected by the digital divide;
- In HIV/AIDS pandemic, the contribution of older generations is today vital, their right to care for their orphaned grand-children could only benefit the socio-economic development but also the human reconstruction of society through restoring an identity, transmitting higher values and life skills;

In all issues, the Right to Development takes into account the generation-specificities of development over the life span and until the end of life.

To generate public attention concerning mainstreaming of older persons, the theme chosen for the International Day of Older Persons in 2003 was 'Mainstreaming ageing: forging links between the Madrid International Plan of Action on Ageing and the Millennium Development Goals'. Various UN programmes, specialized agencies as well as NGOs have made efforts to mainstream the concerns of older persons into their respective agendas.

On the level of operative action, United Nations Population Fund (UNFPA) strives to mainstream ageing into its areas of work, namely reproductive health, gender issues and humanitarian responses to conflict situations. WHO's major mainstreaming objective is to focus on principles and methods of developing health care systems that are responsive to ageing. The 2004 report of the Secretary-General to the General Assembly recommends "to assign full-time focal points on ageing and provide them with adequate resources to further implementation, particularly through appropriate mainstreaming action."

Initiatives by National Human Rights Commission (NHRC)

Ministry of Social Justice had constituted the National Council for Older Persons (NCOP) on 11-1-1999 in which a representative from NHRC was included as a member.

In its meeting held on 8th March, 2002, the Commission noted the details of the implementation of the Old Age Pension Scheme by the Central and State Governments and appointed Shri K. B. Saxena, IAS (Retd.), Former Advisor, Planning Commission for an in-depth study and recommendations.

Shri K. B. Saxena submitted a Report with Suggested Intervention on "National Old Age Pension Scheme: Issues of Policy and Governance". The Report was published by NHRC in October 2007.

The Ministry of Social Justice and Empowerment reconstituted the National Council for Older Persons (NCOP) on 1st August 2005 under the Chairmanship of Ministry for Social Justice & Empowerment. The Secretary General, NHRC is a member of the NCOP. The Council, presently, has 15 official Members and 33 non-official members.

The recent meeting of National Council for Older Person was held on 23rd October 2009 at Parliament House, New Delhi. One of the sessions of meeting was slotted for exclusive interaction of the NHRC with the members of the Council. The issues such as progress of implementation of the Maintenance and Welfare of Parents and Senior Citizen Act 2007, status of adaptation of Act by the states, Model Rules for the State Govt., review of National Policy on Older Persons, 1999 were discussed during this interaction in the meeting.

Health Awareness Week for elderly people

The Commission had organized "Health Week" Awareness Programme for the elderly people (senior citizens) in collaboration with Help Age India from 20th to 24th March, 2006 at New Delhi. Lecture on following topics were delivered by the subject specialists in the field, which were very much informative with regard to the health of older persons:

- Cardio-vascular Disease: How to Prevent Heart Attacks and Strokes
- Diabetes in the Elderly - Myths and Reality
- Vision Problems in the Elderly
- Arthritis and Bone Management
- Disease of the Prostate Gland
- Specific Health Concerns of Older Women
- Mental Health
- Nutrition for the Elderly,

Another Health Awareness Week for the elderly people (senior citizens) was organized by the Commission in collaboration with Help Age India from 26th February to 2nd March 2007 at Ahmedabad. Lecture on various topics such as, Healthy Ageing and Domestic Accidents and Prevention, Pain and its Management, Alternative Medicine, Diabetes and its Management, were delivered by the specialists in the field. A Special health Camp for health screening, Blood Pressure, Blood Sugar was also organized on 2nd March 2007 from 2.00 PM to 4.00 PM by the Commission.

The Commission has engaged its Special Rapporteur Dr. L Mishra in preparation of an Action Plan for the Welfare and Social Security of the Elderly Persons.

The action plan envisages following role for the Commission:-

- Reviewing activities and performance of the institutions like old age home etc., through the Special Rapporteurs of the Commission;
- Undertaking measures for publicity, awareness, familiarization, and sensitization of the public as well as Central and State Government Officers towards the older persons.
- Promoting action research on issues relating to elderly.

In Nov. 2010, the Commission has constituted a core Group on health, safety, and welfare of the elderly people under the chairmanship of Member-in-charge of the subject. The Core Group has been mandated to collect and compile data base on the magnitude of the problem and challenges faced by the elderly, review the activities of various Ministries/ Departments and give suggestions for qualitative improvement and change in the policies and programmes relating to senior citizens.

5.2. Role of NGOS

While there is a large NGO sector active in the field of ageing in countries where demographic transition is already advanced, in the developing world the number of organizations is much smaller. Non-governmental organizations working with older people have a very narrow focus and concentrate mostly on welfare, drawing their inspiration charitable institutions, including religious orders. Those founded in recent years have continued to see themselves primarily or solely as service providers to older people in need. In many cases these NGO share a view of ageing as problematic, a time of increasing difficulty compounded by social and cultural change. The problems of aged are compounded by factors like family change (notably the decline of the extended family) as well as of changing cultural values, which are seen as leading to the social and economic marginalization of older people. Responses to these problems cannot be solved through macro policy initiatives alone. Therefore approaches which meet the perceived needs of individuals or small groups of elders at a local level should be emphasized. In developing countries this has often taken the form of work which substitutes for inadequate or non-existent public services, most characteristically residential, domiciliary or day care for frail older people. Other services include basic health provision, and development of income-generating or credit schemes for older people and their families. These activities tend to be relatively small-scale, urban-based 'projects', operating on short-term and/or precarious funding.

In relation to ageing a body of expertise has grown up, starting with the work of HelpAge International in the early 1990s, which has now begun to influence a small but increasing number of governments to employ participatory approaches to compliment more quantitative research in the formulation of policy on ageing. (HelpAge International has supported participatory-based research studies in, inter alia, Cambodia [1997], Tanzania [1998], Ghana and South Africa [1999], Mozambique [2000], and Vietnam [2001].) Participatory approaches enable older people to express their concerns and participate in activities to address them (not only at community level but also in engagement with policy makers). These processes have the capacity to raise awareness within communities regarding rights and issues of social exclusion of the aged and this would prove to be an empowering experience for older people, leading to meaningful change.

In order to involve older people in problem-solving research and development activities, NGOs can take stewardship in engaging older people in community-level action. However, NGO working in ageing have been relatively inactive in this area because of

their unidirectional focus on welfare and not on development. There has to be better integration of NGOs and state which will nurture learning and knowledge transfer. For example, there are instructive experiences from NGO working with people with HIV and AIDS in fighting discriminatory practices, such as isolation and stigmatization of sufferers. In the early 1990s these NGOs successfully developed and promoted at international forums a concept of the right of people with AIDS to community support. This principle is being upheld by innovative community-level education programmes, including HIV/AIDS awareness training for older midwives in East Africa. Likewise, the rights of older people to community support need to be promoted with other issue-based organizations and across sectors. There is a strong case for reversing the often held view that older people, particularly those who are poor and frail, are a burden to their communities. As a starting point, discriminatory practices by some of these same organizations have been challenged, for example the consistent refusal of local-level officials in micro-credit organizations to make loans available to older people. (At such points direct advocacy can achieve a positive response. Recent Help Age International lobbying of BRAC, a Bangladeshi NGO specializing in micro-credit, has led to a change in their age-restriction policy.)

For rights-based approaches at community level to take hold and have significant impact they need (as shown by the examples of NGOs working in fields such as HIV/AIDS and disability) to be increasingly supported by NGOs at all levels. Again progress has so far been slow. However, there are some examples of effective NGO activity. In 1996 NGOs working in Bolivia for example, helped to achieve the passage of a law recognizing the rights of older people and launched a national programme for their legal protection and support, including the payment of a non-contributory annual lump sum 'pension'. Whilst such national law can uphold rights and promote good practice, resources will continue to be contested at various levels. Thus NGOs increasingly need to monitor policy implementation. National policies already exist in some countries for example, such as free medical care for older people, that fail to take effect because of poor communication, implementation and enforcement structures. A developmental approach, based in a human rights perspective, will need to go beyond welfarist orientations in promoting awareness and protecting legislation. Enabling older people to participate fully in this process is thus a priority.

Non-governmental organizations can also play a proactive role in policy making and should act as a major stakeholder at international level. The international debate involving ageing more or less directly has taken place in three separate, hardly overlapping arenas, in the past 20 years.

Firstly there has been the discourse framed by the United Nations' 1982 World Assembly on Ageing. This conference viewed 'old age as a problem' which needs intervention. Its outcome was an 'International Plan of Action on Ageing' (the Vienna Plan), which laid out a set of universal recommendations for government action. However, non-governmental organizations were accorded little or no role in the implementation of the Vienna Plan and no framework was laid down for them.

Second arena includes policy development for social security reform. Though this issue drew attention from all the countries (developed and developing) around the world but it involved NGO even less. For older populations, the key focus has been the debate over pension reform which was completely monopolized by the World Bank. In a publication named "Averting the Old Age Crisis", it points out 'income security in old age [as] a worldwide problem' and states that 'the challenge is to move forward systems of income maintenance without accelerating the decline in informal systems and without shifting more responsibility to government than it can handle'. The World Bank's diagnosis and its prescription for pension reform have not gone unchallenged, and there is vigorous debate as to the appropriate roles of public and private provision of old-age social protection. The point to make here is that the NGO sector has up to now played little or no role in this dialogue.

The third policy arena concentrates around the wider development debates. The civil society has mostly focused on the core development issues, such as poverty, health, gender, the environment and the like, NGO lobby on ageing, so has been notably absent. The International Development Targets, benchmark indicators set for development progress by the Copenhagen Social Development Summit of 1995 and modified by the General Assembly at the Millennium Summit, make no mention of ageing as an issue, and there has so far been little discussion or inclusion of ageing as more than a peripheral issue on the margins of the main debates.

The disconnections between these three arenas for policy discourse are not simply the result of a collective failure of the NGO working on ageing issues. International organizations such as the United Nations and the International financial institutions, notably the World Bank have made little progress in linking the elements of the growing global debate on ageing. National level policy making rarely tries to integrate various stakeholders working for the aged and even policies are made without encompassing the aged.

In this context it is not feasible to expect a small and under-resourced NGO sector to make the necessary connections between all these policy arenas. The challenge for NGO in ageing is to build on the experience they have derived from their substantial body of knowledge and experience in direct work with older people. They need to go beyond the service delivery to make the necessary causal links between the reality of their experience of older people's poverty at community level and the wider policy agendas of which old-age poverty is one outcome. They need to learn the vocabulary of policy making, to understand the ways that ageing, which has been described as one of the great architectural issues of this century can be inserted into the policy agendas of governments and international organizations. Non-governmental organizations need to forge better links not only among themselves, but also with organizations working in related fields, many of whom have relevant experience to offer. They also need to make connections with the growing number of academics working on gerontological issues in the developing world, and to raise the awareness of those in development studies who as yet have had little exposure to ageing issues. This is a substantial and ambitious programme.

5.3. NGOs working for Elderly people

1) AISCCON: All India Senior Citizens' Confederation :

Formed in 2001, AISCCON is the largest national organisation to bring together and represent senior citizens across India. Today AISCCON has Federations / Associations affiliated to it from 25 States in India.

It devotes itself to networking, advocacy and research on the issues concerning welfare and development of senior citizens with governments at both the state and national level. The organization also provides service activities including health care (Physiotherapy services, eye care services and other advisory services) services.

FESCOM: The Federation of Senior Citizens Organisations of Maharashtra:

The Federation of Senior Citizens Organisations Maharashtra (FESCOM) was established on December 12, 1980 in Mumbai, to unify and strengthen the comprehensive welfare activities of senior citizens and their organisations under one banner with the aim of utilising their knowledge, experience, wisdom, energy, and skill for the welfare of society in general and of senior citizens in particular.

FESCOM follows a two-pronged approach to ensure quality of life to its members. On the one hand, they develop and implement programmes aimed at addressing the basic needs of their members, such as shelter, education, entertainment, and inclusion. On the other hand, they ensure the rights of their members through sustained advocacy initiatives with the authorities at each level. The key activities include conducting seminars, workshops, group discussions, and annual conferences, meeting with government authorities for seeking concessions to and rebates for senior citizens to which they are entitled, and corresponding with the Prime Minister's Office, the Ministry of Finance, the Government of Maharashtra, and the Reserve Bank of India to draw their attention to issues concerning the welfare of senior citizens.

HelpAge India

HelpAge India is secular, not-for-profit organization registered under the Societies' Registration Act of 1860. Established in 1978, Help Age India is a leading charity platform in India working with and for disadvantaged elderly and has become the representative voice for India's elderly. Dedicated to improving the status for India's senior citizens, it works in 23 states providing medical services, poverty alleviation and income generation schemes in urban and rural India.

HelpAge is also slowly moving from Welfare to Development services for the elderly in urban & rural areas. In rural India it is concentrating on long term sustainability of programs through formation of Elder Self Help Groups, restoring dignity and economic independence among the poor elder community, while in urban India it is urging elders to stay active and form Advantage Groups under its Advantage Card program, which not only helps provides the urban elder with benefits and discounts of various services, but also urges them to 'Get Active, Stay Active'.

Dignity Foundation:

Dignity Foundation is an NGO for the cause and care of the older persons with its headquarters at Mumbai. Dignity Foundation was established in April 1995, to cater to the needs of the elderly, starting with the publication of the magazine Dignity Dialogue, Dementia Day Care Center and Old Age Home.

Harmony:

The Harmony for Silvers Foundation, founded in 2004 by Tina Anil Ambani, is a non-government organisation working to enhance the quality of life of the elderly in India. It envisages India's elderly as 'Silver Citizens'—glowing and proud. Harmony's mission is to create an environment where silvers, irrespective of their cultural beliefs, can retain their dignity, self-respect, pride and self-confidence. Harmony is actively networking with other agencies and organisations in India and abroad for exchange of expertise, ideas and experiences. The first step in this direction was taken in April 2006, when the foundation co-hosted the International Roundtable Workshop on Elder Abuse in Pune, in collaboration with International Longevity Centre, India, International Federation on Ageing, Singapore Action Group for Elderly, HelpAge International, and the Government of India.

The Family Welfare Agency:

The Family Welfare Agency (FWA) has been established since 1950 in the city of Mumbai, Maharashtra, India. It is a voluntary social organization, registered under the Bombay Public Trust Act works on grass root level.

The agency has developed from working with general community based issues to providing specialized services in the field of Ageing and Mental Health.

The FWA has worked at three levels preventive, promotive and curative within the community and nearby areas. The agency has, thus progressed from 'remedial' to 'therapeutic' and has now broadened its approach with a 'social development' perspective, emphasis on integrating approaches. This integrated development approach has been instrumental in enhancing the quality of life along with people's participation to achieve the same.

ARDSI (Alzheimer's Related Society of India):

Alzheimer's and Related Disorders Society of India (ARDSI) is a registered national, non-profit voluntary organization engaged in the care, support, training and research of dementia since its inception in 1992. It is the only national organisation whose activities are exclusively devoted to help the dementia victims and their families. The main activities of ARDSI are to: Raise awareness, to develop services, to train family members and professionals, to undertake research.

ARDSI has been in the forefront to disseminate knowledge about dementia to the public through various forums and is actively involved in developing services like respite care, day care, home care, setting up memory clinic, conducting training programmes for the family members, doctors, nurses and social workers and promote research.

Shree ManavSevaSangh :

Started in 1924 Shree ManavSevaSangh is a Non-Profit Organization in the field of welfare activities for the Orphan Children and less Privileged Women & Senior Citizen. It has a Mission to shape and impact the lives of orphaned, abandoned, destitute, Helpless Children and Women. From the very modest start in 1924, of giving food and shelter to poor and needy, the institution has grown into a model social service organization for all the needs of these children, women, and elder citizens.

Jeevan AdharSevaSanstha :

It is a NGO working for Homeless Elderly at Vakola Flyover, Santacruz east, Mumbai.

Silver Inning Foundation:

Silver Innings is a Social Entrepreneur organization working for cause of Elderly; it also hosts Silver Innings.Com, www.silverinnings.com Pioneer in promoting web based application for Elders, it's a Comprehensive and dedicated Website for Elderly. Providing need base service, networking and advocacy for Senior Citizens forms important aspect of Silver Innings.

The group also consists of Silver Inning Foundation a registered NGO dedicated for Senior Citizens and their family. At Silver Innings we are working towards creating Elder Friendly World where Ageing becomes a Positive and Rewarding Experience.

5.4. National Policy on Aged

Over the years, the government has launched various schemes and policies for older persons. These schemes and policies are meant to promote the health, well-being and independence of senior citizens around the country. Some of these programmes have been enumerated below.

The central government came out with the National Policy for Older Persons in 1999 to promote the health and welfare of senior citizens in India. This policy aims to encourage individuals to make provision for their own as well as their spouse's old age. It also strives to encourage families to take care of their older family members. The policy enables and supports voluntary and non-governmental organizations to supplement the care provided by the family and provide care and protection to vulnerable elderly people. Health care, research, creation of awareness and training facilities to geriatric caregivers have also been enumerated under this policy. The main objective of this policy is to make older people fully independent citizens.

Constitutional Provisions

In Constitution of India, entry 24 in list III of schedule VII deals with the Welfare of Labour, including conditions of work, provident funds, liability for workmen's compensation, invalidity and Old age pension and maternity benefits. Further, Item No. 9 of the State List and item 20, 23 and 24 of Concurrent List relates to old age pension, social security and social insurance, and economic and social planning.

Article 41 of Directive Principles of State Policy has particular relevance to Old Age Social Security. According to this Article, "the State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in case of undeserved want.

II. Legal Provisions

The right of parents, without any means, to be supported by their children having sufficient means has been recognised by section 125 (1) (d) of the Code of Criminal Procedure 1973, and Section 20(1&3) of the Hindu Adoption and Maintenance Act, 1956.

Personal Laws:

The moral duty to maintain parents is recognized by all people. However, so far as law is concerned, the position and extent of such liability varies from community to community.

(a) Hindu Laws:

The statutory provision for maintenance of parents under Hindu personal law is contained in Section 20 of the Hindu Adoption and Maintenance Act, 1956. This Act is the first personal law statute in India, which imposes an obligation on the children to maintain their parents. As is evident from the wording of the section, the obligation to maintain parents is not confined to sons only; the daughters also have an equal duty towards parents. It is important to note that only those parents who are financially

unable to maintain themselves from any source, are entitled to seek maintenance under this Act.

(b) Muslim Law:

Under the Muslim law also children have a duty to maintain their aged parents. According to Mulla (Muslim title applied to a scholar or religious leader):

(i) Children in easy circumstances are bound to maintain their poor parents, although the latter may be able to earn something for themselves.

(ii) A son in stressed circumstances is bound to maintain his mother, if the mother is poor, though she may not be infirm.

(iii) A son, although poor, is earning something, is bound to support his father who earns nothing.

According to the Muslim law, both sons and daughters have a duty to maintain their parents under the Muslim law. The obligation, however, is dependent on their having the means to do so.

(c) Christian and Parsi Law:

The Christians and Parsis have no personal laws providing for maintenance for the parents. Parents who wish to seek maintenance have to apply under provisions of the Criminal procedure Code.

The Code of Criminal Procedure (Cr.P.C):

The Cr.P.C 1973 is a secular law and governs persons belonging to all religions and communities. Daughters, including married daughters, also have a duty to maintain their parents. The provision for maintenance of parents under the code was introduced for the first time in Section 125(1) of the Code of Criminal Procedure in 1973. As per the code if any person having sufficient means neglects or refuses to maintain his father or mother, unable to maintain himself or herself, a Magistrate of the first class may, upon proof of such neglect or refusal, order such person to make a monthly allowance for the maintenance of his father or mother, at a monthly rate as the magistrate thinks fit, and to pay the same to such person as the Magistrate may from time to time direct.

III. Government Policies and Schemes for Older Persons

Over the years, the government has launched various schemes and policies for older persons. These schemes and policies are meant to promote the health, well-being and independence of senior citizens around the country. Some of these programmes have been enumerated below:

a. National Policy for Older Persons

The central government came out with the National Policy for Older Persons in 1999 to promote the health, safety, social security and well being of senior citizens in India. The Policy recognizes a person aged 60 years and above as a senior citizen. This policy

strives to encourage families to take care of their older family members. It also enables and supports voluntary and non-governmental organizations to supplement the care provided by the family and provide care and protection to vulnerable elderly people. The policy has identified a number of areas of intervention- financial security, healthcare and nutrition, shelter, education, welfare, protection of life and property etc. for the wellbeing of older persons in the country. The main objective of this policy is to make older people fully independent citizens.

This policy has resulted in the launch of new schemes such as-

1. Strengthening of primary health care system to enable it to meet the health care needs of older persons.
2. Training and orientation to medical and paramedical personnel in health care of the elderly.
3. Promotion of the concept of healthy ageing.
4. Assistance to societies for production and distribution of material on geriatric care.
5. Provision of separate queues and reservation of beds for elderly patients in hospitals.
6. Extended coverage under the Antyodaya Scheme with emphasis on provision of food at subsidized rates for the benefit of older persons especially the destitute and marginalized sections.

b. National Council for Older Persons:

A National Council for Older Persons (NCOP) has been constituted by the Ministry of Social Justice and Empowerment to operationalize the National Policy on Older Persons. The basic objectives of the NCOP are to:

- Advise the Government on policies and programmes for older persons
- To provide feedback to the Government on the implementation of the National Policy on Older Persons as well as on specific programme initiatives for older persons
- advocate the best interests of older persons.
- provide a nodal point at the national level for redressing the grievances of older persons which are of an individual nature.
- provide lobby for concessions, rebates and discounts for older persons both with the Government as well as with the corporate sector.
- represent the collective opinion of older persons to the Government
- suggest steps to make old age productive and interesting
- suggest measures to enhance the quality of inter-generational relationships.
- undertake any other work or activity in the best interest of older persons.

c. Integrated Programme for Older Persons:

Implemented by the Ministry of Social Justice & Empowerment this scheme provides financial assistance up to 90 per cent of the project cost to non-governmental organizations or NGOs as on March 31, 2007. This money is used to establish and maintain old age homes, day care centres, mobile medicare units and to provide non-institutional services to older persons.

The Scheme of Integrated Programme for Older Persons (IPOP) is being implemented since 1992. Under the Scheme financial assistance up to 90% of the project cost is provided to Non-Governmental Organizations for running and maintenance of old age homes, day care centres and mobile medicare units. The Scheme has been revised w.e.f. 1.4.2008. Besides an increase in amount of financial assistance for existing projects, Governments/ Panchayati Raj Institutions/ Local Bodies have been made eligible for getting financial assistance. Several innovative projects have also been added as being eligible for assistance under the Scheme. Some of these are:

- Maintenance of Respite and Continuous Care Homes
- Day Care Centres for Alzheimer's Disease/ Dementia Patients,
- Physiotherapy Clinics for older persons;
- Help-lines and Counseling Centres for older persons;
- Sensitizing programmes for children particularly in Schools and Colleges;
- Regional Resource and Training Centres
- Training of Caregivers to the Older Persons;
- Awareness Generation Programmes for Older Persons and Caregivers;
- Formation of Senior Citizens Associations etc.

The eligibility criteria for beneficiaries of some important activities/ projects supported under the Scheme are:

- Old Age Homes - for destitute older persons
- Mobile Medicare Units - for older persons living in slums, rural and inaccessible areas where proper health facilities are not available
- Respite Care Homes and Continuous Care Homes - for older persons seriously ill requiring continuous nursing care and respite.

Issues and Challenges in Supporting the Older Poor in India

- The institution and functioning of the family as a support structure for older people is under severe pressure because of poverty, unemployment and changing attitudes and as such external support is needed to strengthen the family and provide supplementary income;
- Since the older people are disadvantaged by stereotypes which largely discredit the poor older workers in the unorganized sector, necessary measures are required to create opportunities, increase the competence of older workers and counterbalance this negative image;

- Incidence of widowhood among women even before reaching old age results in a serious disadvantaged experience of old age;
- Lack of food is a major cause of poor health; priority for elderly in these circumstances receiving nutritional supplements is highly desirable.
- The configuration, design and general physical environment in which older people live including housing, transport, work place and recreation could be made more user friendly to achieve greater independent personal mobility, safety and convenience;
- Systematic and analytical studies on the needs of the elderly in India, both urban and rural, are required to add substance to the many preliminary and exploratory studies already made;
- On account of the shortage of trained personnel in many specialist fields, the training of professionals to organize and promote services and programmes for the elderly needs to be given high priority, especially in such areas as family support, financial provisions, health care and community involvement.

The specialised health needs of the older people require greater attention through the expansion and integration of geriatric and gerontological training in the medical curricula, mainstreaming of geriatric services in the Primary Health Centres and geriatric rehabilitation in the integrated Community Development programmes as an integral component of community based services would ensure that the full range of support services is accessible to older people in the health system.

At this age of their life, the senior citizens need to be taken care of and made to feel special. They are a treasure to our society. Their hard work has helped in the development of the nation. The youth of today can gain from their experience, in taking the nation to greater heights.

Here are ten reasons why the Working Group should recommend the strengthening of legally-binding standards on the rights of older people and the development of a new protection regime:

1. The number of older people worldwide is growing at an unprecedented pace. People over sixty years of age make up an ever greater percentage of the world population. Today, 760 million people are over 60; by 2050, that number will have risen to 2 billion. Older people already outnumber young children (0-4) and will outnumber children under 15 by 2050. This trend is global. Today, 65 per cent of people over 60 live in less developed countries; by 2050, 80 per cent will.

2. There is no dedicated protection regime for older people's rights. While the rights of women, children, prisoners and people with disabilities are all protected through special international conventions or standards, no such standards exist for older people despite their specific vulnerability to human rights violations.

3. There are clear gaps in protections available to older people in existing human rights standards. Only one of the existing human rights instruments explicitly prohibits age

discrimination. This has resulted in a failure in many countries to address the multiple forms of discrimination older people face. Specific provisions regarding issues like elder abuse, long term and palliative care, are also absent from existing human rights standards.

4. Older people's rights are neglected in the current human rights framework. UN and regional human rights bodies have largely ignored the rights of older people. For example, of 21,353 recommendations the Human Rights Council made during the entire first round of its peer to peer human rights review process of all UN member states (known as Universal Periodic Review), only 31 recommendations referred to "elderly" people or people of "old age".

5. Age discrimination and ageism are widely tolerated across the world. Negative ageist attitudes towards old age and older people are deeply ingrained in many societies and, unlike other forms of prejudice and discriminatory behavior, are rarely acknowledged or challenged. This leads to widespread marginalization of older people, and is at the root of their isolation and exclusion.

6. Older people are highly vulnerable to abuse, deprivation and exclusion. A growing body of evidence shows that many older people face abuse and violence in their own homes, and in institutional and long term care facilities. Many are also denied the right to make decisions about their personal finances, property and medical care. They are often denied social security, access to health and productive resources, work, food and housing.

7. Older people hold rights but are often treated with charity instead of as rights holders. Many governments see ageing predominantly as a social welfare or development issue. This reduces older people to recipients of charity rather than people who should enjoy their rights on the same basis as everybody else. A paradigm shift is needed from a social welfare to a rights-based approach.

8. National protections of older people's rights are inconsistent. National standards on the rights of older people are patchy and inconsistent, as are protection regimes. As a result, few countries collect data on violations of the rights of older people. Violations will continue unaddressed as long as there is a gaping lack of information on their nature, prevalence, and cause.

9. Respect for older people's rights benefits society as a whole. Violations of the rights of older people lead to exclusion, poverty, and discrimination of older people. Yet, older people make key contributions to any society through their experience and wisdom. Better protection of the rights of older people will allow societies to better capitalize on the potential that older people represent. There is clear evidence, for example, that when older people's right to social security is realized, there is a positive impact on reduction of poverty rates, restoration of older people's dignity, reduction of child labour and increased enrolment in schools.

10. Older people are an increasingly powerful group. Older people represent a rapidly growing constituency and are among the most loyal election participants. When they vote, they can have significant political influence. Governments need to address their rights and needs or they risk losing support from this increasingly large block of voters.

5.6 References

1. Bali, Arun, (2001): Care of the Elderly in India Changing Configurations, Indian Institute of Advanced Study, Shimla.
2. National Sample Survey Organisation. *Socio-economic profile of the aged person*. 2nd Round (July 1986-June 1987) No. 367. Revised Report, New Delhi : Department of statistics, September 1989.
3. .Siva Raju, S. 2000: "Ageing in India: An Overview", in 'Gerontological Social Work in India', Murli Desai and Siva Raju (Eds.), Delhi, B. R. Publishing Co
4. Siva Raju, S. 2004: "Profile of Elderly and Organisations Working for their Care: A Study in Mumbai", Family Welfare Agency, Mumbai (Mimeo) Vijay Kumar, S. 2000: "Social Security in Indian Context", cited in Vijay Kumar, S. 2003: "Economic Security for the Elderly in India: An Overview", An Aging India: Perspectives, Prospects and Policies, The Haworth Press p.45-65, New York.
5. Subrahmanya, R.K.A. (199.) Income security for the elderly in India. BOLD, Quarterly Journal of INIA (UN). 4 (2),

5.5. Questions

Long type questions

1. Discuss about the various constitutional provisions that are available for senior citizens of India.
2. Describe the role of National policies in assisting the aged.
3. Explain the role of NGOs in supporting the elderly population.
4. Discuss the state government policies and programmes in favour of aged.

Short type questions

1. Discuss about the socio-cultural and civil rights of elderly people in India.
2. What are the different legal provisions that are available for elderly Muslims and Hindus in India?
3. Is National old age pension scheme is enough in assisting the aged, give your view.
4. Describe the objective of National council for older persons (NCOP).