Article

Aging Population in Bangladesh
A new and important group in terms of social and health policy of a country

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Abstract

The ratio of aged population in Bangladesh is much higher than any other developing nations around the world. It is projected that by the year 2025, the country alongside other countries in the south Asian zone will record an approximate half of the total aged population in the world. Though it is anticipated that due to religious and cultural tradition in Bangladesh, generally the old people are being taken care of by their families, but factors such as transition of socio-economic and demographic trend, changing social core values resulted from foreign cultural invasion, poverty and other numerous structural features, have destroyed the traditional system of care and have set various challenges and concerns related with their livelihood and status, social help, and wellbeing. This changing situation influence the policy evaluators to consider the issue of aging dynamics an affirmative way so that they can and vow appropriate strategies and to incorporate this issue in the mainstream development activities with the intention that Bangladesh can pick up a sustainable future. In this regard, the government of Bangladesh along with different non-governmental organization have already taken different policy initiatives to set forward the issue of aging welfare related awareness and activities; however, all of these are not functioning correctly. As such, all the inclusive understandings among the rule makers indicate the importance of the issue of aging population which put emphasis that social beliefs and traditional customs should be revived to benefit this specific group.

Key Word: Population, Aging, Social Health and Welfare, Government Policies, Bangladesh

INTRODUCTION

The average life expectancy in Bangladesh has increased to 72 years in 2017 (BDNews, 2018) from 68.86 years in 2007 (Countryeconomy.com, 2007). According the survey of Sample Vital Registration System (SVRS), with a yearly growth rate 1.34 percent, the country's population as of January 1, 2018 stood at 16, 36, 50, 000. The survey revealed that the life expectancy among the females (73.5 years) is higher than their male counterparts at 70.6 years which indicates the higher survival rates among females. In 2016, female life expectancy was 72.9 years while 70.3 years for male (NEWAGE, 2018).Life expectancy is considered as the average number of extra years that an

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individual, of a given age, can hope to live (Santrock, 2002). There is no doubt that unprecedented medical science advancement, improved nourishment and better standard of public health caused the decline of death rate which contributes to living longer, resulting in the diametrical increase of the world's population (H. Khan & G. Leeson, 2006; Mann, 2004). For human beings, the oldest age recorded is 122 years which is also defined as the "maximum life span;" she was Jeanne Calment who was born in 1875 and died in 1997 (Santrock, 2002). The US Census Bureau revealed that in 2000, the range of the elderly people aging over 65 years belonged to the 13 to 18 percent among which the highest ratio belonged to Italy (18.1 percent). Accordingly, it is estimated that the world's elderly people (65 and above) will increase up to 50 percent by the year 2030 (Mann, 2004).

Definition of Old

One definition of old age is simply chronological. Chronological terms and variation in cultural practice alternatives, but still the term "Aging" or "Old age," refer to physical appearances, key life occasions (e.g. retirement or disengagement of work), or social roles (like grandparenthood, or traditional obligations). However, generally, old age incorporates more than three decades. Most societies differentiate between "old old" and "young old" and this is more meaningful to think as far as a steady change, as opposed to a sharp cut-off among adulthood and later life. Beside the controversy, demographic aging, characterized as an expansion in the level of a populace aged 65 years of age or over, is presently a set up pattern in most world regions (Lloyd-Sherlock, 2000). The term "demographic aging" also often refers to "the overall situation and activities in older ages, primarily arising as a result of sustained fertility decline and longer life expectancy" (Khan & Leeson, 2006). Some researchers examine aging in terms of quality of life such as mental comfort, cheerfulness, self-esteem and life satisfaction, physical fitness and its functioning, social expectations and unique of perceptions of an individual, among others, contribute for a healthy and satisfactory aging in the later part of an elderly individual. Accordingly, social gerontologists emphasize on factors like social and individual capitals, self-mastery on life, autonomy and independence (Andrews & Herzog, 1986; Ann Bowling, 2004; Larsen, Diener, & Emmons, 1985; O'boyle, 1997a).

World Population Aging

Compared to developed nations, the growth rate of aging population in less developed countries is faster since 1980 (Glass & Balfour, 2003; S. Islam, Rahman, Al Mahmood, Al Mamun, & Khondoker, 2019; Khan & Leeson, 2006; Prakash, 1999). Particularly, the ratio of population increase is three times higher in Asian and Latin American countries than other parts of the world during the year between 1990 to 2025, achieving 855 million (Lloyd-Sherlock, 2000). Accordingly, studies demonstrate that by the year 2050 almost 1.2 billion of the estimated 1.5 billion elderly populations, 65 years or more, will live in less developed countries (Khan & Leeson, 2006).

Population aging as a subject matter has been under-explored especially in poorer nations where the focus has been on limiting causes of death for children such as diarrhoea and communicable diseases. These incidences do not only challenge welfare programs like health services along with the social security activities, but also an absence of strategical activities at the universal level exist. The 1994 International Conference on Population and Development (ICPD) could be an example of these where 15 key propositions for future approach, yet none of these related with aged population (Islam et al., 2019; Lloyd-Sherlock, 2000).

Population Aging and Bangladesh

In Bangladesh, the population growth of aged 60 years and above, is faster than other developing and least developed countries (Islam et al., 2019). One particular reason is demographic transition from high fertility and mortality to low fertility and moderate mortality, has resulted in improved socioeconomic conditions and public health programs, contributing to larger elderly aging population. Though the estimated population aging is generally the consequence of decreases in birth rates, this is not principally because of an increase life expectancy rather there remain some other factors like reduced national GDP and asset values resulted in lower number of workers and consumers. Also, saving proportions and cash values also contribute to lower rate of fertility over the last three decades. The UN envisages that the TFR (Total Fertility Rate) will fall underneath by the year 2030, and its medium projection for 2050 is 1.85; this sensational alteration in fertility would have real repercussions on the Bangladesh population age structure. According to the Bangladesh Bureau of Statistics, about 12.5 million, which is 7.5 percent of the country's total population constitutes the elderly people (IPS, 2019) and it is estimated that in 2050, there will be 40.5 million aged people in Bangladesh, which is approximately 17% of the entire population (Khan & Leeson, 2006). Among the 20 developing countries (low middle income country, LMIC) Bangladesh has the leading number of aged population. By the year of 2025, it is projected that Bangladesh, alongside other countries in south Asian zone will record an approximate half of the total aged population in the world (Chaklader, Haque, & Kabir, 2003; Kabir, 1994). The progress of the elderly population continue to rapidly increase (Kabir, 1992) because it is anticipated that due to religious and cultural tradition, in Bangladesh, generally the old people are being

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taken care of by their families, but factors like transition of socio-economic and demographic trend, changing social core values resulted in foreign cultural invasion, poverty, and other numerous structural features have destroyed the traditional system of care (Islam & Nath, 2012) and has set various challenges and concerns related to their livelihood and status, social help, and wellbeing (Islam et al., 2019; Khan, 2006). As a result, the pace of increasing aged people is quicker in developing countries like Bangladesh compared to advanced countries (Glass & Balfour, 2003; Khan & Leeson, 2006; Prakash, 1999).

Even though there is still argument about whether expanded life span implies an augmentation of solid dynamic lives or an expansion of morbidity, regarding this research work in UK and USA proposed that the earlier one is happening. In any case, this finding is not all inclusive and the information for developing nations are especially uncertain. In this regard, one survey from Mexico revealed that the population of aging was related to lengthy periods of morbidity, and that diagnoses were being made before, which further expanded the general time of treatment (Fnnzs, 1980; Lloyd-Sherlock, 2000; Manton, Corder, & Stallard, 1997; Sidell, 1995). However, in Bangladesh, life expectancy is considered as the responsible factor of increasing elderly population and it is expected that by the year 2050, the ratio of elderly population will be one in five, which is also conditional on the achievement of replacement of fertility in Bangladesh. As a result, there is a chance of being affected by several obstacles and encounters in dealing with a growing aged population, which incorporates not restricted to destitution, family structure, social and cultural norms and principles, lacking human services facilities for the elderly people (R. Kabir, Khan, Kabir, & Rahman, 2013). Alongside, relatively increased number of aged people is responsible for higher healthcare costs. Not only this, the higher percentage of older population also responsible for rising per-capita expenditure compared to the middle aged group in any region in the world. One reason for this is the diverse pattern of variation for age-specific health service which costs among the health service sector that may reflect the varying wellbeing administration needs of the age groups. For example, the sustained uneven expense increments among the elderly people for services like intense inpatient care may reproduce an expanded need among those age groups for emergency clinical treatment, while acute outpatient facilities may not exhibit as steady a connection between requirement for consideration and patient age (Bowling et al., 2001; Seshamani & Gray, 2002).

The characteristics of the social structure in Bangladesh is that the family as a social unit assumes to perform the duties to care about the older and younger people (Chan, 1997; Khan & Leeson, 2006). Here in Bangladesh, traditionally elderly people often live with the oldest son and in this regard, it is important to remember that the extensive care for the elderly persons turn out to be a concerning issue, as it involves the scope of supporting mechanism incorporating nursing and help in home, different types of communal care and day care, private consideration, and long-stay medical clinics (Barikdar, Ahmed, & Lasker, 2016).

In this regard, one particular cause for the vulnerability of the older people is that, in a patriarchal social structure where the family is regarded as the sole foundation of help for the elderly people along with the eldest sons are considered as the prime source of protection and financial support for the parents in their old age indicates that this specific supportive strategies for the aging people in Bangladesh is not a good position at all and the situation become worse during the economic distress and migration, particularly, when the responsible sons migrate due to seek better life and when the overall social change take places (Amin, 1998), that ultimately causes the old people to be deserted in country territories that are often lonely and uncared for (Cain, 1991; Kabir & Salam, 1991; Khan & Leeson, 2006).

As a result, the people of Bangladesh will face demographic challenge in population aging in the absence of existing traditional family support (Kabir et al., 2013). The proportion of the dependency will demonstrate an expansion from 8.7 in 1990 to 16.2 in 2025; therefore, the burden will increment for young active members and the government (Khan & Leeson, 2006). The existing medical care services are confronting difficulties because of the quick increase of the elderly population as contrasted with other age gatherings. Because of aging, the reduction of cerebral capacity will, in the end, be the reason of missive burden on the families not only in the social and economic perspectives, but also communal perspectives. One research by Kabir et al. (2013) portrayed that the combination of longevity and decreasing fertility create change in the age structure from young to old. This grouping is causing consequences on the household health-care and unmet need of the health care facilities in community region.

The above evidence demonstrates that there will be less individuals to support aging people in upcoming years and also increase the cost of burden for extended period of care. As a result, the people of Bangladesh will face demographic challenge in population aging due to absence of existence of traditional family support. On the basis of the above mentioned reason, the motivation behind the paper is to identify incipient issues and difficulties of the older people and build up an information based wellbeing situation and social circumstance of old individuals in Bangladesh and to address suitable policy approaches for the old human services in the future.

ISSN 2651-6837

Methodology

To examine this question, the authors reviewed information (a systematic review) retrieved from records accessible mainly in scientific electronic databases (PubMed, Scopus and Web of Science, ProQuest and Jstore). Google and Google Scholar were also used to look through keywords, e.g. "aging", "social health", and "Bangladesh'. Ongoing and unpublished research works, as well as reports from three leading Bangladesh daily online newspapers (BD News 24, IPS and New Age) were analysed. Overall 121 documents were gathered from the databanks of nation-wide and global peer reviewed journals and websites from 1985-2019 addressing the aging related topics and the search was restricted only to the documents, which were in English. From those documents, 53 were selected for full review for this manuscript, and 74 documents were skim read and screened out. Online sources of social and public health and aging related journals were investigated for relevant publications. Quantitative and qualitative studies reporting on demographic transition and life expectancy were incorporated in this review.

Critical examination was done in terms of current aging circumstance in Bangladesh by giving quality wellbeing, and the policies of different nations were additionally inspected. Relevant conference presentations regarding aging and socio-economic health in Bangladesh, together with discoveries of verifiable perceptions and a cross-sectional investigation of elderly population in Bangladesh, were incorporated. The survey endeavoured to add to the current writing as new discoveries and furthermore fundamentally assessed existing discoveries.

Policy Programs on 'Ageing' in Bangladesh: Public Health and Policy Perspectives

At present aging is perceived as a concerning issue globally due to its direct linkage with health care and different dimensions of social policy (Lloyd-Sherlock, 2000). Policy evaluators consider the issue of aging dynamics as an affirmative way so that they can and vow appropriate strategies and to incorporate this issue in the mainstream development activities with the intention that Bangladesh can pick up a sustainable future (Khan, 2009).

By looking at the general aging patterns in a country, it is imperative to recognize which bunches are benefiting most from the procedure. In this regard, except the developed countries, one of the striking feature is whether aging of the population predominantly influences benefits particularly the privileged sections or whether it is happening crosswise over society all in all, including also the underprivileged people. A significant number of the developing nations mostly influenced by aging comprises large middle classes. Hence, the test of meeting of the welfare and other wellbeing requirements of the older people would be less serious for the country, since these gatherings are bound to have monetary resources and other autonomous methods for help. Undoubtedly, for this situation, fair approaches should try to focus on those segments, who are right now less inclined to achieve seniority as opposed to older individuals themselves. The very few research data demonstrate that even though poorer individuals are less inclined to touch old age, a significant and rising marginal still do as such. May be a few of these have privileges to medical coverage or have made arrangement for later life. To be sure, for a considerable number of them, a protected old age might have come as a surprising gift - something which had not occurred to their parents or grandparents. While they might even now represent a little portion of older individuals in developing nations, they entail the help of explicit arrangement interventions (Lloyd-Sherlock, 2000).

Minkler and Holstein (2003) argued that with improved monetary circumstances, constructive variations in physical and frequently social situations, and upgrades in medicinal services and human services get to, elderly individuals can have a pleasing old age (Bernard, 2000; Fried et al., 2004; Gabriel & Bowling, 2004; Schmidt, 1994). In this regard, quality of the life such as mental wellbeing, pleasure, optimism and life satisfaction, physical health and functioning, social expectations and the individual's unique perceptions, among others, contribute to a healthy and satisfactory aging in the later part of an elderly individual. Accordingly, social gerontologists emphasized social and personal resources, self-mastery over life, sovereignty, and freedom (Andrews & Herzog, 1986; Ann Bowling, 2004; Larsen et al., 1985; O'boyle, 1997b). On the other hand, fears were unequivocally connected to aging and included stresses over losing wellbeing or potentially autonomy. Additionally, poor wellbeing and views were some of the time related with hostile life occasions, for instance deprivations and happenings of these, and worries of aging, sick wellbeing, reliance and future hazards (Gabriel & Bowling, 2004).

Social and Health Policy based on Aging (World Wide)

Information from the Organisation of Economic Cooperation and Development (OECD) divulges that, in the advanced countries, per capita expenses for the older population particularly for the person who are aged 65 years or above have commonly expanded at a similar rate or more rapidly than among those under age 65 (Seshamani & Gray, 2002). Sustainable subsidy for the wellbeing care system for aged in OECD member countries is getting concern due to the number of aged population is growing high. The proportion of aged people have a policy effect on their health care scheme. As a result, senior citizens have more health care services than younger persons and it

ISSN 2651-6837

is estimated that aged people consume about 40% of total health care expenditures (Kalisch, Aman, & Buchele, 1998). Generally, health care services have three scopes: population, benefits, and cost. On that note, some advanced countries have universal health care coverage for all their citizens. On the contrary, developing countries' health care system is characterized by high charges, ineffective use of technology, little or bumpy coverage of financing and package, scarce anticipatory care, and disparity in health results (Chomik & Piggott, 2015).

Table 1. *Policies for aged people*

Country	Health & Social Policies for Aged	GDP Per Capita (US$)
Canada	The Canadian Retirement System, Medicare Policy	45,032.1
USA	Health Care Policy, Social Security Policy	59,531.7
Norway	Health Care Provision	75,504.6
Japan	Long-Term Care Insurance Scheme	38,428.1
Singapore	Employment Policy, Central Provident Fund, Health Care, Housing Scheme	57,714.3
India	National Program of Health Care for the Elderly	1942.1
Bangladesh	National Health Policy, Pension for Retired Government Employee, Social Safety Net Programs	1,516.5

Source: World Bank national accounts data, and OECD National Accounts data files, 2017.

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If we put our eyes on Canada, a well-developed country characterized by public supported medical care system ensures the widespread coverage on the basis of need rather than ability to pay. Moreover, approximate 70% of the total spending on health is sponsored by the government. The average per-capita expenditure on health was US$ 4,363 in 2012. Furthermore, the Canadian government has old age security as a part of retirement scheme which provides a monthly payment ($540 per month) to all people aged 65 years and older (Sheets & Gallagher, 2012). Another developed country from Asia, Japan created a new social protection scheme known as Long-Term-Care Insurance (LTCI) for the aged people in the year 2000, which brings radical changes in social security system of Japan. In this insurance scheme, general public tax contributed 50% and the rest 50% comes from the premium of the registered person. LTCI scheme provided home care (home help services, staying nurse services, visiting cleaning service, and visiting rehabilitation services), respite care (day care services, medical day care services, short-stay services) and institutional care (nursing home, rehabilitation facility, and geriatric ward). As a matter of fact, aged people of Japan are going through a variety of public health and social programs by which the aged may remain healthy and active as long as possible (Matsuda, 2002).

ISSN 2651-6837

Norway, a welfare country, developed their health and social care systems and provide primary and long-term care for aged people. It is to be noted that, Norway is the country, who expends more per capita on caring for its elderly people than any other developed and developing nations through various models of care for the aged based on needs and their social context. Norwegian government committed to their citizens that everyone will have a free reserved flat after retirement as well as the support and care that they might need. As a matter of fact, about ten percent of the annual budget goes towards this care services. Health care provision of aged in Norway is based on some levels of care: home visit of health care workers, home care system, day care system, residential apartments (the aged are allocated in these apartments based on their care needs) and nursing homes (Gupta, 2013).

OECD countries developed a long-term health care system for aged as well as they are concerned about how to finance this system. In the United States, about 97% people over 65 years of age participate in Medicare program. The budget of this particular program is based on payroll taxes of the working population and beneficiary premiums and cost-sharing. Countries such as Czech Republic, Finland, and Sweden, under the social assistance scheme, finance long-term care services through general public expenditure. Usually, the source of spending is divided into a few levels of government. In Australia, for example, 60% of community care costs are funded by the Commonwealth government, 35% by State governments, and five percent by local governments. The service recipient is sometimes charged with out-of-pocket payments (for example, customers in Sweden now pay about nine percent of the actual average cost). This payment, however, is usually linked to income (e.g. Finland), added by the government if the recipient could not pay (e.g. Greece), or the State specifies the services for which the user fees cannot be charged (e.g. Slovak Republic). In addition, there are some countries where general taxation or health insurance schemes fund health services. Moreover, a combination of funding under the National Health Service and social assistance schemes (e.g. Canada, Italy and Switzerland) is used to fund long - term care services (Kalisch et al., 1998).

Social and Health Policy for Aged: A Scenario from Socioeconomic Perspective

It has been shown that socioeconomic status (SES) is linked to healthy aging and improved life expectancy. However, the socioeconomic disadvantage of elder people tends to marginalize them and can eventually lead to ill health. In recent years we observed many changes in our social institutions like in the family and economy which increased the demands for public and government care in older individuals coming from ill health. For this reason, as a remedy for such health inequalities, universal health insurance is being debated. In this circumstances, the older people and their families will need assistance for economic and social care (Donkin, Goldblatt, & Lynch, 2002; Lobo, De la Cámara, & Gracia-García, 2017).

Basically, we observed the need for social care support only in Western countries. But the developing countries are now facing population aging and they must need the social care support. Social care policies are quite distinct across nations and sometimes across the same nation. Moreover, cultural norms have a strong impact on such policies. Due to this, the policy makers are now facing the reality of increasing demand for social care. Therefore, they are also concerned with the distribution of economic resources, as this will have decisive effects on the elderly people's life (Dening & Thomas, 2013; Lobo et al., 2017). Welfare countries are much more concern in terms of providing social protection and care to the older people. In a like manner, developing countries are now incorporating the social protection policies for old age people. But these policies have to face the problem like economic unsustainable condition. If people want to avoid the possibility of poverty among the elderly, people have to be economically solid (Lobo et al., 2017).

In this era of industrialization, improvement in education, income, occupation, and wealth is associated with better health outcomes. It is found out that, individuals with low socioeconomic status, have less information related to health care as well as they are not actively involved with the health promoting activity. Moreover, they experienced physical and environmental hazards on a regular basis (Adler & Stewart, 2010).

Another study showed that, psychological discomfort among the elderly have often been associated with socioeconomic status, which increased both disease risk and death rate of aged people. Additionally, stressful life events and lack of social support may lead to the risk of depression among all age groups (George, 1996).

Indian Perspective

The NPHCE is an articulation of the international and national commitments of the government as envisaged under the UN Convention on the Rights of Persons with Disabilities, National Policy on Older Persons adopted by the Government of India in 1999 and Section 20 of "The Maintenance and social of Parents and Senior Citizens Act, 2007" dealing with provisions for medical care of senior citizens. The Vision of the NPHCE are: (1) to provide accessible, affordable, and high-quality long-term, comprehensive and dedicated care services to an ageing

ISSN 2651-6837

population; (2) to create a new "architecture" for ageing; (3) to build a framework to create an enabling environment for "A society for all Ages;" and (4) to promote the concept of Active and Healthy Ageing.

Package of Services under NPHCE

The programme incorporated promotional, preventive, curative and rehabilitate facilities as an integrated way for the older people. The overall bundle of service and variation depend on facility to facility. The bundle incorporates health campaign, protective services, diagnosis and supervision of geriatric medical problems (out- and in-patient), day care facilities, rehabilitative services and home based care depends on needs. Districts are linked to RGCs for providing tertiary level care (Verma & Khanna, 2013).

Bangladesh Policies

In relation to this, by conceptualizing the importance of aging, particularly the health and different socio-economic problems of the older people, the association of medical scientist of Bangladesh established the Bangladesh Association for the Aged and Institute of Geriatric Medicine (BAAIGM) during in 1960. This capital centre based organization only provide some parts of the services towards the retired government officials, mainly who were living in the Dhaka city with the help of different organization (Khan & Leeson, 2006). Accordingly, at present, in Bangladesh constitution, the government of Bangladesh along with different non-governmental organization have already taken different policy initiatives to set forward the issue of aging welfare related awareness and activities but those all are not functioning correctly (Khan, 2009). One concrete example regarding this is the high labour force participation of the older people in Bangladesh compared with many other countries in the world. The average monthly income of the older people is approximately 3204 taka (US$ 47) that clearly depicts the high income inequality among the older people living under the poverty line. This income inequality is a grave concern (Rajan, Perera, & Begum, 2002).

The Bangladesh government has a strong safety net programme through which aging population receive benefits (Old Age Allowance programme formulated in 1998). Non-government agencies are also playing a vital role to ensure welfare related awareness of the aged population and also demonstrating a rising trend over the years (Khan & Leeson, 2006; Khan, 2009), but it is a matter of fact that at present specific social security programs are designed for the retired military, government and industrial workers. This is because, in Bangladesh population aging contribute to the increment of yearly fiscal demands of the government particularly in the sector of income support, health and other social services for the older population (Khan & Leeson, 2006).

Though, there is a tradition in Bangladesh is that the caring for the older people generally depend on their family members, but at present the position and status of elderly individuals have been undermined by a few interrelated factors, for example, the decrease in the quantity of joint or more distant families, change in good and moral qualities brought about by fast urbanization, and complexities of modem life. As a result, with increasing population aging will produce enormous burden on the families, communities, and nations as a whole. In this regard, it is a very difficult for policy makers to think of a strategy that could serve the older people regarding physical care and economical support due to the changing nature of the family system, the older people generally left alone and face not only the economic and health related problem but also the emotional problem on their own (Islam et al., 2019; Khan & Leeson, 2006).

The population scientist of Bangladesh mentioned that policymakers should take effective steps for safeguarding numerous necessary services for the poor, middle-class, and urban rich ageing population by increasing the number of service providing institutions. "The ageing population must be integrated to society by involving them with their old profession," including generating endowment funds by building partnership between different sections of society and sectors of economy, presenting a deduction system from wages at earlier ages as a forced savings for old age allowance, founding community ageing deposit scheme, streamlining the retirement age, and finding way out for resulting crisis in occupational mobility (IPS, 2019).

Bangladesh National Human Rights Commission (NHRC) mentioned that the ageing population, especially women, are a very vulnerable group in Bangladesh and the policymakers must take steps to protect these susceptible people and ensure their rights. Furthermore, it was mentioned that the National Policy on Older Persons are not executed for lack of sincere efforts by the experts concerned, while the Parents' Maintenance Act–2013 are not being imposed due to lack of its rules and regulations and awareness among public (IPS, 2019).

Ministry mentioned that four years back, they have formulated a work plan in light of the National Policy on Older Persons to provide the aged population with several facilities, including health cards, ID cards, reserved seats, and tickets at reduced rates during their travel in trains, buses, health access vouchers, steamers, accommodation,

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saving schemes. However, the ministry could not implement those due to red tape (bureaucratic complications) (IPS, 2019).

Under the situations, Bangladesh's rights activists and population, experts suggest that the government should take appropriate policies and programmes to provide to the specific needs, including finical, health, civic amenities of the growing number of the ageing population (IPS, 2019).

Old Age Pension

Just a couple of Asian nations, for example, Japan and Singapore have an old age pension scheme (Khan & Leeson, 2006). The old age pension scheme, to some extent ensure the money flow of the elderly people, which acts as an instrument that enable the elderly people to do whatever they like and also make them self-dependent to participate in society and enjoy themselves rather make them dependent on others (Gabriel & Bowling, 2004).

The Bangladesh government has very recently took the old age pension scheme in to the consideration as a welfare policy, but the government also has to pay attention in the relevant issues like illiteracy, unemployment, and poverty to the huge population. So it is very important for the non-governmental organization to come forward and play role for complementing and supplementing the government facilities. In this connection, it is very important and also challenging for the policy makers to fund and implement the old age pension scheme and how they will disburse the resources for health care services of the older people (Khan & Leeson, 2006) the reason of which is, the rapid expansion of old patients among the elderly people create new difficulties in the therapeutic framework because the older people require increasingly medical services with respect to their more youthful partners (Etzioni, Liu, Maggard, & Ko, 2003; Gerdtham, Lundin, & Sáez-Martí, 2005).

Conclusion

In one article published by Jahangirnagar University, the authors identified 12 types of vulnerabilities and these are: economic crisis, lack of social dignity, accommodation problem, falling health, illness, mobility problem, physical assault, recreation problem, emotional vulnerability, far from relatives, and food crisis and family burden, which are faced by the aging population of Bangladesh. Furthermore the authors mentioned that the aging population needs economic support including clothing, food, medical care and housing along with cultural support (IPS, 2019).

With the increasing number of aged people in Bangladesh, a range of care system under health and social policy must be developed. In Bangladesh, there is a small range of health and social policies for the aging population. At this moment, there is old age allowance only for poor aged, as well as pension and other financial policies only for the retired government employees. However, the Bangladesh government has a social safety net programs by which a small range of aged people get some benefits. However, like other advanced and welfare countries, Bangladesh has yet to manage and create a universal health coverage for the aged. Similarly, there are no health insurance and long-term care policies by which aged people could get their health care support. As the country's per capita income is very low contrary to advanced countries, it is not possible to maintain universal health coverage for the aging population. Nevertheless, a universal arrangement amongst rule makers indicates the importance of the issue of aging population in the national developmental agenda (Khan, 2009). Thus, Bangladesh need to rise per capita income and the government should spend more in health and social policies so that in the future, the aging population can receive free healthcare facility from the government. Donations from the rich and elite people from the country, as well as from rich countries can be explored. Donations from Islamic religious community (also known as zakat/fitra) can also be explored. Non-government agencies can play a pivotal role here as well. Above all, Bangladesh should bring back the social beliefs and traditional customs to benefit this specific group.

Authors' contributions

SM designed and conducted the literature review and contributed to the manuscript structure, designing the methodology as well as drafting and overall editing of the manuscript. TS, AT, CB, and JD also contributed in literature review and reviewing and editing of the manuscript. All authors read and approved the final manuscript.

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ISSN 2651-6837

Appendix: *Summary of the studies included in the review*

Study	Country	Study Purpose	Correlates/Factors	Study Findings
Amin, 1998	Bangladesh	The purpose of this study was to investigate whether rising landlessness leads to increasing fragmentation and nucleation of families in rural Bangladesh.	Increasing survival of sons to adulthood, old age dependency, changing fertility, household type, income, lifecycle stage, early and universal marriage, living standard	81% of the elderly in Village A and 91% in Village B live with or adjacent to married or unmarried sons, compared with 91 per cent in Char Gopalpur. Nuclear households are the dominant type in the study villages and in Char Gopalpur: 66 per cent in Village A, 62 per cent in Village B, and 56 per cent in Char Gopalpur. The average age of joint household heads is 50 years, compared with the much lower average age of the heads of nuclear households (40 years) and of extended households (41 years).
Andrews and Herzog, 1986	USA and Canada	To examine the quality of survey measures varies with the age of the respondent.	Age, gender, education, race, life quality (housing, standard of living, family life, health, etc.), attitudes about economic matters (changes in business conditions, personal finances), behavioral reports (drinking beer, overeating, watching television), and ratings of the respondent's employer and work group (interest in workers' welfare, improvement of working conditions, quality of decision making, etc.)	As respondent age increases (a) the percentage of true score variance in survey measures tends to decline, (b) the percentage of both random and correlated error variance tends to increase, and (c) people tend to have more interrelated-or less differentiated-views about their world.

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ISSN 2651-6837

Study	Country	Study Purpose	Correlates/Factors	Study Findings
Barikdar et al, 2016	Bangladesh	The purpose of this study was to explore the situation of old age people in Bangladesh.	Social, mental, medical and economic problem	Most of women in rural and slum area do not own land and other property and they are on worse situation in the old age. Traditional family patterns are breaking down which change norms and values such as respect to elderly people in the family and the community. The elderly suffers from multiple health problems. Such as, weakness, tooth problem, hearing problem, vision problem, body ache, back pain, rheumatic pain and stiffness in joint, dementia, prolonged cough, breathing difficulty, asthma, palpitation, high blood pressure and micturition incompetence, which may demand long term psychosocial treatment, nursing care and hospitalization. In this modern life children are living in cities for earning, or for education. Their parents live in separately in the rural setup, and in this busy life children are not able to visit their parents regularly.

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ISSN 2651-6837

Study	Country	Study Purpose	Correlates/Factors	Study Findings
Gupta, 2013	Norway	The aim of this study was to discuss various models *health and social care to the older people at various levels with a focus on Nursing home care in Norway*.	Home visits, home care services, day care services, residential apartments for elderly, nursing homes and community hospitals.	*Norway spends more per capita on caring for its elderly than any other country in developed or developing nations. Health and social care systems in Norway have been able to provide range of prevention, primary care, management of chronic diseases, geriatric care, and more formal long-term care to the elderly people*

ISSN 2651-6837

Study	Country	Study Purpose	Correlates/Factors	Study Findings
Islam and Nath, 2012	Bangladesh	The study shows a future gloomy picture of the elderly support facility in terms of both economic and caring aspects.	Proportion of aged person, proportion of children, aging index, median age, young dependency ratio, old-age dependency ratio, total dependency ratio, potential support ratio, familial support ratio, elderly support ratio by adult male or female and elderly sex ratio.	From the demographic point of view, elderly persons will face the problem of financial and nursing support except for the measures with familial support ratio measures. This familial support for caring about the elderly may not be available due to lack of economic solvency of the society. According to the potential support ratio (PSR), there are approximately 9 persons available in active population to support per elderly people though the actual economic support depends on the employment opportunity of economically active population. Due to the comparatively large number of active population, there is no visible support facility shortage now in term of PSR. The support in old age can be achieved in a variety of ways. The family support, public and private social assistance, mutual benefit, social insurance, personal savings, occupational pensions are some of the programs to be taken for future.

ISSN 2651-6837

Study	Country	Study Purpose	Correlates/Factors	Study Findings
Kabir, 1992	Bangladesh	The purpose of this study was to explore the demographic and socioeconomic aspects of aging in Bangladesh.	Demographic and socioeconomic characteristics of aged people.	Bangladesh as a country with an expected rapid increase in the aged population by 2025 and without any formal program for the welfare of the aged. The aged population is expected to increase from 4.90 million in 1980 to 17.62 million in 2025 (1 out of every 10 persons). Retirement age from the formal sector ranges from 57 to 65 years. In the informal sector the elderly work for as long as health permits. The elderly population aged 60 years and older will show an increase in the old age dependency ratio from 8.7 in 1990 to 16.2 in 2025. For this reason, the burden will increase for young wage earners and the government. Currently social security programs for the aged only apply to retired military, government, and industrial workers.

ISSN 2651-6837

Study	Country	Study Purpose	Correlates/Factors	Study Findings
Kabir et al, 2013	Bangladesh	To assess the situation of elderly population in Bangladesh.	Fertility and mortality data, health services, dependency and social security.	The support index shows that there will be fewer persons to support elderly population in future with implications in traditional family care. The care index shows the cost of burden for long term care associated with the shift in the population age structure.

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ISSN 2651-6837

Study	Country	Study Purpose	Correlates/Factors	Study Findings
Kalisch et al, 1998	OECD countries	To provide a good basis for summarizing the main social policy trends with respect to the broad coverage of social protection arrangements, assistance for families, assistance for unemployed people of working age, retirement incomes, health care, long-term care and housing assistance in OECD countries.	Social and health policies.	Sustainability of funding for the health care system for aged in OECD member countries is getting concern due to the number of aged population is growing high. The proportion of aged people have a policy effect on their health care system. As a result, senior citizens have more health care services than younger persons and it is estimated that, aged people consume about 40 percent of total health care expenditures. Some advanced countries have universal health care coverage for their all citizens. Developing countries health care system is characterized by high out-of-pocket costs, poor use of technology, low and uneven coverage of financing and service, inadequate preventative care, and inequality in health outcomes.

ISSN 2651-6837

Study	Country	Study Purpose	Correlates/Factors	Study Findings
Matsuda, 2002	Japan	The aim of this study was to discuss the health and social system for the aged in Japan.	Long-Term-Care Insurance (LTCI) scheme, preventive activities and health promotion.	Japan implemented a new social insurance scheme for the frail and elderly, Long-Term-Care Insurance (LTCI) on 1 April 2000. In this insurance scheme, budget is based on 50 percent from general tax and other 50 percent from premium of the insured person. Care management services covered by LTCI scheme are home care (home help services, visiting nurse services, visiting bathing service, and visiting rehabilitation services), respite care (day care services, medical day care services, short-stay services) and institutional care (nursing home, rehabilitation facility, and geriatric ward).

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ISSN 2651-6837

Study	Country	Study Purpose	Correlates/Factors	Study Findings
Sheets and Gallagher, 2012	Canada	To sketch the aging in Canada.	Demographics of aging, health and public policy, retirement systems, health care expenditures.	Canada has tremendous pride in its publicly funded health care system that guarantees universal coverage for health care services on the basis of need, rather than ability to pay. About 70 percent of Canadian health care spending is financed by the government. In 2012, the average per capita spending for health care in Canada was US$4,363. Canadian government have old age security as a part of retirement system which provides a monthly payment ($540 per month in 2012) to all citizens aged 65 and older.

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ISSN 2651-6837

Study	Country	Study Purpose	Correlates/Factors	Study Findings
Verma and Khanna, 2013	India	This particular study discussed about the National Program for the Health-Care for the Elderly (NPHCE) in India.	Package of services under NPHCE for elderly.	The National Program for the Health-Care for the Elderly (NPHCE) is a new hope for healthy aging in India. The Government of India adopted he UN Convention on the Rights of Persons with Disabilities, National Policy on Older Persons in 1999. The NPHCE providing accessible, affordable and high-quality long term care services to an ageing population. Moreover, this program is creating a "Society for all Ages" for promoting the concept of active and healthy aging. This program is combined of several health promotions, preventive services, diagnosis and management of geriatric medical problems (out- and in-patient), day care services, rehabilitative services and home based care services for the elderly and providing them in various Government health facilities.

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