Chapter 2

REVIEW OF LITERATURE

Studies on ageing of human population are of quite recent origin. The phenomenon of ageing being conceived in terms of chronological measurement became an area of demographic research in the initial years of gerontological research. The socio-economic changes comprise emergence of nuclear families, smaller number of children per couple, greater longevity, physical separation of parents from adult children as a result of rapid urbanization and age-selective rural-urban migration, together with the changing values of younger generation against the older ones.

The ageing of a population is an obvious consequence of the process of demographic transition. Being ahead in this process, the developed regions of the world have experienced its consequences and the developing world is well on its way to facing a similar scene. Developing countries have more elderly persons in absolute terms because of their large population base. A recent emphasis on studies pertaining to the elderly in the developing world is due to their increasing numbers and deteriorating conditions. While their increasing number is attributed to demographic transition, their deteriorating condition is considered as the end result of the last eroding traditional family system in the wake of rapid modernization and urbanization. As neither of the circumstances is avoidable, the reason seems to be the lack of adequate preparedness. However, the available studies have addressed multiple dimensions of the situation of the elderly by projecting their future size and composition, assessing their needs and difficulties with regard to health, social adjustment in old age etc.

The recent emphasis pertaining to the elderly in the developing world is attributed to their increasing numbers and deteriorating
conditions. The lives of many older people are affected more frequently by the social and economic insecurity that accompany demographic and development process (World Bank 1994).

Most of the studies on old age have been conducted in the western countries. Very few such studies have been conducted in India. A brief review of the existing literature has been given below. These studies have been arranged in order i.e. International level studies followed by national level studies and then state level studies.

**International level studies**

Alam H. and others (2013), in their study identified the socio-economic problems as well as factors responsible for the problems of persons with old age in district Dir Lower Khyber Pakhtunkhwa Pakistan. A sample of 45 persons with old age was obtained through purposive sampling technique. The quantitative approach was used to analyze the data. The collected information disclosed that persons with old age were facing problems in decision making, denial and verbal abuse, separation from spouse as well as married sons. They had low social status in the community as well as in their families. The persons with old age were also facing health problems due to expensive medicines and lack of personal money to spend for their health. Thus the problems of the senior citizens were found to be increasing with the passage of time. In order to overcome these problems and for raising the status of persons with old age, proper role of family members revival of religious value, media and government intervention were suggested.

Rathi R., Radhika R. (2012), in their article “Socioeconomic Status and Life satisfaction in Cross-Cultural Perspective: The Elderly in Japan and India” examined the distinct socioeconomic factors, level of life satisfaction of elderly and factors associated with the life satisfaction of elderly in Japan and India. The results considerably demonstrated that even though the Japanese elderly were in better position in socio and economic status compared to their Indian
counterparts. On the other hand level of satisfaction was observed to be higher among Indian elderly than Japanese. The findings of the study also revealed the association between distinct socioeconomic factors such as education, convoy composition, leisure activities etc. and life satisfaction of elderly in both the countries. This is an interesting observation as this leads to further deliberation of the role of other factors for the lower levels of satisfaction among Japanese. The level of satisfaction related to one’s personal fulfillment, ‘economic condition’ and ‘leisure’ was markedly low among Japanese respondents (56 percent, 36 percent and 36 percent) compared to India (77 percent, 41 percent and 51 percent), thus leading to lower levels of overall life satisfaction among them. This clearly indicated the influence of cultural differences and its impact on the life satisfaction across nations.

Nanthamongkolchai, S., et al. (2011), in their article “Successful Ageing : A Case Study of Rayong Province, Thailand” examined the proportion of successful ageing and influencing factors on the successful ageing in Rayong province, Thailand. The study used secondary data from the project of “Life Happiness of the Elderly in Rayong Province”, a study conducted in 2008. Total 400 respondents with age 60-80 years were taken for the study. It was observed that 27.5 percent of the ageing in Rayong Province was successful ageing assessed by 3 criteria which were having a good family relationship, high self esteem, and high life happiness. The factors influencing the success of ageing with statistical significance were family monthly income and social activity participation. The ageing with sufficient family income had a 7.5 times higher chance of success than those with sufficient income, and the ageing who participated at a high level in social activity had a 62 times higher chance than those with low participation. The family and responsible organizations should encourage the community participation of the ageing and provide sufficient income to lead to success in ageing.
Shoaib, M., Sarfraz K. and Mohsin H.K. (2011) in their study “Family Support and Health Status of Elderly People: A case study of District Gujrat, Pakistan” analysed the impact of family support on the health status of the elderly people in District Gujrat Pakistan. Total 120 respondents were sampled from four villages of Gujrat. Results of the collected data showed a positive relation between family support and health status of the elderly people in Gujrat. Almost all sampled elderly people living in rural areas of Gujrat were supported by their family members. Majority of the respondents were living with and supported by their children and had feeling of belongingness to their families. Statistical test showed that there was association between family support and health status of the elderly people in Gujrat.

Naing, Myo, M., Sutham, N., and Chokchai M. (2010) in their study ‘Quality of Life of The Elderly People in Einme Township Irrawaddy Division, Myanmar’ analysed the quality of life of the elderly people in Einme Township Irrawaddy Division, Myanmar, and factors related. A cross-sectional survey was conducted among 209 elderly aged 60 and over. Data was collected by using structured interview questionnaire from feb 1 to 21, 2010. The majority of the elderly people (80.9 percent) had a moderate level of quality of life, followed by high level (17.2 percent) and low level (1.9 percent). The factors that were statistically significantly related to the quality of life of elderly were education level, current illness, self esteem, family income, family relationship, and social support. In addition self esteem and family relationship could significantly predict the quality of life of elderly by 53.3 percent. Self esteem had the highest predictive power of quality of life. To promote quality of life of the elderly, responsible organizations should establish activities that enhance elderly self-esteem and promote good family relationship.

Munsur, A.M., K.M. Tareque, M. Rahman, (2010) analysed the socio economic backdrops, living arrangements, health status and
abuse and their determinants of the elderly women in Rural Naogaon District of Bangladesh. The data was collected from seven villages by using probability proportional to size (PPS) sampling. Logistic regression analysis was used for finding the determinants of living arrangements, health status and abuse of the elderly women. The study observed that an overwhelming majority of the elderly women in the age-group 60-69 years who were widowed, illiterate, had no education and income, economically dependent, living with married children. They were found to be unhealthy, suffering from arthritis related illness and were taking treatment from village doctors. The study also revealed that, nearly 35 percent elderly women were abused, mostly mentally abused due to poverty. On the basis of findings it was suggested that the elderly people especially female elderly in Bangladesh and developing nations as well should be provided secured later life.

Sijuwade, P. O. (2008), in his paper on "Coping with Economic Problems in Old Age and Civil Society's Response" studied the social and economic problems of elderly for Nigeria. He observed that the contemporary society was differential towards the elderly due to gradual erosion of traditional values and rapid socio-economic changes. They not only suffered from health and social problems but also faced the economic stringency. The findings of the study highlighted that most of elderly experienced financial difficulty and income was the most important item of deprivation in their life after withdrawing from work life. They had no significant savings or properties with them. Two-thirds of them were dependent on their children for the fulfillment of their needs. This situation did upset them emotionally but belief in religion helped in maintaining social integrity. Seeking support from family members was most preferred strategy to cope with income inadequacy. The state has not yet developed the mechanisms to respond to the emerging aging challenge.
In World Economic and Social Survey (2007), the implications of ageing for social and economic development around the world have been analysed. According to the survey, the share of population in the working ages will shrink and the labour force itself will grow older. This holds especially for the countries, mostly developed, with low fertility rates. Changes in society simultaneously produced by industrialization, increasing participation of women in the labour force, decreasing family size, diminishing importance of extended families and increasing internal and international migration among other factors had an important implication for the well-being of older people. It was also observed that with population ageing, the demand for medical practitioners in developed and developing countries was set to rise.

Alam, M. and K. Mehtab (2005), in their paper, "Beyond the Current Demographic Scenario: Changing Age Composition, Ageing and growing insecurities for the aged in India and Pakistan", presented an overview of important demographic changes in two major South Asian countries – India and Pakistan. This paper argued that much of the insecurities faced by the aged in India and Pakistan were the creation of recent economic – demographic changes in both the countries. Demographically, both were moving to become old and young – Old, because of their fast declining mortality and added life span, and young owing to past fertility and its momentum by implications, older adults would look for opportunities in high productivity formal economy. Economic changes of these countries were however failing to comply at both the levels – i.e., no or at best negligible public pillared income security net for the aged, and jobless growth posing serious labour market issues for the growing stock of young. Much of these issues, especially the lack of quality employment, may not allow the younger people to transfer enough resources to their ageing dependents – majority of them, as evident from this analysis, were impoverished and suffered by multiple
diseases. Hence, expecting that the families will be able to transfer enough resources for elderly care may not completely work in either of these countries. Protective subsidies were therefore must, for which finances need to be generated through fiscal measures.

Levkoff, S., MaCarthur and J. Bucknall (2005), in their study on, "Elderly Mental Health in the Developing World" observed that the absence of savings and security net compelled most of the elderly to continue their work status as long as they can. The situation was true for those whose main occupation was either agricultural oriented (in rural areas) or employed in the unorganised sector (in urban areas). Hence, the work participation rate of these elderly persons continued till their physiological condition permits because of absence of any social insurance available to them. The elderly who had no savings or pensionery benefits had to depend on their sons, daughters or near relations for their livelihood. The situation was worse for women whose primary role was within the household and the family. The study suggested the need to improve the economic and health conditions of elderly.

Legare and Martel (2003) attempted to highlight the differences and similarities regarding the living arrangements of the elderly in Canada, Switzerland, United Kingdom and Finland. They also investigated the effects of these differences and similarities in demographic trends. The countries studied had shown great similarities in living arrangements, notwithstanding their cultural differences. Living alone was becoming popular although gender differences do exist. A good proportion of elderly women lived alone while their male counterparts lived with the spouses, a phenomenon explained by the higher life expectancy among females. Thus the study observed that emerging demographic trends and increasing divorce rates influenced the living arrangements at old age greatly.

Bongaarts, J. and Z. Zimmer (2001), in their paper, "Living Arrangements of Older Adults in the Developing World: An Analysis of
DHS Household Surveys', reconstructed the demographic data of households for 43 developing countries, including 11 Asian countries that participated in the demographic and Health Survey (DHS) programme between 1990 and 1998. They analysed the pattern of living arrangements of the older adults. The study observed that most older adults tend to live in large households and they were likely to be living with an adult child, who was more likely to be male than female. They also found that on an average, nearly one out of 10 older adults lived alone, and that the probability of living alone was greater for older women than men. Women were much less likely to live with a spouse in the household, while a slightly greater proportion of older women than men lived with adult children. The programme also noted a weakening of extended family links in conjunction with socio-economic development.

Sven E. Wilson (2001) in his study “Socioeconomic Status and the Prevalence of Health Problems among Married Couples in Late Midlife” analyzed the association between socioeconomic status (SES) and the prevalence of mutually occurring health problems among married couples in late midlife. Data was based on the 1992 US health and Retirement study. Two health measures were used: (1) Self-assessed health status and (2) an index of functional limitations and activity restrictions. SES indicators used were household income, education, and insurance coverage. The study had found in general, after adjustment for age cohort, a strong association was found between the health of a married individual and the health of his or her spouse. Socioeconomic Status was highly associated with the joint occurrence of health problems among marriage partners. Public health policy should pay particular attention to the interaction between health, SES and interpersonal relationships.

Weil, D. N. (1997), in his article "The Economics of Population Ageing" examined the causes of population ageing and found that the sources of population ageing lie in two demographic phenomena: rising life expectancy and declining fertility. An increase in longevity raises the average age of the population by raising the number of
years that each person is old relative to number of years in which he is young. A decline in fertility increases the average age of the population by changing the balance of people born recently (the young) to people born further in the past (the old). Of these two forces, it is declining fertility that is the dominant contributor to population ageing in the world today.

Hogan, Eggebeen, and Clogg (1993), in their study "The structure of intergenerational exchanges in American families", examined intergenerational support in a large national sample of more than 5000 adults who had (i) surviving parents and (ii) one or more children under 18 at home. Four specific types of supports were examined: financial, care giving, (to a child or parent), assistance with household tasks, and emotional support or advice. Analyses of exchanges between the older two generations indicated that more than half (53 percent) of middle-generation adults were low exchangers, giving or receiving very little and 11 percent were high exchangers, typically both giving and receiving a variety of support with their ageing parents. Women were more active as exchangers then were men and co-resident parents both received and gave high levels of support. African Americans were, contrary to the findings of above research, less likely to be involved in intergenerational exchanges, a result explained by a shortage of resources within their families.

Andrews, G.R. (1987), in his study “Ageing in Asia and the pacific: A Multidimensional Cross-National Study in four countries” analysed the health and social aspects of ageing in four developing countries: Korea, the Philippines, Fiji and Malaysia. The key findings were compared and contrasted with those of a similar 11-county WHO study in Europe. In broad terms, the overall demographic, physical, mental health and social patterns and trends associated with ageing as demonstrated by age group and sex differences were consistent throughout the four countries studied. Comparisons with European findings in other similar studies underlined the fundamental universality of age-related changes in
biophysical, behavioural and social characteristics. The importance of the family in developing countries was evident with about three-quarters of those aged 60 and over in the four countries living with children, often in extended family situations. Levels of adverse health behaviour and the prospect of changing patterns of morbidity with further increases in the total and proportional numbers of aged persons pointed to a need for emphasis on preventive health measures and programmes directed to the maintenance of the physical and mental health of the ageing population.

Longman, P. (1987), in his book "The new politics of ageing in America" has argued that younger generations are in inevitable conflict with their elders. His estimates showed that the average net income and wealth of the young were lower than those of the elderly recipients. He suggested a rise in the normal age of retirement and a ceiling on the net income and wealth of the elderly for them to be entitled to public security.

**National level studies**

Husain, Z., Saswata, G. (2011), in their research article on "Is Health Status of Elderly Worsening in India? A Comparison of Successive Rounds of National Sample Survey Data", used unit-level data for 1995-96 and 2004, and examined changes in reported health status of the elderly in India and analysed their relationship with living arrangements and extent of economic dependency. It was observed that even after controlling for factors like caste, education, age, economic status and place of residence, there had been deterioration in self-perceived current health status of the elderly. The paper argued that, although there had been changes in the economic condition and traditional living arrangements – with a decline in co-residential arrangements – this was not enough to explain the decline in reported health status. The authors called for a closer look at narratives of neglect being voiced in developing countries.

Lena A., Ashok K., Padma M., Kamath V., Kamath A (2009), in
their paper, "Health and social problems of the Elderly: A cross sectional study in Udupi Taluk, Karnataka", examined the health and social problems of the elderly and their attitude towards life. The results showed that a major proportion of the elderly were out of the work force, illiterate, partially or totally dependent on others, and suffering from health problems with a sense of neglect by their family members. There was a growing need for interventions to ensure the health and to create a policy to meet the care and needs of the disabled elderly. Social Security Schemes should be made more flexible to cover a larger population.

Rajan, Risseeuw and Perera (2008) made some observations regarding health status of elderly in India by using NSS data. Their analysis revealed a huge majority (70 percent) of the elderly reporting their health status to be ranging from ‘excellent’ to ‘good/fair’ while around a quarter of the elderly reported their current health to be poor. Previous analysis had uncovered that such a high percentage of positive assessment of health status was despite a large number of the elderly reporting to be suffering from at least one disability or chronic ailment. Their analysis threw light on the difference in self-reported health status across sex. Despite the female disadvantage in reported health status and preponderance of older women among immobile elderly, a much greater proportion of men were hospitalised as compared to their female counterparts (87 vs. 67 per 1000). The diseases among the elderly for which there were more hospitalised cases than the rest were heart diseases, cataract and bronchial asthma. Based on these observations made on the health status of India’s elderly they suggested that some definite health intervention was necessary to cater to specific complications in old age.

Alam, M. (2008), in his draft paper "Ageing, Socio-Economic Disparities and Health Outcomes: Some Evidence from Rural India" examined the inter-state variations in the distribution of rural aged, and their socio-economic and health conditions. The specific value
addition provided by this paper is its focus on rural ageing that has so far been paid minimal attention in the recent economic literature on ageing in India. The results of this study indicated that illiteracy, low level of consumption, widowhood, growing age and economic dependency caused deterioration in the socio-economic conditions of older people. The socio-economic conditions of the old may or may not be helpful in bringing them any major health advantage, these conditions were indeed critical in terms of exposure of the aged to serious health risks. This would require sustained corrective measures directed at by improving the rural economy through appropriate investment efforts as well as the creation of elderly care infrastructure.

NSS Report (2006), titled "Morbidity, health care and the condition of the Aged" surveyed about the dependency ratio of old age, their living arrangements and health status of the old age people in India. The survey found that out of the total 66.4 million aged population in the country about 75 percent resided in the rural areas and remaining 25% in urban areas. Results regarding information on living arrangement of the elderly showed that about 57 percent of the aged were living with their spouses and another 32 percent were living without their spouses but with their children, while about 4 to 5 percent were living with other relations and non-relations. Nevertheless, 4 to 5 percent were still living alone. As regarding the economic dependency the results showed that 85 percent of aged was economically dependent either partially or fully. The situation was worse for elderly females than males. About 55 to 63 percent of the aged with sickness felt that they were in a good or fair condition of health. The proportion among the aged without sickness was 77 and 78 percent. Possibly they considered their sickness as a problem of ageing. Among the aged, the men seemed to be feeling that they had a better health condition even with sickness compared to the aged women. As against this, about 13 to 17 percent of the aged who were not even sick considered themselves as having a "poor" state of health.
Chakraborti, R. Dhar (2004), in his study on The Greying of India gave an exhaustive detail on various conceptual and measurement issues relating to population ageing in India. He analysed the demographic and socio-economic characteristics such as size, age-sex composition, spatial distribution, and social and economic conditions of the ageing populations in India in the context of Asia. He identified that two main factors responsible for ageing were fertility and mortality. He also found that the old age dependency was higher in rural areas than in urban areas, there were more females than males among the aged. Moreover, 70 percent of the aged in India depended on others for their day-to-day maintenance, about 54 percent of the aged owned financial assets and housing though many of them did not have any management rights or control over them. The prevalence of chronic diseases among the aged was quite high and it was higher still in urban areas. Problems of the joints and throat were the most common, the prevalence of the disability among the aged was also very high. It was not easy task to develop and implement effective strategies that foster graceful ageing. The authors suggested that despite these difficulties, the civil society and the government must work concertedly to evolve a situation where ageing will really recognized and identified as a ‘triumph of civilisation’.

Gupta, I. and D. Shankar (2002), in their paper "Health of the Elderly in India: A Multivariate Analysis" examined the socio-economic status and health of the elderly people in India. A high level of economic dependence of elderly on others, especially for women, was observed in their study. It had also been observed that 75 percent of the elderly men lived with their spouses; only around 39 percent of the elderly women lived with their spouses. The rest lived with their children. It had been concluded that elderly, those living with spouses had a better chance of warding off disability than those living without their spouses. This result was extremely important, indicating that living arrangements may have a direct as well as indirect impact on
health. The prevalence of disability will increase with age, and there will be an urgent need to extend assistance to the elderly, especially the older individuals among the elderly.

Siva, R. S. (2002), in his study, "Meeting the needs of the poor and excluded in India", examined the economic problems of elderly and found that as people live longer and into much advanced age (say 75 years and over), they required more intensive and long term care, which in turn may increase financial stress in the family. Inadequate income was a major problem of elderly in India. The most vulnerable were those who did not own productive assets, had little or no savings or income from investments made earlier, had no pension or retirement benefits, and were not taken care by their children; or they lived in families that had low and uncertain incomes and a large number of dependents. There was a need to pay greater attention to the increase the awareness on the ageing issues and its socio-economic effects and to promote the development of policies and programmes for dealing with an ageing society.

Bhat, Anita K. and Raj D., (2001), in their study, "Ageing in India: drifting intergenerational relations, challenges and options", focused on drifting intergenerational relations, and old age security in India. India, like many other developing countries in the world, is presently witnessing rapid ageing of its population. Almost eight out of 10 older people in India live in rural areas. Urbanisation, modernization and globalization had led to changes in economic structure, erosion of societal values and weakening of social institutions such as the joint family. It was found that in this changing economic and social milieu, the younger generation was searching for new identities encompassing economic independence and redefined social roles within, as well as outside, the family. The changing economic structure had reduced the dependence of rural families on land, which had provided strength to bonds between generations. The traditional sense of duty and obligation of the
younger generation towards their older generation was being eroded. The older generation was caught between the decline in traditional values on the one hand and the absence of an adequate social security system, on the other. So there was a need for policy implications for improving the well being of India's Senior Citizens.

National Human Development Report (2001) "Some other Aspects of Well Being" depicts that in India, the proportion of elderly to the total population in rural areas was higher than that in urban areas. In urban areas the proportion of elderly females had been marginally higher than that of males, but the reverse was true in case of rural areas. The proportion of elderly to total population was the highest in Kerala. It was also higher in Punjab, Haryana and Himachal Pradesh, which were relatively better off states. One another state with high proportion of elderly was Orissa, which was among the poorest states in the country. The number of widows among the elderly was about three and a half times more than the number of widowers. Thus, the time spent by the elderly women as widow was considerable because differences in the male-female marriage age in these states were much larger. Haryana, Himachal Pardesh, Kerala and Punjab had a high old age dependency ratio as compared to other states of India. This could have serious implications for the well-being of the elderly. It was relatively lower in the North-Eastern region. There was a need for the careful implementation of some other policies, like National Policy for Older Persons in 1999.

Visaria, P., (2001), in his paper on, "Demographics of Ageing in India" studied about the problems and needs of the aged in India. He identified their demographic and economic characteristics. He found that only 4 to 5 percent of the aged lived alone, about 46-47 percent lived with spouse and other relatives and among others 33 to 35 percent lived with their children. About 5 percent of the aged lived with "other relations or non-relations". Further, it was also concluded that about 76 percent of the aged, who were economically dependent
on others, received support from their children or grandchildren, about 14 to 15 percent depended on their spouses; only 6 to 7 percent reported that they depended on others. It was observed that about 52 percent of the rural age and 54 percent of the urban aged reported that they suffered from a chronic disease. The most frequently reported ailments were problems of joints, cough, and high or low blood pressure. These chronic ailments would raise the needs of the aged for medical or health-related expenditure. The extent of which they are able to meet their needs has to be examined carefully. The society required to evolve mechanisms to facilitate responsive policies to ensure that these aged do not suffer unnecessary hardships.

CSO (2000), in its study revealed that there appeared to be a significant difference in the health situation of the elderly living in rural areas in comparison to those living in urban areas of India. The elderly people living in rural areas appeared to be much healthier as compared to those residing in urban areas. The prevalence of chronic disease among females was higher than that among males in the case of urban areas while reverse is the case in rural areas.

Vasantha Devi and Premakumar (2000) in their investigation had brought to light that elderly members were confronted with various nutritional, physiological and other general problems in India. The rural elderly were mostly illiterate with low income. They suffered from more nutritional, physiological and other problems. The men were more literate, economically independent and faced less physiological and nutritional problems as compared to their female counterparts. When the literacy level, income level and employment status improved, they seemed to be more comfortable with their health conditions and living status.

Yadav, V.S. (2000) conducted a study to find out different correlates of depression among the aged and found that those who held high depression level were found to be involved more in religious activities in India. He further concluded that decreased level of
participation in social activities disturbed family background; less family association and functional solidarity increase the level of depression. This results in serious socio-psychological problem to the elderly especially in a country like India where the family solidarity and family relations are valued to a great extent.

Yadava K.N., S.S. Yadava, D.K. Vajpeyi, (1997), in their study, “A study of aged population and associated health risks in rural India” examined the prevalence of age-related diseases in different socioeconomic and demographic groups. The study was based on a sample of 267 aged persons (> 60 years) collected through a survey conducted in the rural areas of the Varanasi district of Uttar Pradesh, a northern province of India. Various socio-behavioral factors were found to play a significant role in determining the health conditions of aged people. Overall, 37 percent of men and 70 percent of women rated their health condition as “bad”. The incidence of illness after age 60 years was 77 percent among women and 61 percent among men. Most common were chest problems such as asthma, tuberculosis, and bronchitis. The percentage of unhealthy persons was slightly lower among illiterates and those with a university education than men and women with primary or middle school educational levels. These educational differences were presumed to reflect class-based occupational histories. In general, those with middle levels of education were employed in household industry or businesses with high exposure to disease. Men and women with unsatisfactory, conflictual family relationships also experienced increased health problems. Although respondents expressed the view that the shift from joint to nuclear family systems had lowered the status of the elderly, 62 percent maintained they did not need any further support from their families. A demand for some type of old age pension from the government was proposed, however. These findings suggested a need for increased social responsibility for the health and well-being of India’s aging population.
Pathak (1982) in his study based on hospital data found that 62.6 percent of the elderly patients in India had Cardiovascular ailments, 42.4 percent had gastrointestinal problems, 32.5 percent had uro-genital problems, 19.8 percent had nervous breakdowns, 19.2 percent had respiratory problems, 11.6 percent had lymphatic problems, 7 percent had high or low blood pressure, 11.2 percent had ear and eye problems, 4.8 percent had orthopedic problems, 5.7 percent had surgical problems while 37.3 percent of the elderly had problems with all their system.

Rao (1979) in his study, “Old Age can Be Happy”, observed that because of better health facilities people live longer in India and its typical socio-economic conditions like poverty, breaking up of joint family system and care of the aged persons posed a threat on them. While the increasing numbers of the elderly is attributed to demographic transition, their deteriorating condition is considered a result of the fast eroding traditional family system in the wake of rapid modernisation and urbanization.

Soodan, K. S. (1975), in his study, ”The role and status of the aged in the Family”, examined the status of old people in their families. He found that about half the aged of India were wholly dependent upon others. One third of the Aged were still the chief bread winners of their families. A majority of the aged enjoyed no income of their own. An analysis of the assets and liabilities of the aged showed that about a fourth of the aged had yet to meet their major responsibilities connected with the education and marriage of their children. The status of aged should be improved by government by implementing suitable policies and programmes.

D'Souza, V. (1971), in his study ”Changes in social structure and changing roles of older people in India” examined the social problems of older people in India, and concluded that the problems of older people in India had arisen because the structure of the Indian society was changing fundamentally. As a result of this, positions in
the family and roles available to the older people had also undergone a change. He found that wherever the older persons were still in leadership positions, it was mainly because of their larger wealth and higher degree of education rather than their old age. There was a severe need to improve their roles in society.

**State level studies**

Balamurugan, J., G. Ramathirtham (2012), in their study examined health status of elderly people and their perceived health needs in three rural communes of Poducherry. This study was descriptive in nature. An attempt was made to describe the situation and major health problems faced by the elderly from 213 elderly population of aged 60 and above in three rural communes of Poducherry. Findings revealed that majority of the elderly, both male and female were unhealthy as the most common health problems they faced include eye sight, hearing, joint pains, nervous disorder, weakness, heart complaints, asthma, tuberculosis, skin diseases, urinary problems and others. More health problems were reported by women compared to men.

Wason and Jain (2011), in their study, ‘Malnutrition and Risk of Malnutrition Among Elderly’, of 962 elderly persons aged 60 and above in Jodhpur city, it was found that nearly 50 percent of the subjects were at risk of malnutrition in low income group which was higher than the high income (29.5 percent) and middle income groups (33.3 percent). It was observed that risk of malnutrition was more among females than among males. It was also observed that respondent’s age and income significantly affect the Mini-Nutritional assessment scores of the aged population.

Khan and Raikwar (2010), in an empirical study of 320 people over 60 years of age in Delhi, selected through multi-stage stratified random sampling, suggest that 89 percent of the respondents expected that their family members should take care of them but only 37 percent are actually taken care of their family members. Ninety-two
percent of the elderly felt that they should be included in important household matters but only 26 percent of them were actually involved in family affairs.

Balagopal (2009), to examined morbidity among 206 sampled elderly in an urban slum in Chennai showed that 40.5 percent of ailments of the elderly were not medically treated and the two most important reasons for not seeking care were financial problems and the perception that the ailment was not serious. He concluded that social policy of developing countries like India underplays the healthcare requirements of the elderly, especially elderly women.

Mehrotra, N. and Batish (2009), conducted a study in Ludhiana City to explore the problems faced by elderly females and to seek suggestions by them to overcome these. A random sample of forty elderly women above the age of sixty years was carved out from BRS Nagar and Civil Lines area of Ludhiana City. The data was collected through personal interview. Major physical problems faced by elderly females were reduced vision (81.25%), dental decay (77.50%), body weakness and pain (68.75%) whereas major economic problems were high medical expenditure, lack of freedom in spending, low personal income etc. Amongst socio-psychological problems, stress and strain was the prominent problem followed by declining authority, loneliness, feeling of neglect and so on. It had been concluded that there was urgent need for efforts on the part of the government to ensure guaranteed income, health care, social services, recreation and other requirements of the aged which will go a long way to reduce the problems of elderly. The most needed task was inculcation of cultural values amongst young generations, so that they understand problems of elderly and feel the responsibility for their proper care.

Kumari S. and T.V. Sekher (2009), in their study on "Health status and Living arrangements of Elderly in Punjab: An Analysis of NSSO Data" examined with the help of NSSO Data (52nd and 60th round) about the Living arrangements of aged, their economic
dependency and their health problems. The findings of their study highlighted that overwhelming majority of elderly were living with spouse and children. Only about 3 percent of elderly were living alone. Regarding economic dependency, the study found that about 55 percent of elderly had to depend on others for their day-to-day maintenance. The situation was worse for the elderly females (80 percent). Major health problems reported by elderly include Blood Pressure, Diabetes, and Heart problems. Among the aged, not much differences has been found between male and female. The government should apply some corrective policy measures to improve the condition of the elderly in Punjab.

Bhatia, Swami, Thakur and V. Bhatia, (2007), in their paper on, “A study of health problems and loneliness among the elderly in Chandigarh”, examined the health related problems and loneliness among the elderly in different micro-environment groups. Urban and rural areas of Chandigarh were taken under study. During the study, it was found that out of the total 361 aged persons of Chandigarh, 311 (86%) persons reported one or more health related complaints, with an average of two illnesses. The illness was higher among the females (59.5%) as compared to males (40.5%). The main health-related problems were disorders of the circulatory system (51.2%), musculoskeletal system and connective tissue (45-7%). It was also found that loneliness was prevalent more in females (72.8%) as compared to males (65.6%). Loneliness was more prevalent among persons who lived alone (92.2%) as compared to those who lived with their spouse (58.9%) or when husband and wife lived with the family (61.4%). It was higher among the widows (85.2%) and widowers (75.8%) who lived with the family as compared to the aged who lived with the spouse (58.9%) and the aged husband and wife who lived with the family (61.4%). Special services should be started in the hospitals as the majority of the aged have one or more health-related problems. The aged persons should be involved in social activities to avoid loneliness among them.
N., Suresh K. (2002), in his article, "The old age problems and care of senior citizens", focused on the knowledge of caregivers about old age problems and care of senior citizen at home in Thalavoor Panchayat of Kollam District of Kerala. A sample of forty caregivers of elderly was selected by multistage random sampling technique from 390 care givers of four wards. It was found that 57.5% of care givers were daughters and daughters-in-law, 87.5% other members of the family were taking care of the elderly with the identified care givers. 52.5% of elderly were living in joint family. Only 20% of senior citizens did not suffer from any disease, 22.5% each were suffering from hypertension and arthritis, 7.5% each were suffering from the asthma and diabetes mellitus, 5% each were suffering from other diseases. Analysis revealed that only 20% of caregivers had adequate knowledge regarding old age problems and care of elderly. So there was need to develop more health education programmes in the community as well as mass media for the family caregivers of the elderly to make the care more effective.

Singh, K.P. (2001), in his paper, "Ageing Trends in an Agrarian State: A case study of Punjab", examined the ageing trends in the state of Punjab. The paper was based on the data drawn from secondary sources. The findings of the study indicated that the proportion of population 60 and over was increasing rapidly in the state due to decline in fertility and mortality and increase in life span. This rapid increase in population 60 and above will pose serious problems especially in rural areas due to migration of young adults, more daughter-in-laws working outside the home, shrinking family size and higher cost of living. In rural areas people were self employed, hence had no social security. Therefore, the elderly population in the state required immediate attention of the government as well as of voluntary organisations.

Sarasa, R. S. (2001), in her study, “Socio-Economic Conditions, Morbidity Pattern and Social Support among the Elderly Women in a
Rural Area” examined the social, economic and health problems among elderly women, their morbidity pattern and their support system for Kerala. A sample of 100 elderly women had been taken from Sreekaryam Panchayat in Thiruvananthapuram district of Kerala. Wards of this Panchayat were divided into two urban and rural, based on the nearness to the city Corporation. Majority of woman in this study were illiterate and perhaps this might have been one of the reasons for negligence in their health problems. 26% of the elderly women were in lower socio-economic group, 70.5% in middle socio-economic group and only 4% were in upper socio-economic group. 60% of the aged women in this study were widows. Lack of accessibility to transport was one of the reasons for the elderly women in rural set up not utilizing health care services. The major chronic diseases among the elderly women were arthritis, hypertension and diabetes. Daily activities were performed by 80% of the woman by themselves. More than 70% of the elderly women enjoyed social relations, social interactions, physical support, financial support and social support mainly from their family members (spouse, children, or in-laws). Government assistance was enjoyed by very few elderly women in the study group. The increased life expectancy of elderly women in rural area does not mean that their life is free from morbidity or disability and it is not a healthy life expectancy. Elderly women should be given legal security against abuse and harassment. A national security programme should be designed in such a way that elderly people who are disabled, frail and destitute become eligible to governmental support. Policy makers should evaluate successful programmes for the elderly of other countries and adopt them to suit local conditions and economic viability. Strategies should also be developed to create general awareness on the specific problems of the elderly women.

Kaushal A. (1996) in her research on Familial Relations and Problems of the Aged in Urban Punjab, concluded that although sons, daughter-in-law and grand-children had no time to sit with the
elderly, but during illness they tended them due to apprehension of social criticism. A large number of the aged vented out their anger and frustration by talking with their spouses, daughters and by involving themselves in religious activities. They had cordial relationship with their spouses and daughters, but not with the sons and daughter-in-laws. Most of the aged were dissatisfied with the frequency of their visits of their children. They felt lonely and thought that their children were careless about them. Despite all difficulties in adjusting to their adult children, they all wanted to live in the family and not in institutions like old age homes. Widowers were willing to consider the option of shifting to an old age home; because life became miserable at home after death of their spouse. But the widows preferred to live in the family.

Upadhyay, R.K. (1992), in “A study of the Problems of the Aged and Need for Social intervention in the States of Haryana and Himachal Pradesh” found that aged suffer from many problems like lack of proper housing, proper care and attention in families. While examining their status, the study found that majority of the aged were not optimistic about any change in their present situation and they did not think that family members, neighbours or aged themselves could do anything in this regard. The study found that main problems of the aged have been economic hardships and physical sufferings because of loss of occupation and physical vitality and over and above the rural folk are deprived of basic minimum amenities.

Mishra, S. (1976), in her study of "Social Adjustment among Retired Government Employees of Chandigarh" has found that old age had started emerging as a social problem in Indian society due to the socio-cultural changes brought about by the industrial revolution. According to her the main contributing factors for the emergence of the social problem of old age were the changing social structure, especially the family structure; individualistic values, negative attitudes of the younger generation towards the aged and the compulsory retirement
from the economic activity. Since present urban Indian families needed supportive services to look after their aged members, they should be provided various types of help and the burden of looking after the aged people should be shared by the society.

Singh, J. (1962), in his study "Problems of the Old People in Burail" examined the problems of old people of a village near Chandigarh. He found that the aged head of the families hold a greater authority and influence, but once he lost his status of being the head, the effect was just the reverse. He also found that one of the most serious problems of the later years was loneliness, isolation and frustration. He suggested that more care should be given to the old people by their family members.

The review of the earlier studies reveals that many scholars view the elderly as passive receivers of care. Further, the problems of the vulnerable elderly like widowed females, disabled, fragile older persons and those from the unorganised sector are inadequately covered. The wide variation in levels of development and socioeconomic status of people living in different geographical regions make national level studies on elderly essential. Analysis of both secondary and primary data needs to be attempted, wherever necessary, which in turn will help to focus on ageing issues. From review of literature, it has been observed that majority of the studies relating to elderly have been done at the international level and only a few scattered efforts have been made at the national level at the state level. For the state of Punjab, the studies relating to elderly have been very scanty. Whatever efforts have been made, remained confined only to either economic or social or health problems. These problems relating to elderly in Punjab have not been studied collectively. Thus, it is felt that there is need for such type of study. The present study will be comprehensive in nature as it will consider all the problems (economic, social and health) of elderly for the state of Punjab.