LATER LIFE IN INDIA :
AGEING WELL IN PERSPECTIVE

Centre for Research in Wellbeing and Happiness

Policy Report

October, 2025

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ACKNOWLEDGEMENT

It gives me immense pleasure to present the inaugural policy report of the Centre for Research in Wellbeing and Happiness (CRWBH), FLAME University, Pune, India. The CRWBH policy report is the flagship publication of the centre, launched to address population-level challenges and opportunities in the areas allied to wellbeing and happiness.

The first policy report, **"Later Life in India: Ageing Well in Perspective"**, aims to examine the regional (state-level) patterns and progress towards the timely goal of holistically enhancing the ageing experience in India. The report is the outcome of CRWBH's overarching research project, India Wellbeing Insights, aimed at understanding the intricacies related to wellbeing measurement issues in especially in the Indian context. Drawing on a range of secondary data sources, this report seeks to illuminate the health capacity to work and broader dimensions related to ageing well in India. It is both a scientific undertaking and a collective commitment toward ensuring that older people in our country age well with dignity.

The 2025 report, Later Life in India: Ageing Well in Perspective, was prepared by the team and staff members of the Centre for Research in Wellbeing and Happiness, FLAME University, Pune, India. The Board of Advisors, the Academic Advisory Council, and the internal team of CRWBH provided navigation, guidance and background material to cover relevant policy aspects in the report.

This report was authored by the CRWBH team at FLAME University, Pune, India: Sunil Rajpal (lead), Abhishek Kumar (co-lead), Shreya Ronanki, Nehantha Sathesh, Neelima VP, Saroj Kumar, and Mohit Pandey. Komal Ahluwalia and Anirudhan Pedathil from the IEG, Delhi, contributed towards drafting the chapters. Anushka Ramesh and Nikita Suri assisted in the literature review.

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Above all, this report is the outcome of a collective spirit of inquiry, dedication, and collaboration. It reflects the hard work of researchers, the generosity of reviewers, the vision of institutional leaders, and the unwavering commitment of all involved. It is our sincere hope that "**Later Life in India: Ageing Well in Perspective**" will not only contribute to academic and policy discourse but also inspire meaningful action to secure a dignified, inclusive, and resilient future for the elderly in India.

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Abbreviations

AAY	Antyodaya Anna Yojana
AB-PMJAY	Ayushman Bharat – Pradhan Mantri Jan Aarogya Yojana
ADB	Asian Development Bank
ADLs/IADLs	Activities of Daily Living / Instrumental Activities of Daily Living
AI-CAD	Artificial Intelligence–based Computer-Aided Detection
AIIMS	All India Institute of Medical Sciences
ALIMCO	Artificial Limbs Manufacturing Corporation of India
CHC	Community Health Centre
CHCs	Community Health Centres
DALYs	Disability-Adjusted Life Years
DMHP	District Mental Health Programme
EDS	Elevated Depressive Symptoms
GOI	Government of India
IGNOAPS	Indira Gandhi National Old Age Pension Scheme
IIPS	International Institute for Population Sciences
IPSrC	Integrated Programme for Senior Citizens
LASI	Longitudinal Ageing Study in India
LFPR	Labour Force Participation Rate
LIC	Life Insurance Corporation of India
LTC	Long-term care
MPCE	Monthly Per Capita Expenditure
NCOP	National Council for Older Persons
NCSrC	National Council of Senior Citizens
NCD	Non-Communicable Disease
NFHS	National Family Health Survey
NHM	National Health Mission
NP-NCD	National Programme for Prevention and Control of Non-Communicable Diseases

AAY	Antyodaya Anna Yojana
NPHCE	National Programme for Health Care of the Elderly
NSAP	National Social Assistance Programme
NSS	National Sample Survey
NSSO	National Sample Survey Office
OECD	Organisation for Economic Co-operation and Development
NGO	Non-governmental Organization
OPD	Outpatient Department
PHC	Primary Health Centre
PHCs	Primary Health Centres
PIB	Press Information Bureau
PLFS	Periodic Labour Force Survey
PM-JAY	Pradhan Mantri Jan Arogya Yojana
PMVVY	Pradhan Mantri Vaya Vandana Yojana
PwDs	Persons with Disabilities
DWPS	Destitute Widow Pension Scheme (Tamil Nadu)
RGCs	Regional Geriatric Centres
RSBY	Rashtriya Swasthya Bima Yojana
RVY	Rashtriya Vayoshri Yojana
SCWF	Senior Citizens' Welfare Fund
SCHIS	Senior Citizen Health Insurance Scheme
SE	Standard Error
SRS	Sample Registration System
SWB	Subjective wellbeing
TB	Tuberculosis
UHC	Universal Health Coverage
UNWPP	United Nations World Population Prospects
WHO	World Health Organization
WPR	Worker Population Ratio

Executive Summary

Wellbeing of India's Elderly in Focus

- **Population ageing in India is rapid, with headcount numbers set to rise substantially in the upcoming decades.** Rising life expectancy (72 years in 2023) and declining fertility rates (1.9 births per woman in 2025), coupled with improvements in education, women's empowerment, healthcare, and sanitation, have set India on an ageing trajectory. The share of the elderly (aged 60 years or above) in India has grown from 5.4% in 1950 to 9.9% in 2020, and is projected to more than double to 20.6% by 2050. The country is projected to be among the top three countries with the highest number of oldest-old (aged 80 years or above) and centenarians (aged 100 years or above), marking unprecedented survival gains. This transformation presents both opportunities and challenges. With 71% of the elderly living in rural areas with limited infrastructure, timely investments will open doors for a 'silver dividend' rather than risking 'ageing before getting rich.'

- **Health (physical and mental) status and healthcare needs will change as ageing brings more serious system-level challenges in the form of NCDs and functional impairment**. In the context of an incomplete epidemiological transition, the health profile of the Indian elderly reflects a 'double burden' of longstanding infectious diseases coexisting with rapidly rising NCDs. Three-fourths of elderly Indians suffer from at least one NCD, 40% face disabilities, and 24% report limitations in performing activities of daily living (ADLs). Alongside disease, functional and cognitive decline exacerbate vulnerability and highlight the urgency of nursing care. Mental health issues affect one in three elderly, yet remain widely undiagnosed due to social stigma and poor awareness. A healthcare system historically focused on maternal and child health must now direct resources towards geriatric care by strengthening community-based healthcare services and formalizing long-term care.

- **Financial dependency in later life warrants urgent policy attention, especially from a gender perspective.** Advancing age, declining health, and mobility naturally increase dependence on families or households. When families themselves are under economic strain, vulnerability is compounded at a household level. Around 40% of the elderly in 2018 belonged to the bottom two MPCE quintiles, with notable interstate disparities. Better performance of states like Kerala, Delhi, and Punjab as opposed to Odisha, Bihar, and Chhattisgarh reflects the scope of improvement in existing social security systems. With India witnessing an ageing trajectory with more elderly women, the need for promoting financial and social independence is even more pronounced. Women face a unique disadvantage of age, dependency, and gender. This calls for immediate policy focus on gender-sensitive and more inclusive interventions that are targeted towards hard-to-reach populations.

- **Policy efforts in India need to adopt an integrated and lifecycle approach for overcoming ageing-attributed challenges and ensuring elderly wellbeing.** India's share of the elderly population is set to be among the top five countries in the world, making ageing not just a demographic shift but a development priority. This translates to exceptionally large absolute numbers in the context of its population, uniquely positioning the country at the forefront of geriatric policy. Ageing trajectories are shaped by lifelong exposure to risk factors, educational attainment, wealth accumulation, and social capital. This requires a long-term, lifecycle approach with interventions at different stages of life as opposed to programmes operating in silos. Long-term planning that connects health, financial support, social engagement, and wellbeing policies is necessary for ensuring ageing with dignity rather than mere survival.

Health of India's Elderly

- **Increasing longevity needs to be translated into healthy ageing.** Life expectancy in India has significantly improved by about 10 years over the last two decades. Such increments are consistent across sex, place of residence, and even states, including socioeconomically worse-off states like Uttar Pradesh (2018-22: 67.2 years), Bihar (2018-22: 69.0 years), and Jharkhand (2018-22: 69.4 years). However, healthy life expectancy (years lived in good health) lags, with the gap between life expectancy and healthy life expectancy widening from 4.3 to 5.1 years for men and 5.3 to 6.1 years for women between 2000 and 2019. Healthy ageing requires a greater focus on preventive care to delay disease onset and preserve functionality.

- **Female elderly have a higher burden of hypertension and elevated depressive symptoms**. Nearly 40% of women (28.5% of men) were diagnosed with Hypertension, and women across all ages have a higher prevalence of elevated depressive symptoms as opposed to men. These findings imply late diagnosis and treatment accessibility issues, highlighting the caregiving roles of women who often neglect personal health. Further, rising female widowhood heightens loneliness, social isolation, and mental health issues. At the same time, underdiagnosis and underreporting resulting from social stigma around mental health continue to persist.

- **Addressing Mental healthcare by integrating it with primary healthcare points merit attention.** The treatment gap for mental disorders in India remains over 60%, with rural elderly being particularly underserved. Social stigma and poor awareness mask the actual prevalence rates and the true scale of the issue. Behavioural interventions through community-based activities, cognitive–behavioural counselling, and peer-support visits integrated into primary healthcare could transform this hidden burden into a normalized priority for the elderly in need and ensure support for resilient ageing trajectories.

- **Healthy ageing in India requires focus on improving lifestyle habits among younger and older-age cohorts.** Preventive care is as important as curative care. Dietary patterns, physical activity, avoidance of risk factors, and other lifestyle habits have been widely described as important markers of good health. Increasing policy focus on younger as well as older age cohorts is critical. Health campaigns and routine checkups for adults and the elderly; behavioural nudges to curb alcohol and tobacco consumption among younger cohorts; and age-friendly community infrastructure for all age groups, can potentially instil healthy lifestyle habits across the life course.

- **Universal Health Coverage (UHC) needs to diversify the services to include the healthcare requirements of the elderly cohort, especially elderly women.** The AB-PMJAY (*Ayushman Bharat - Pradhan Mantri Jan Aarogya Yojana* by the Government of India (GOI), the Comprehensive Health Insurance Scheme (Tamil Nadu), and the *Mahatma Jyotiba Phule Jan Arogya Yojana* (MJPJAY, Maharashtra) have been notable insurance schemes that have expanded financial protection and improved healthcare utilization uptake. Yet, low private sector participation, awareness, and outreach, infrastructural gaps, and fraud (misuse) remain major gaps. Prioritizing geriatric care to UHC and extending all essential healthcare services (physical and mental) to socioeconomically vulnerable, including elderly women, is crucial in reducing persisting disparities.

Work and Economic Security of Older Persons

- **Female participation rates are much lower compared to males.** Working status shows wide gender gaps, with 44% of elderly men but only 19% of elderly women working. These inequalities persist throughout the life course, with women's employment rates systematically remaining below men's. Limited access to formal jobs, social constraints, and lack of financial independence are reflected through these gaps.

- **The elderly in most parts of India want to work and contribute, reflecting a sizeable untapped resource.** Almost half of elderly men and 13.7% of elderly women continue to be part of the labour force after the age of 60, yet are excluded despite the lack of opportunities. With healthier longevity, this untapped potential could open doors for a potential silver dividend given policy investments in avenues for volunteering and developing age-friendly workplaces.

- **Female elderly in India are more vulnerable and dependent in financial terms.** 90% of financially dependent elderly are women, and this pattern is consistent across places of residence. Financial dependency disproportionately affects elderly women because of lower accumulated earnings and limited asset ownership over the life course. Given the modest pensions upon widowhood, a gender-sensitive approach to enhance financial literacy and economic independence in later life is crucial.

- **There is a huge scope for pensions to fill the gap by increasing the coverage among elderly women.** Among the elderly receiving pensions, only 14% are women. While the rates are slightly higher in southern states like Tamil Nadu (38.7%) and Kerala (23.3%), they are exceptionally low in Haryana (3.5%), Punjab (4.8%), and Rajasthan (5%). Stark disparities in pension schemes for women across states call for immediate policy attention to widow and destitute pension schemes in states that are lagging.

- **Increasing financial literacy to better prepare the population for later life could be the key to financial independence and a better sense of wellbeing.** With changing family structures, equipping not just the elderly, but individuals across the life course with financial knowledge is the first step towards economic independence in later life. Community-based initiatives and awareness campaigns will enable the elderly to make informed choices on savings and investments and plan for retirement to enhance autonomy in facing the challenges of old age.

Family Care and Social Life of the Elderly

- **Notably higher proportion of elderly women live alone in many populous states of India.** This signals two demographic realities: longer life expectancy and widowhood. Elderly women are much more prone to living alone compared to elderly men. Among female one-person households, 58% are elderly, compared to 34% among male one-person households. This proportion is even higher in Tamil Nadu, Kerala, and Andhra Pradesh. Although solitary living among women is associated with vulnerability, it can also signal a preference towards economic independence enabled by strong social security nets or wealth accumulation in wealthier states. Consideration of state-specific contexts is crucial to better understand the condition of one-person households across the country.
- **Indian elderly, especially women from poorer households, report unmet long-term care needs.** 60.5% of the elderly with three or more ADL limitations receiving no care are women, with the share reaching 80-90% in Tripura, Lakshadweep, and Uttarakhand. Almost half of the elderly with unmet long-term care needs belong to the poorest two quintiles. This warrants the need for accessible and affordable formalized care, especially for marginalised groups.
- **Active interventions are required to engage the elderly for more frequent socialization.** Social and religious engagement have been associated with healthy and active ageing. However, only 19% and 9% of Indian elderly reported participating in social and religious activities, respectively. Plausible explanations include disability and mobility limitations; this calls for developing technology-based innovations and investing in elder-friendly infrastructure.
- **Family caregiving is prevalent for most of the elderly in India.** In India, much of the responsibility of elderly care rests on the family. Owing to the deep-rooted culture of intergenerational support, this system ensures companionship, strengthens bonds, and plays a positive role in maintaining the identity and emotional security of the elderly. While the demands on caregivers may be heavy, the continual prevalence of the family-based care model acts as an important social buffer in the absence of adequate formal elderly care.
- **Struggles of informal caregivers (family members and relatives) need urgent attention.** While wealthier households can supplement care through institutional services, poorer households rely almost entirely on family support, regardless of adequacy. This dependence places significant strain on informal caregivers (often women) who juggle household responsibilities, economic pressures, and care duties simultaneously. The stress and opportunity costs of caregiving, including lost income and limited personal time, are substantial. Integrating existing fragmented systems across healthcare, social protection, and community services is essential to relieve caregiver burden and ensure sustainable long-term care delivery.
- **A more formal approach to long-term care is required in India.** Changing living arrangements and out-migration of younger members are straining the family-based care system. With a rapidly growing share of the elderly, it is worth noting that families cannot shoulder the full burden of elderly care effectively. An integrated service-delivery approach involving community-based interventions (day-care services, volunteer activities, information campaigns) and formal long-term care (home-based care, ambulatory services, mobile healthcare units, and old-age homes) could provide promising results.

Subjective Assessment of Wellbeing by India's Elderly

- **Elderly women face heightened risks of loneliness and low life satisfaction.** This is a reflection of rising widowhood, declining health and mobility, and gradual withdrawal from social activities. With very low employment rates across their life course and limited pension coverage, elderly women often become financially dependent, reinforcing cycles of vulnerability.
- **Urban elderly consistently report higher levels of life satisfaction than rural counterparts.** The possible explanations for such patterns could be greater access to healthcare and community support services. Urban settings offer more opportunities for social participation through clubs, senior groups, and public spaces. These environments also allow older adults to maintain autonomy and pursue personal interests, contributing to a stronger sense of purpose and wellbeing in later life.
- **Social participation emerges as the strongest driver of wellbeing in later life.** Community engagement through clubs, religious gatherings, volunteering, or informal interactions improves happiness and reduces loneliness and depression. Low social and religious engagement among Indian elderly highlights the potential of unrealized benefits of low-cost, high-impact interventions.

Ageing Well in India

- **Timely policy efforts are required to prepare India well for the ageing population.** India's elderly population is projected to double from around 10% in 2020 to over 20% by 2050, placing it among the world's largest ageing nations. The rise in the oldest-old and centenarian cohorts adds pressure on healthcare, social security, and caregiving. Delayed policy response may result in "ageing before getting rich," leaving limited resources to support longevity. Proactive measures can avert escalating pressures by anticipating demand in health, housing, social protection, and care services. Timely interventions can transform ageing into an opportunity for social and economic contribution rather than a burden.
- **Both public and private sector-led investments are essential to ensure wellbeing in later life.** Government expenditure frameworks alone cannot ensure the wellbeing of an increasingly ageing population, especially with competing demands in health, education, and infrastructure. Private capital, insurance markets, and community partnerships must play a larger role in pensions, care services, and housing. Healthy ageing generates economic returns by extending working lives, encouraging elderly participation, and reducing the costs of late-life morbidity. Such joint investment can ease fiscal strain while enabling extended economic participation and late-life security.
- **Improving early diagnostics of NCDs among the elderly in India requires efforts from both the demand (behavioral aspects) and supply (infrastructure) sides**. NCDs dominate the health burden of elderly Indians, but diagnosis is often delayed. On the demand side, social stigma, limited awareness, and low health-seeking behavior discourage timely check-ups. On the supply side, primary healthcare facilities, especially in rural areas, lack trained staff and diagnostic equipment. Expanding affordable screenings, building the capacity of frontline workers, and using digital platforms for record-keeping can improve early detection. Strengthening preventive care reduces the costs of late-stage complications and improves healthy longevity.
- **Increasing pension coverage to economically dependent and vulnerable elderly is of utmost importance to ensure economic security and a better sense of wellbeing.** A significant share of elderly Indians remains outside of pensions, particularly women and those in informal employment. Extending pensions to the poorest households and enhancing the adequacy of transfers can reduce economic dependence on family support. Reliable pensions not only secure daily living but also enhance autonomy in later life.
- **A mixed model of formal and informal care can be effective in improving support care to the elderly.** Family remains the cornerstone of elderly care in India, but rising longevity, widowhood, and nucleation of households make reliance

on kin alone unsustainable. Formal care services are limited and geographically concentrated. A mixed approach, which strengthens family caregivers through training and respite support, while expanding professional services in home care, day care, and nursing, could generate promising benefits. This balance protects cultural preference for family-based care while addressing growing unmet long-term care needs.

- **Gender dimension to all aspects of ageing warrants urgent and special policy and research attention.** Elderly women live longer than men but often face greater dependency due to fewer years of paid work, lower savings, and weaker pension entitlements. Widowhood further heightens risks of isolation and economic insecurity. Addressing these disparities requires pensions designed with gender sensitivity, better access to preventive and mental health care for women, and stronger community-based support.

- **Interventions are required to increase knowledge about healthy and active ageing.** Preventive health promotion remains limited among the Indian elderly. Physical activity, regular screenings, and awareness of nutrition, diet, and sleep quality are low. Programs that target both younger and older cohorts, encouraging lifestyle habits that delay functional decline, are needed. Campaigns that frame ageing as an active and purposeful process can counter stigma and promote engagement. Dissemination through schools, workplaces, and community centres ensures awareness across the life course.

- **A life-cycle, lifelong, and population-wide approach is the long-term sustainable solution for ensuring overall elderly wellbeing**. Ageing outcomes are shaped in early phases of life by nutrition, education, and employment opportunities. A life-cycle perspective links interventions across these stages, while lifelong approaches reinforce continuous investment in skills and health. A population-wide lens ensures that ageing policy addresses all age groups, not only the elderly. This integrated approach will enable India to secure both longevity and wellbeing, while preparing today's youth as well as elderly to age with dignity.

01 Chapter
Wellbeing of India's Elderly in Focus

Background

India's remarkable socio-economic progress over the past few decades has profoundly transformed its demographic landscape. These developments have ushered in an era of enhanced quality of life, extended lifespans, and declining fertility rates that are rapidly ageing the population. Life expectancy has surged from a modest 46 years in 1960 to 72 years in 2023, with projections estimating it will reach, driven by advancements in healthcare, nutrition, and sanitation. Improved education, women's empowerment, and access to family planning services led to a decline in the total fertility rate from over 5 births per woman in the 1970s to 1.9 in 2025.[2] This demographic shift has swelled the elderly population (aged 60 and above). By 2050, this figure is expected to balloon to nearly 20% of the population, presenting both opportunities and challenges for a nation where 71% of seniors reside in rural areas with limited infrastructure. In response, Indian policymakers have intensified focus on holistic elderly wellbeing, prioritizing health,[3] productive work, economic security,[4] and social engagement to foster dignified aging. Against this background, this report evaluates the advancements achieved in promoting overall elderly wellbeing while identifying the challenges that lie ahead.

Timely action is required to avoid the risk of growing old before getting rich. Unlike developed nations that experienced gradual transitions over several decades, India faces the prospect of 'ageing before getting rich,' a phenomenon where societies become demographically old before accumulating sufficient resources or developing robust social and healthcare infrastructure to support ageing populations.[5] India's situation is uniquely complex due to its massive scale, vast regional heterogeneity, and pervasive socioeconomic disparities. Widespread socioeconomic disparities create unequal ageing burdens, and the erosion of traditional family support systems leaves many elderly vulnerable.[6,7]

The Asian Development Bank emphasises this concept, noting that societies may become old before amassing sufficient resources or developing robust social and healthcare infrastructure to adequately support ageing populations. India's per capita income of $2.71 thousand as in 2024 is substantially lower than Japan's $32.5 thousand, even when it reached 14% elderly population in 1994, intensifying the resource constraints for addressing ageing challenges.

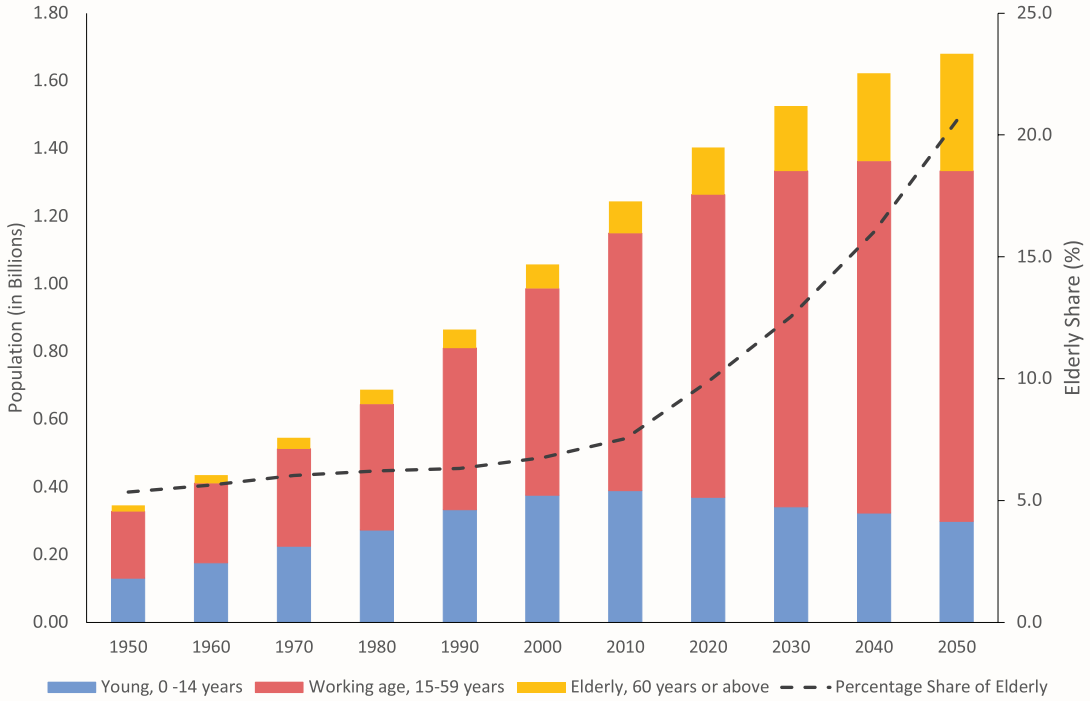
Contrasting Ageing Trajectories across regions. The regional heterogeneity of India's demographic transition adds complexity absent in more demographically homogeneous societies. Southern states, including Kerala, Tamil Nadu, and Karnataka, along with Himachal Pradesh and Punjab, have advanced significantly in their demographic transition, with fertility rates below replacement level and rapidly increasing elderly population shares.[8] These states face immediate pressures to develop sophisticated geriatric healthcare systems, long-term care infrastructure, and age-friendly environments. Kerala shows a 16.5% elderly population share, while northern states like Uttar Pradesh maintain an 8.9% elderly population share, illustrating the demographic divide.

Conversely, populous northern and central states, including Uttar Pradesh, Bihar, Jharkhand, and Rajasthan, maintain higher fertility rates and substantial youth populations.[9] This demographic diversity creates a dual economic burden where states must simultaneously invest in education and employment for large youth populations while preparing for future ageing. The challenge is more complex than that faced by nations with homogeneous demographic profiles, as failure to address either dimension could compromise the other. Such regional variation necessitates differentiated policy approaches rather than uniform national strategies.

Prevalence of Chronic Conditions. Approximately 75% of elderly Indians suffer from at least one chronic disease, such as diabetes or cardiovascular issues, while 40% face disabilities and 24% report limitations in daily activities like bathing or dressing. Mental health issues, including depression, affecting one in three seniors, are often underdiagnosed. Despite initiatives like "Ayushman Bharat PM-JAY", which covers seniors aged 70+ with up to ₹5 lakh in free healthcare, out-of-pocket expenses are straining finances for many.

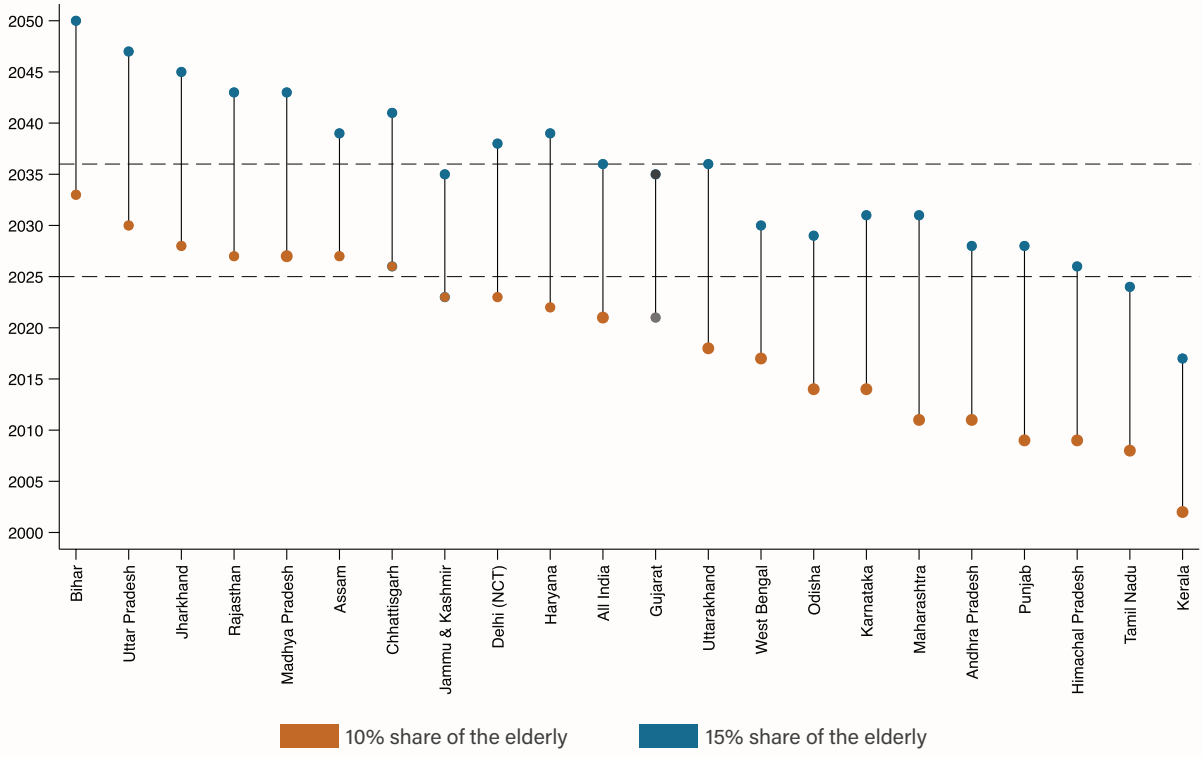
In the following sections, we provide an overview of critical aspects shaping elderly wellbeing in India. First, Population Ageing in India examines the demographic

Figure 1.1: Population age-composition (%) in India, 1950-2050, UNWPP 2024



Source: United Nations, Department of Economic and Social Affairs, Population Division (2024). World Population Prospects 2024. https://population.un.org/wpp/
UNWPP – United Nations World Population Prospects

Figure 1.2: Population share of elderly across major states in India, 1991-2050, census of India 1991 and census of India population projections 2011-36



Source: Population Projections for India and States, 2011-2036, Census of India 2011. Office of the Registrar General & Census Commissioner, India (2019) https://nhm.gov.in/New_Updates_2018/Report_Population_Projection_2019.pdf ; Census of India 1991 https://censusindia.gov.in/census.website/data/census-tables
Note: Data was available for 1991, 2011, 2016, 2021, 2026, 2031, 2036. Data beyond 2036 was extrapolated till 2050. Data for Jharkhand, Chhattisgarh, and Uttarakhand are not directly comparable before and after the year 2000 (Andhra Pradesh before and after 2014) due to their separation from Bihar, Madhya Pradesh, and Uttar Pradesh (Telangana), respectively. Elderly - 60 years or above

trends fuelling the growth of the elderly population. Next, the elderly profile highlights the socioeconomic characteristics of India's elderly. Finally, Ageing and Deprivation analyses the key challenges faced by the elderly, such as economic insecurity.

1.1 Population Ageing in India

India, like much of developing Asia, is undergoing a rapid demographic transition toward an older population structure. The share of the elderly aged 60 years and above in India increased from 5.4% in 1950 to 9.9% in 2020 and is projected to more than double by 2050 **(Figure 1.1)**. In absolute terms, this represents a dramatic rise in the elderly population, reflecting both declining fertility and rising life expectancy. At the same time, the working-age population, which stood at 0.89 billion in 2020, is expected to peak by 2030 before gradually declining, while the child population is shrinking. This ageing transition will have far-reaching consequences for India's economic growth, labor market dynamics, fiscal sustainability, and social welfare systems, making it imperative to prioritize policies that address the needs and wellbeing of the elderly.[10]

Certain states are experiencing rapid aging, whereas others are progressing through a slower demographic transition. By 2005, most Indian states had an elderly population share of less than 10%, with only Kerala crossing this threshold **(Figure 1.2)**. By 2025, both Kerala and Tamil Nadu are projected to have reached the 15% mark, while several other states have surpassed the 10% threshold. Looking ahead to 2036, only nine states, primarily in the northern region, are expected to remain below the 15% elderly share. These patterns highlight significant spatial variation in ageing across India. Southern and western states, led by Kerala and Tamil Nadu, have already transitioned into aged societies and will continue to see a rise in their elderly populations. In contrast, states such as Bihar and Uttar Pradesh are expected to experience a delayed but sharp ageing process after 2030, reflecting regional differences in fertility decline and health outcomes.

Over the next few decades, the dependency ratios across states will increase. In 2021, Kerala recorded the highest old-age dependency ratio at 22.5%, followed by Himachal Pradesh (19.4%) and Tamil Nadu (18.6%) **(Figure 1.3).** By 2036, these ratios are projected to surpass 30%, reaching 38.3% in Kerala, 32.7% in Tamil Nadu, and 30.3% in Himachal Pradesh. Northern states such as Bihar (13.1%) and Uttar Pradesh (13.2%) currently have lower ratios but are expected to experience substantial increases, approaching 18% by 2036. Overall, the old-age dependency ratio, which reflects the burden on the working-age population, is projected to rise significantly across all states. Kerala is expected to remain the highest, while states with currently lower ratios will see faster relative growth. This trend underscores the need for region-specific policies to strengthen social security, healthcare, and other age-related support systems.

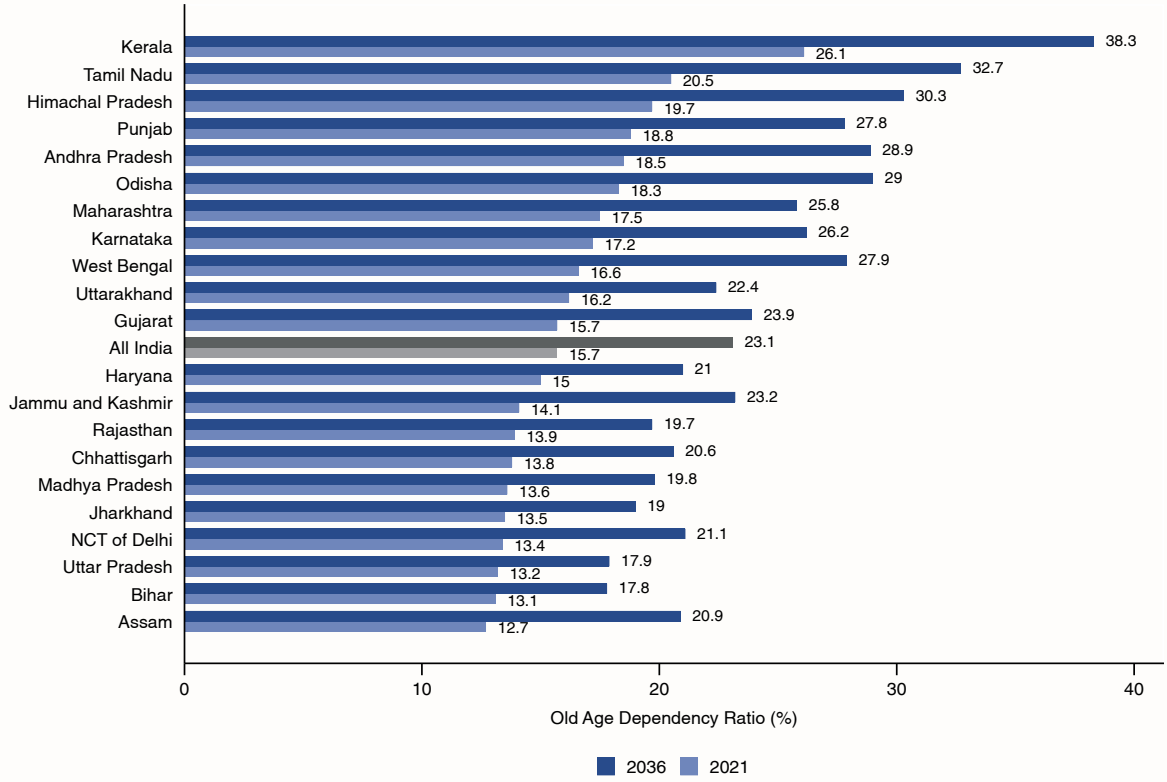
There are regional inequalities in life expectancy at later life stages. Jammu and Kashmir reports the highest life expectancy at age 60, followed by Punjab, Delhi, and Odisha, whereas states such as Chhattisgarh, Bihar, and Uttar Pradesh have the lowest values **(Figure 1.4).** The gap in life expectancy at 60 between the highest and lowest performing states is approximately five years. These figures highlight significant interstate differences in elderly longevity, with northern states consistently lagging behind. Such disparities point to regional inequalities in health outcomes and longevity during later life stages, underscoring the need for targeted interventions to improve elderly health and wellbeing across underperforming regions.

1.2 Elderly Profile

Elderly survival is higher among women, a pattern that remains consistent across all three time periods **(Figure 1.5).** Age distribution data show that women consistently outnumber men in older age groups, with the gender gap widening at advanced ages. The proportion of elderly women is projected to increase more rapidly than that of men, particularly in the 80-plus bracket.

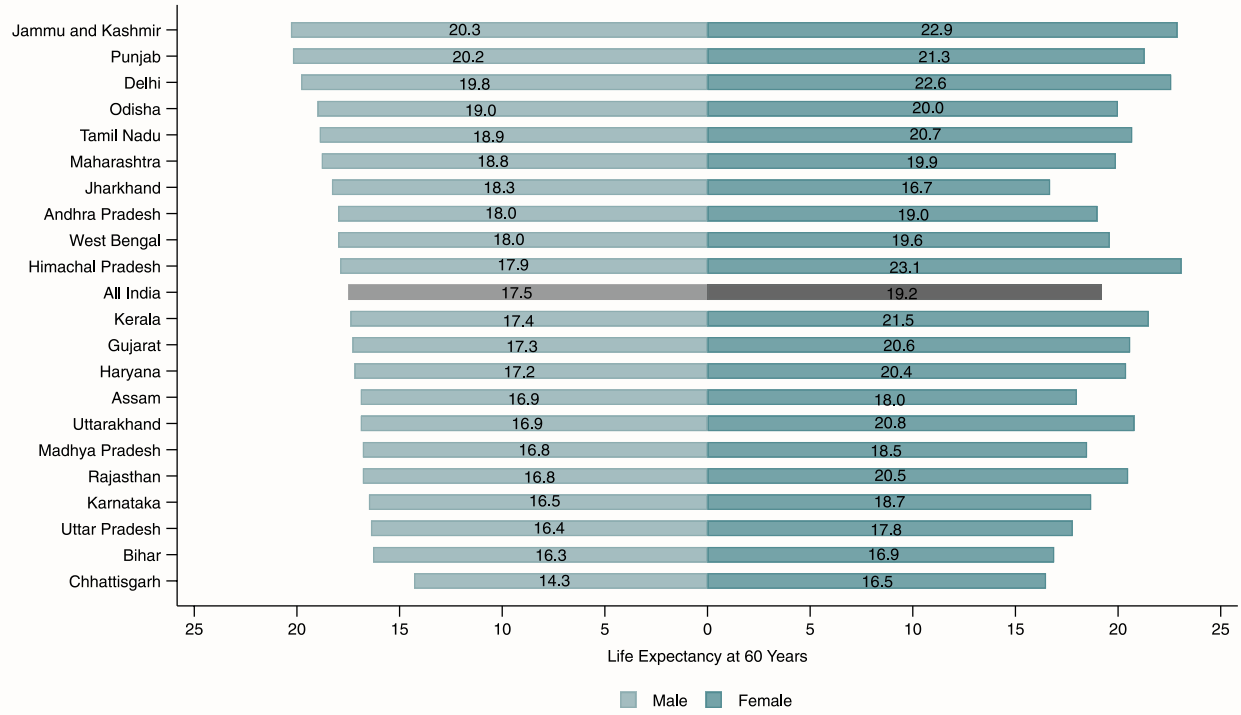
The percentage distribution of the elderly population has been shifting over time, particularly within the 80+ age group. A notable trend is the increasing share of elderly men in this bracket, which suggests that more men are surviving into advanced ages. This improvement can be attributed to rising life expectancy, supported by better access to healthcare, declining mortality rates, and overall improvements in living conditions. The shift highlights not only the demographic transition toward greater longevity but also the need to address the specific health, economic, and social support requirements of an expanding male population in the oldest-old category. This trend underscores the need for gender-sensitive policies and programs to address the specific health, social, and care needs of older women.

Figure 1.3: Old age dependency ratio (%) across major states in India, 2021 and 2036, census of India population projections 2011-36



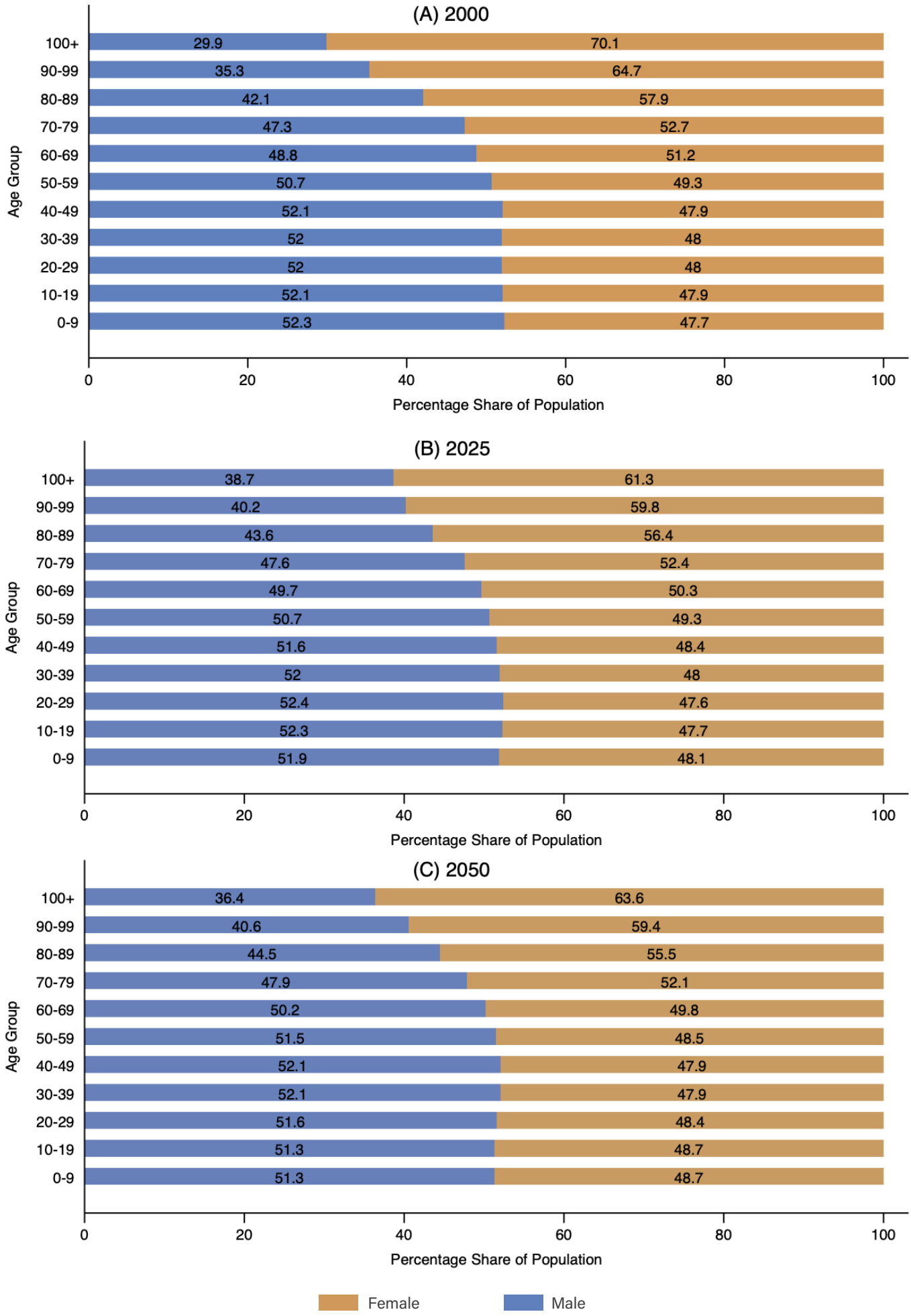
Source: Population Projections for India and States 2011 – 2036, Census of India 2011. Office of the Registrar General & Census Commissioner, India (2019). https://nhm.gov.in/New_Updates_2018/Report_Population_Projection_2019.pdf
Note: The old-age dependency ratio is the population in the old-age group, defined as 60+, over the population aged 15–59.

Figure 1.4: Life expectancy at 60 years in major states, SRS, India, 2016-2020



Source: SRS - Sample Registration System -Abridged Life Tables 2016-2020, Office of the Registrar General & Census Commissioner, India https://censusindia.gov.in/nada/index.php/catalog/44376/download/48048/SRS_STAT_2020.pdf
Note: The labels refer to the Life Expectancy at 60 years in the period 2016-20.

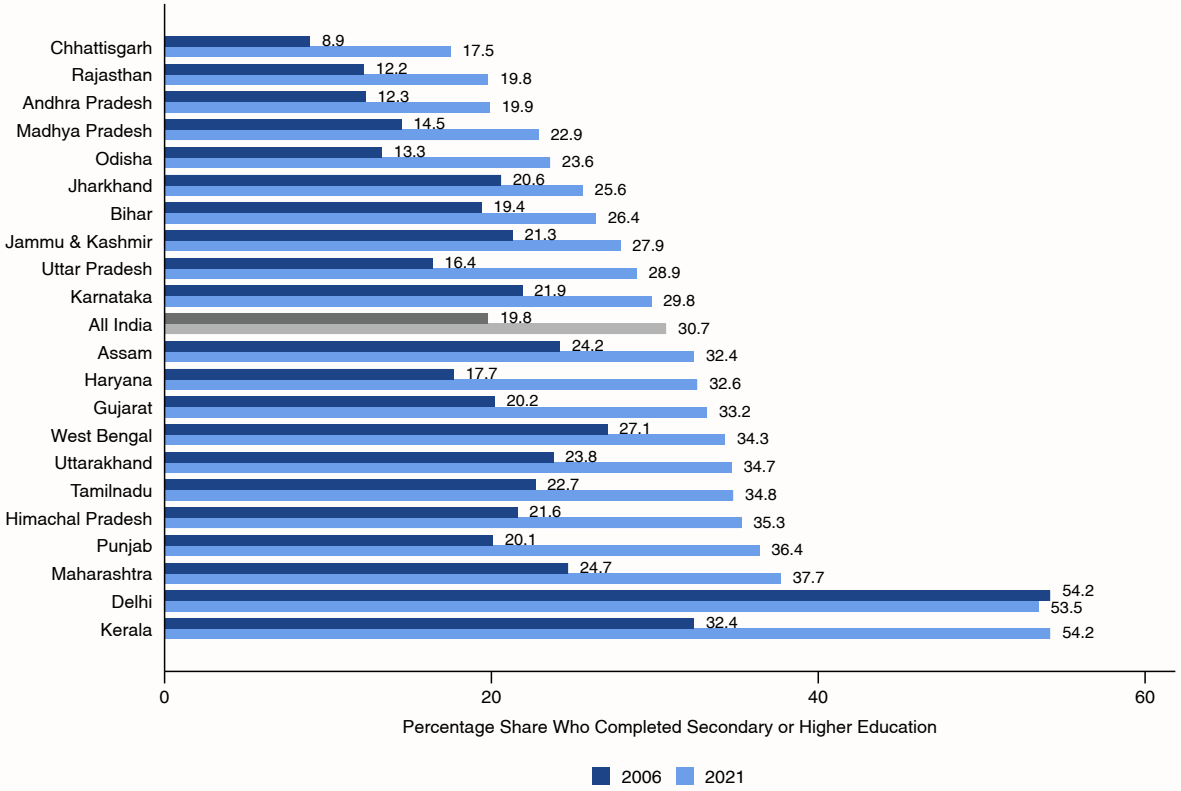
Figure 1.5: Percentage distribution of population across sex by age groups, India, 2000-2050, UNWPP 2024



Source: United Nations, Department of Economic and Social Affairs, Population Division (2024). World Population Prospects 2024. https://population.un.org/wpp/

A clear and consistent disparity has emerged in the educational attainment of elderly populations across Indian states, particularly in the proportion of those aged above 60 with secondary or higher education. States like Delhi and Kerala stand out, with a significantly higher percentage of elderly individuals reporting secondary or higher education compared to other regions **(Figure 1.6).** This trend, which has persisted for 20 years, reflects the relatively stronger educational infrastructure and socio-economic conditions in these states, enabling greater access to advanced education among their aging populations. In stark contrast, less than one-fifth of the elderly in states such as Chhattisgarh, Rajasthan, and Andhra Pradesh have attained secondary or higher education. This low educational attainment in these regions highlights systemic challenges, including limited access to schooling, economic constraints, and possibly cultural factors that may have prioritized early workforce entry over education in past decades.

Figure 1.6: Percentage of elderly with completed secondary or higher education across major states, India, NFHS, 2006-2021

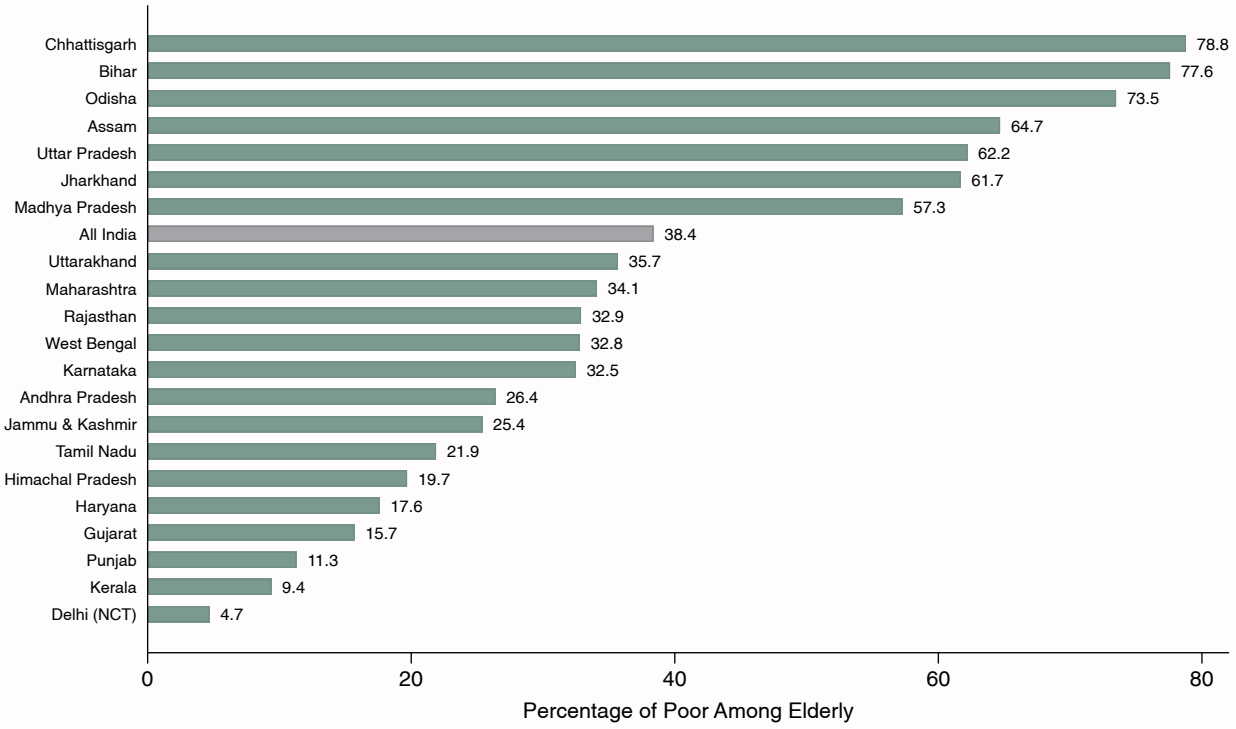


Source: : NFHS - National Family Health Survey (NFHS-3), 2005–06; National Family Health Survey (NFHS-5), 2019–21. Office of the Registrar General & Census Commissioner, Ministry of Health and Family Welfare, Government of India. https://dhsprogram.com/methodology/survey/survey-display-541.cfm
Note: Variable used "Highest education level attained" present in Population Recode . "Secondary" and "Higher" coded as 1, "No education, preschool" and "Primary" coded as 0, Elderly - 60 years or above.

1.3 Ageing and Deprivation

The economic status of elderly individuals across Indian states reveals stark disparities, with significant variations in poverty concentration. In states like Odisha, Bihar, and Chhattisgarh, over three-fourths of the elderly population—73.5%, 77.6%, and 78.8%, respectively—fall within the poorest two MPCE (Monthly Per Capita Expenditure) quintiles, indicating a higher concentration of elderly from destitute households. these northern regions **(Figure 1.7).** In contrast, states such as Kerala (9.4%), Delhi (4.7%), and Punjab (11.3%) report the lowest poverty concentration among the elderly, reflecting greater economic security in these relatively prosperous areas. These findings underscore the critical need for targeted social protection measures to address the heightened economic vulnerability of elderly populations in poorer states.

Figure 1.7: Share (%) of poor (bottom two MPCE quintiles) elderly in total elderly across major states, India, NSS, 2018



Source: : Health, NSS 75th Round 2017-18. National Sample Survey Office, NSSO - Ministry of Statistics & Programme Implementation, Government of India. https://microdata.gov.in/NADA/index.php/catalog/152

Note: The number at the end of each bar refers to the percentage of poor (coded as 1 = poorest 2 MPCE quintiles, 0 = richest 3 MPCE quintiles); denominator – Individuals aged 60 years or above.

1.4 Conclusion

It is time for India to act in a timely manner to invest in the elderly's wellbeing with a long-term perspective towards a rapidly ageing population.[11-12] India's demographic landscape is undergoing a rapid transformation, with some states already experiencing significant population aging. This shift, coupled with inadequate preparedness, risks leaving the elderly vulnerable, particularly as the workforce shrinks, which is going to put a strain on the resources. While poverty rates have declined, the focus must now shift to enhancing overall wellbeing, prioritizing quality of life for the elderly. Given this background, this report is structured as follows: Chapter 2 examines the health of older people; Chapter 3 explores work, retirement, and economic security dynamics; Chapter 4 addresses family, care, and social engagement; and Chapter 5 focuses on subjective wellbeing. Each chapter evaluates progress toward achieving healthy aging in India and identifies priority policy actions to address existing gaps.

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02 Chapter
Health of the Elderly

Background

A healthy life is the key determinant of the individual's overall wellbeing. It is not merely the absence of disease, but it also encompasses physical and functional status to perform the activities of daily life, sound mental health, and cognitive abilities. The World Health Organization (WHO) has explicitly taken cognizance of maintaining functional ability as the prerequisite for healthy ageing and wellbeing at older age. The elderly's health and healthcare needs vary significantly from those of the younger group. For example, unlike the younger populations, the elderly face a greater burden of chronic and acute conditions (which increases further at later stages of life), multiple medication use, and increased need for long-term, supportive healthcare.

This chapter delves into understanding the health status of older people in India from different dimensions to reflect upon potential policy recommendations. Using survey datasets, the chapter looks into the levels and patterns of disease burden (NCDs - chronic conditions) across age, sex, and geographical regions (States). This is followed by a section on examining regional patterns in the mental and cognitive health of the Indian elderly. The physical and functional abilities of older people are discussed further examining limitations to Activities of Daily Living (ADLs). The chapter also discusses the policy implications of gender variations in the health status at later stages of life across different geographies. Healthcare utilisation behaviour and access to healthcare, along with several policy initiatives and efforts on healthy ageing, are discussed in the context of universal health coverage. Finally, the chapter concludes with healthcare system preparedness and policy directions and recommendations for healthy ageing.

2.1. Increased Longevity and Elderly Health

The demographic transition in India presents an opportunity to enjoy the gains from a younger population, but at the same time, it poses formidable challenges for the upcoming decades with population ageing. The country, while capitalizing on its demographic dividend, faces a fundamental shift as its elderly population (aged 60 years or above) is projected to reach 347 million by 2050, constituting more than 20% of the total population.[1] The 'oldest old' (aged 80 and above) will grow by approximately 279% between 2022 and 2050,[2] creating increased demand for specialised long-term care services. While increased longevity reflects socioeconomic progress, it poses significant responsibilities towards ensuring that the additional years are lived with good health and dignity.

The life expectancy at birth in India has increased by more about 10 years in the last two and a half decades. According to the SRS estimates, Census of India, the life expectancy at birth in India increased from 62.8 years in 2000-2004 to 71.3 years in 2018-2022, and is projected to increase to 73.8 years by 2030.[3] The increments in added years to life are notably visible for both rural (61.6 years in 2000 to 68.6 years in 2018) and urban areas (67.6 years in 2000 to 73.2 years in 2018). Regionally, northern and populous states like Uttar Pradesh (2018-22: 67.2 years), Bihar (2018-22: 69.0 years), and Jharkhand (2018-22: 69.4 years) have also noticed substantial gains in life expectancy at birth. In the next decade, life expectancy at birth in India is expected to increase by about 3 years for males and 2 years for females.

However, added years to life do not necessarily translate to healthy years. As per the Asian Development Policy report on ageing, 2024, healthy life expectancy for males was about 4.3 years less than life expectancy at birth in 2000, and this gap further increased to 5.1 years in 2019. For females, the gap between life expectancy at birth and healthy life expectancy increased from 5.3 years to 6.1 years between 2000 and 2019. The overall disease burden among older people has seen a clear shift towards an increasing share of NCDs. According to the WHO estimates, the total Disability Adjusted Life Years (DALYs per 100000 people), for the age group 60-64 years, attributed to NCDs increased from 1527 in 2000 to about 2080 in 2019. It may be important to note that the health profile of India's elderly reflects an incomplete epidemiological transition characterized by a persistent "double burden" where traditional infectious diseases coexist with a rapidly expanding non-communicable disease (NCD) epidemic. Regional variations in disease burden provide evidence of this incomplete transition, with southern and western states having largely completed the shift toward chronic disease predominance, while northern states maintain higher infectious disease burdens alongside emerging NCD challenges.

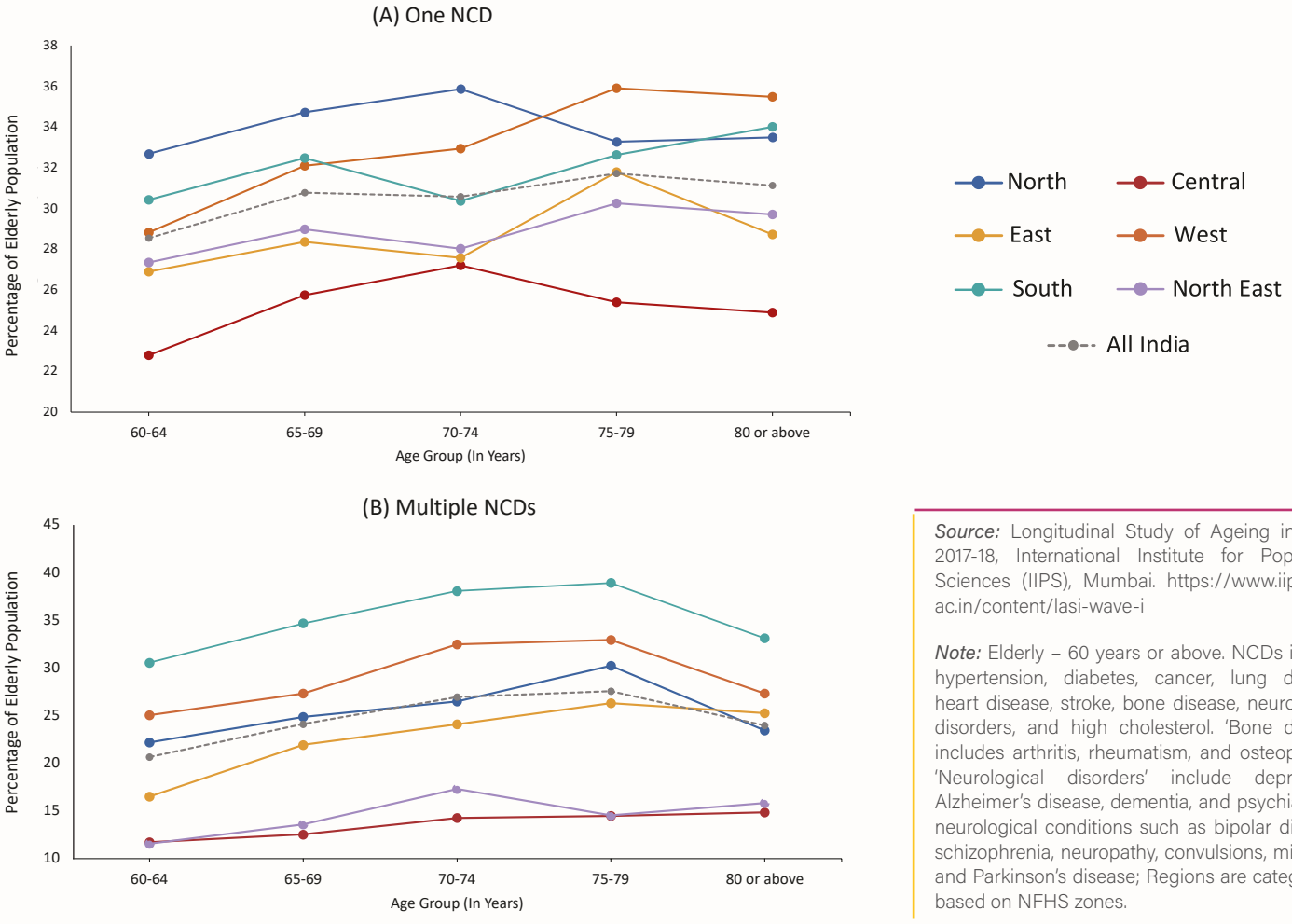
2.2. Elderly Health Status

2.2.1. Burden of Non-Communicable Diseases

Self-reported data from survey datasets show that overall, about 25% to 30% (across age groups) of the total elderly in India suffer from at least one NCD, and about 20% to 25% were ailing from multiple NCDs. Regional variations in NCD burden demonstrate India's incomplete epidemiological transition. In southern states like Kerala and Karnataka, multiple NCD prevalence exceeds 70% among the oldest old, contrasting sharply with northern states. The age gradient is particularly steep in these demographically advanced states, with NCD burden rising sharply after age 70. This contrasts with northern states like Bihar and Uttar Pradesh, with relatively lower NCD prevalence but higher infectious disease burden **(Figure 2.1).** Interestingly, for the age group 60-64 years, the percentage share of the total elderly with multiple NCDs varies from 11% in the central region to 30% in the southern region. However, it is worth noting that self-reported bias can be common in states with low education levels and inadequate diagnostic infrastructure. However, such stark variations in numbers clearly reflect a gap across regions.

States at different transition stages face distinct policy challenges. Those with incomplete epidemiology transitions must simultaneously address communicable disease control while preparing for the rising chronic disease burden. The National Program for Prevention and Control of NCDs (NP-NCD) in India, launched in 2010 and evolved to include population-based screening for common NCDs, faces implementation challenges in regions where healthcare systems remain oriented toward acute care models rather than chronic disease management. The delayed demographic shift in northern and central states is likely to accelerate the growth of NCD burden, posing significant challenges for public health systems that remain oriented toward infectious disease management. The current absence of robust, geriatric-focused public health systems in these regions could pose substantial challenges. This regional disparity demands nuanced, forward-thinking policy responses that anticipate rather than react to epidemiological transitions. Effective and immediate interventions are required to mitigate the risk of unhealthy ageing in the future decades.

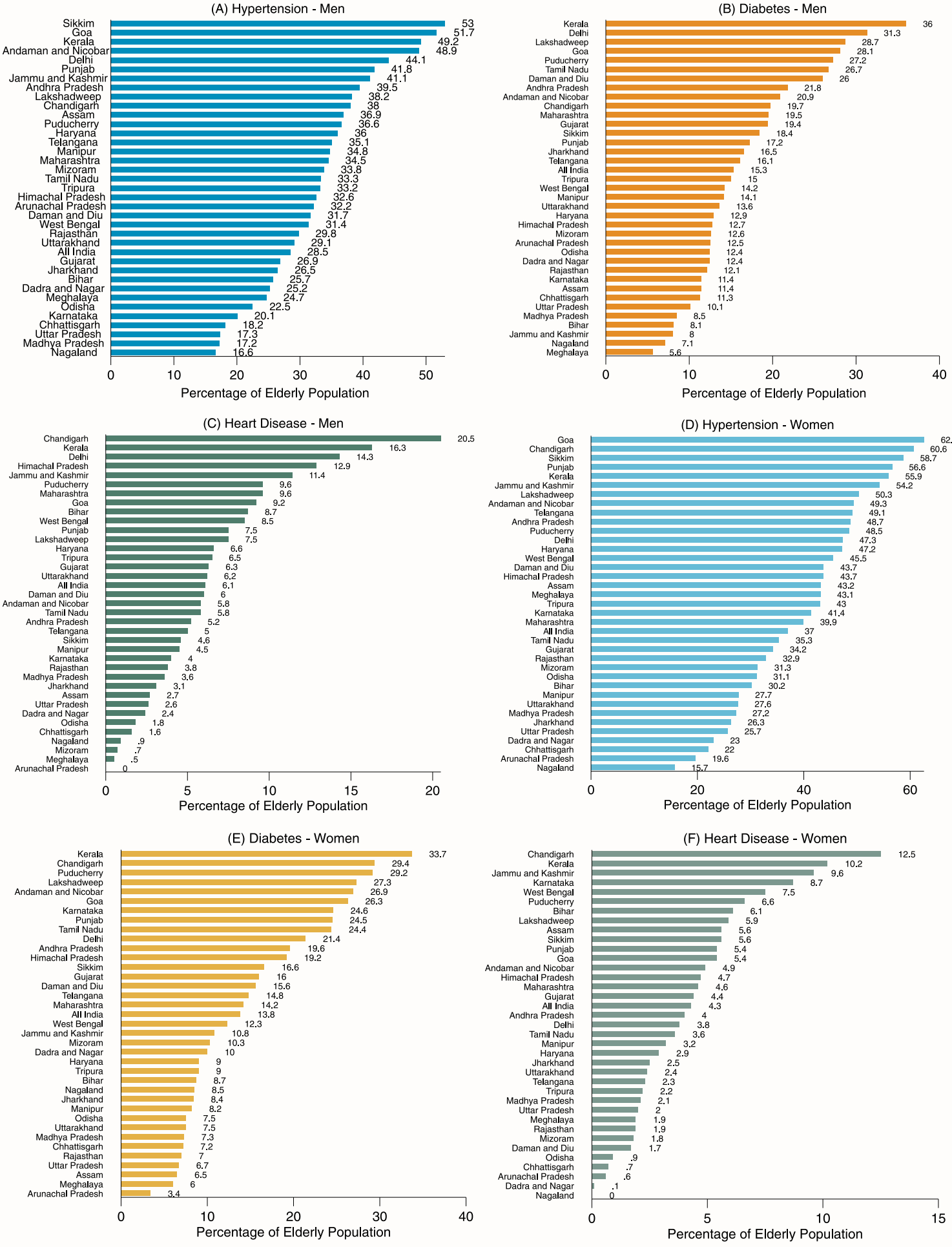
Figure 2.1: Prevalence (%) of non-communicable diseases (NCDs) among the elderly across regions, India, LASI, 2017-18



Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

Note: Elderly – 60 years or above. NCDs include hypertension, diabetes, cancer, lung disease, heart disease, stroke, bone disease, neurological disorders, and high cholesterol. 'Bone disease' includes arthritis, rheumatism, and osteoporosis. 'Neurological disorders' include depression, Alzheimer's disease, dementia, and psychiatric or neurological conditions such as bipolar disorder, schizophrenia, neuropathy, convulsions, migraine, and Parkinson's disease; Regions are categorised based on NFHS zones.

Figure 2.2: Prevalence (%) of hypertension, diabetes, and heart disease among the elderly by sex across states, India, LASI, 2017-18



Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i
Note: Elderly - aged 60 years or above

Hypertension is the most common NCD affecting older Indians (Figure 2.2). Gender differences are notable for chronic disease prevalence, with hypertension affecting 37% of elderly women compared to 28% of men, representing a substantial gender gap demanding targeted interventions. Diabetes shows a male predominance, affecting 15% of elderly men and 14% of elderly women, while patterns in other conditions reveal complex interactions between gender, access, and diagnosis. For heart conditions, survey data indicate similar prevalence rates among elderly men and women (approximately 4% to 6%).

State-level variations are substantial, with heart disease prevalence ranging from 2.1% in some states to over 20% in others (Figure 2.2). The prevalence of diabetes among the elderly was highest in Kerala for both men (36%) and women (33%). The diabetes burden was high for other southern states like Tamil Nadu, Karnataka, and Andhra Pradesh. On the other hand, a lesser proportion of the elderly males were reported to be ailing from diabetes in states like Meghalaya (5.6%), Bihar (8.1%), and Uttar Pradesh (10.1%). Such regional variations have important implications in terms of interpretations. For example, the low prevalence of NCDs in populous and developing states could be the outcome of inadequate diagnostic infrastructure, low utilisation of preventive checkups due to lack of education and awareness, or it simply reflects the advantage of having a younger population with less NCD prevalence. The findings suggest a more targeted approach for both long-term supportive care for chronic conditions and enhancing diagnostic levels across states.

The above pattern for diabetes and heart diseases contrasts with epidemiological evidence showing women experience 33% higher cardiovascular mortality rates, suggesting potential underdiagnosis.[4] This discrepancy likely reflects systematic underdiagnosis rather than true epidemiological patterns. In the United States, however, men showed higher rates of cardiovascular mortality compared to women in both the general population and the population with cardiovascular disease.[5] The underdiagnosis of heart disease in women could potentially stem from multiple interconnected factors. Women often present with atypical cardiac symptoms, including fatigue and breathlessness rather than classic chest pain,[6,7] leading to misdiagnosis or delayed diagnosis by healthcare providers. Many women don't know the signs of a heart attack or have a general notion of it being a 'male disease.'[8] Cultural factors and caregiving responsibilities cause women to delay seeking medical care. These patterns suggest the reported prevalence of heart disease in survey data significantly underestimates the true burden on India's female elderly population. A more gender-sensitive training for healthcare providers and public awareness campaigns tailored to women's health needs is warranted. The healthcare system requires systematic reforms, including gender-specific provider training, culturally sensitive public awareness campaigns, and diagnostic protocols adapted for gender differences in symptom presentation.

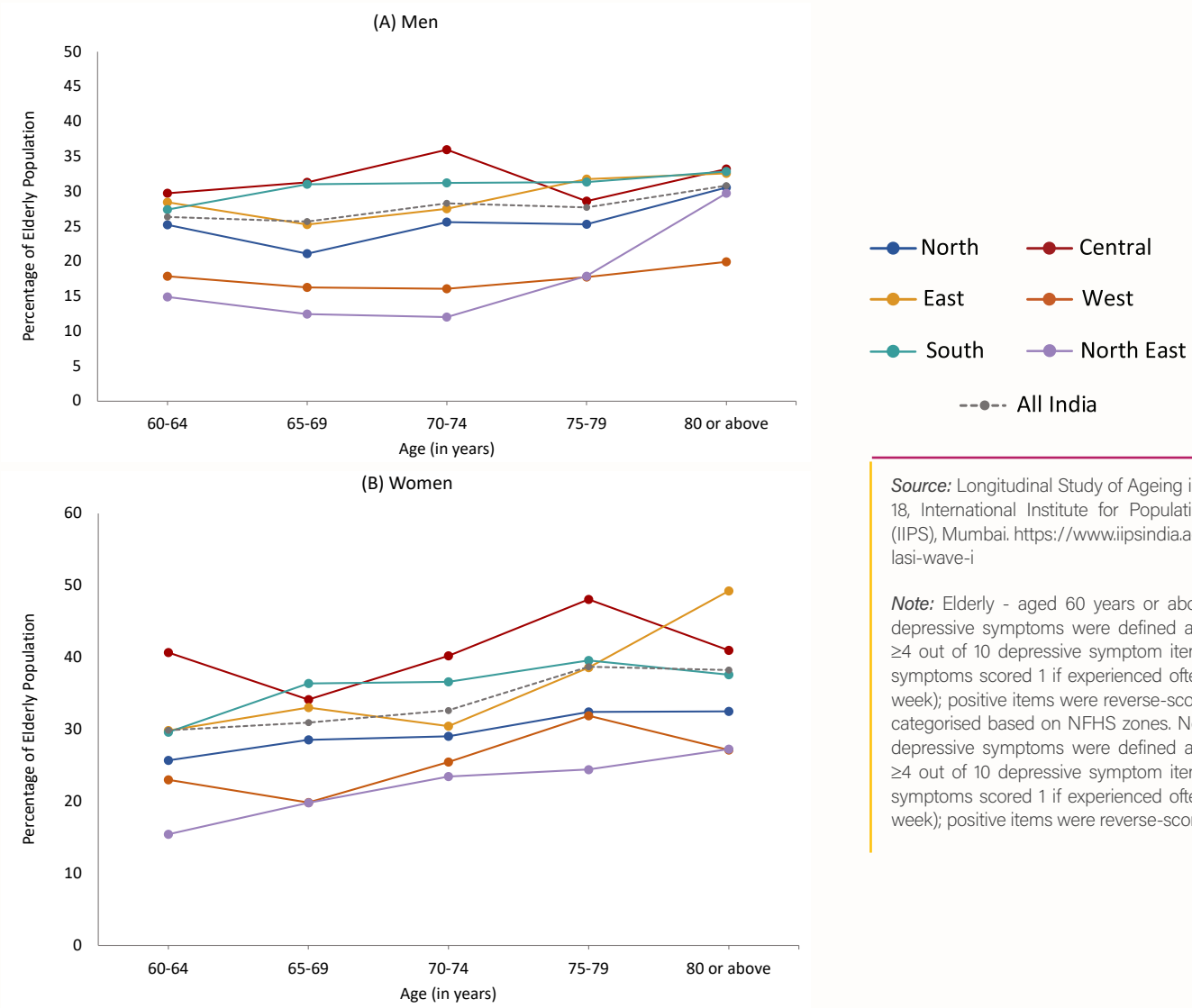
2.2.2. Mental Health of the Elderly

Depressive symptoms affect a substantial proportion of India's elderly population. The prevalence of Elevated Depressive Symptoms (EDS) demonstrates interesting patterns across age groups, sex, and regions (Figure 2.3). About 26% to 28% of the elderly males in India exhibit signs of elevated depressive symptoms. These numbers are higher for female elderly, ranging from 30% to 35% across age groups. Further, central India was reported to have high share of the elderly with elevated depressive symptoms.

A steeper increase in depressive symptoms among female elderly after 70 coincides with increasing widowhood, functional decline, and social losses at later stages of life. Interestingly, the regional variation in the prevalence converges with increasing age for both elderly men and women for all regions. For the 60-64 age group, the prevalence of elevated depressive symptoms ranges from about 15% in the North-East region to 42% in the central India region among elderly males. But, the range narrows at 80 years or above, with 20% in the western region to 30% in central and southern states.

Elderly from the states of Jammu and Kashmir (55.3% and 51.9%), Karnataka (44.3% and 41.1%), West Bengal (41.5% and 39.7%), Delhi (38.6% and 37.3%), and Madhya Pradesh (34.6% and 39.7%) showed a visibly higher prevalence for EDS (among both males and females respectively). This suggests that for an ageing population, mental wellbeing is not solely a function of age or biology but is deeply intertwined with macro-level social and political stability. The chronic trauma and social disruption stemming from conflict and instability in the region likely represent a profound and unaddressed social determinant of mental health, a pattern supported by studies linking adverse early-life and environmental factors to poor mental health outcomes in later life.

Figure 2.3: Prevalence (%) of elevated depressive symptoms among the elderly across regions, India, LASI, 2017-18



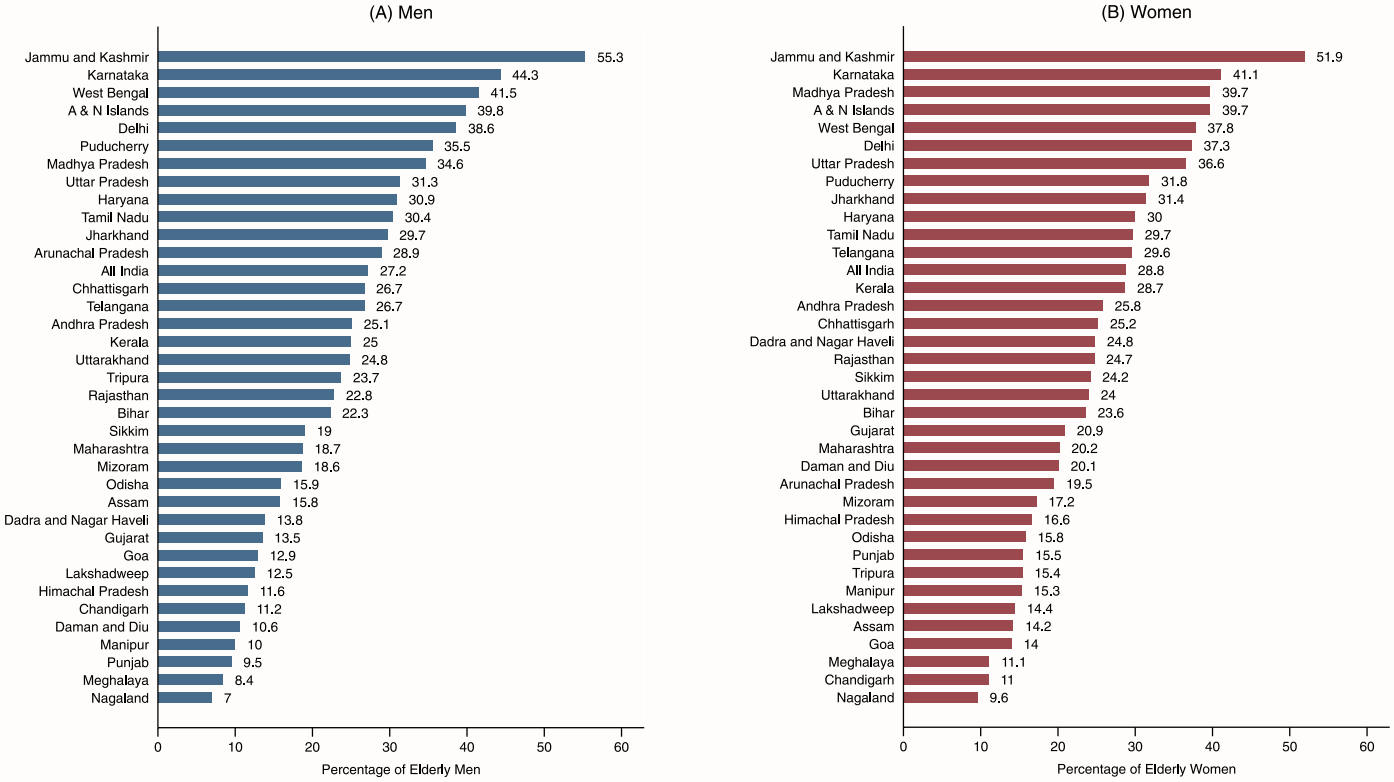
Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

Note: Elderly - aged 60 years or above. Elevated depressive symptoms were defined as a score of ≥4 out of 10 depressive symptom items. Negative symptoms scored 1 if experienced often (≥3 days/week); positive items were reverse-scored; Regions categorised based on NFHS zones. Note: Elevated depressive symptoms were defined as a score of ≥4 out of 10 depressive symptom items. Negative symptoms scored 1 if experienced often (≥3 days/week); positive items were reverse-scored.

The mental health challenges facing India's elderly are inextricably linked to socioeconomic and environmental circumstances, as a deeper analysis of the data on residence, education, and social factors reveals. A stark difference was observed between rural and urban areas in terms of Elevated Depressive Symptoms (EDS) among the elderly residing in these areas. The EDS prevalence was consistently higher among rural elderly (25.9% for men and 30.3% for women) compared to their urban counterparts (23.3% and 25.8%, respectively). Previous studies also asserted such patterns, indicating rural communities face greater challenges in mental healthcare provision due to geographic isolation, limited access to professionals, and the strong stigma associated with seeking help in small, close-knit communities.9 The erosion of traditional family support systems due to the out-migration of younger family members further compounds social isolation and economic insecurity, which are key drivers of this urban-rural divide.

Higher educational attainment (secondary or above) is a significant buffer against depressive symptoms for both men and women across nearly all states (Table 2.1). For men with secondary education or above, the national prevalence of EDS is 19.2% compared to 27.8% for those with below secondary education, and 31.4% for illiterate elderly men. For women, the rates are 26.3, 27.3%, and 34.7% respectively. This protective effect is particularly pronounced among men with higher education, suggesting that education may confer resilience by enabling greater social engagement, improved financial management, and a continued sense of purpose after

Figure 2.4: Prevalence (%) of elevated depressive symptoms among elderly across states, India, LASI, 2017-18



Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

Note: Elevated depressive symptoms were defined as a score of ≥4 out of 10 depressive symptom items (Trouble concentrating, Feel depressed, Low energy, Feel afraid, Low satisfaction, Loneliness, Bothered, Everything an effort, Hopeless, Unhappy). Negative symptoms scored 1 if experienced often (≥3 days/week); positive items were reverse-scored. The elderly include individuals aged 60 years or above.

retirement. However, the data also shows that this protective effect diminishes dramatically after age 80, when social and family support become more critical determinants than individual resources, highlighting the importance of comprehensive social support systems in advanced old age. Further, lower EDS levels among educated women can also be a marker of higher women's empowerment at later stages of life in the form of financial independence, and a better sense of awareness about healthy lifestyle habits.

The findings are consistent with existing literature, showing that low socioeconomic status and poverty increase vulnerability to mental health problems and psychological distress, with a higher prevalence of depression found among uneducated, non-working, and poor elderly.10 Over 70% of India's elderly are financially dependent, and the erosion of joint family structures has exacerbated loneliness and isolation, particularly for older women. Elderly women are further disproportionately affected due to a lifetime of unequal access to resources, caregiving burdens, and financial dependence, while older men often struggle with the loss of social identity and role associated with retirement. Some studies based on global data have also asserted that having children and living close to them positively influences mental and physical health, particularly for older women[11]. Studies have shown that poor mental status and depressive symptoms are closely associated with functional impairment and the onset of NCDs. Decline in functional ability can essentially elevate the sense of depression via loss of self-esteem and a sense of control. Another study on Indian data also observed that depression prevalence is higher among rural elderly with comorbidity[12] .

Table 2.1: Prevalence (%) of elevated depressive symptoms among elderly, by sex and education level, across states, India, LASI, 2017-18

	Elderly Men			Elderly Women		
State	Illiterate	Up to Secondary	Secondary or above	Illiterate	Up to Secondary	Secondary or above
Delhi	59.9	30.0	31.4	42.6	35.1	48.8
Jammu & Kashmir	56.1	63.3	44.7	51.1	83.9	60.8
West Bengal	52.8	39.4	30.9	55.5	42.1	46.1
Puducherry	49.8	35.8	28.8	44.9	19.6	18.8
Karnataka	49.7	36.3	53.5	55.1	31.4	15.7
A & N Islands	42.6	42.7	24.3	44.1	29.6	11.3
Tamil Nadu	37.6	34.3	13.2	42.0	23.5	23.4
Haryana	37.0	25.9	27.7	35.1	28.4	32.0
Chhattisgarh	36.3	23.1	9.2	31.0	32.8	0.0
Uttar Pradesh	34.5	32.4	24.4	39.4	38.7	27.2
Madhya Pradesh	30.9	41.4	28.6	44.3	47.3	23.7
Kerala	29.9	29.3	16.9	38.5	33.2	31.4
Arunachal Pradesh	28.9	37.3	8.7	29.7	17.2	0.0
Rajasthan	28.8	22.9	7.8	26.9	22.4	16.5
Mizoram	28.6	19.8	9.1	20.6	22.4	33.0
Telangana	27.6	26.9	23.8	33.7	30.4	30.9
Jharkhand	27.2	35.4	24.3	36.3	27.8	9.2
Andhra Pradesh	27.0	28.9	11.5	27.3	23.2	17.6
Maharashtra	26.2	19.2	11.4	29.2	17.5	27.2
Bihar	25.5	22.2	13.9	25.4	20.7	26.6
Assam	25.4	15.2	7.8	24.5	18.4	0.0
Goa	24.9	14.0	7.3	21.4	14.6	8.7
Tripura	24.7	25.4	17.4	28.3	22.9	0.0
Sikkim	23.8	12.8	17.6	28.1	34.4	28.5
Daman and Diu	21.2	11.4	4.8	15.8	28.4	29.0
Uttarakhand	19.8	31.5	15.1	26.1	32.0	14.0
Gujarat	17.6	14.5	6.7	19.7	17.0	11.0
Dadra and Nagar	15.7	12.0	12.2	27.7	8.9	13.2
Odisha	13.8	18.0	13.4	20.9	16.3	25.1
Lakshadweep	13.7	11.4	14.3	23.0	14.8	0.0
Chandigarh	12.1	10.3	11.4	3.1	20.7	14.2
Punjab	11.5	8.1	8.0	19.3	17.8	4.2
Manipur	11.4	11.9	5.7	16.2	14.6	7.3
Himachal Pradesh	10.9	10.9	12.7	16.2	22.6	12.1
Nagaland	10.3	6.9	2.3	11.2	1.8	5.7
Meghalaya	2.9	12.6	7.9	18.1	13.8	0.0
All India	**31.4**	**27.8**	**19.2**	**34.7**	**27.3**	**26.3**

Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

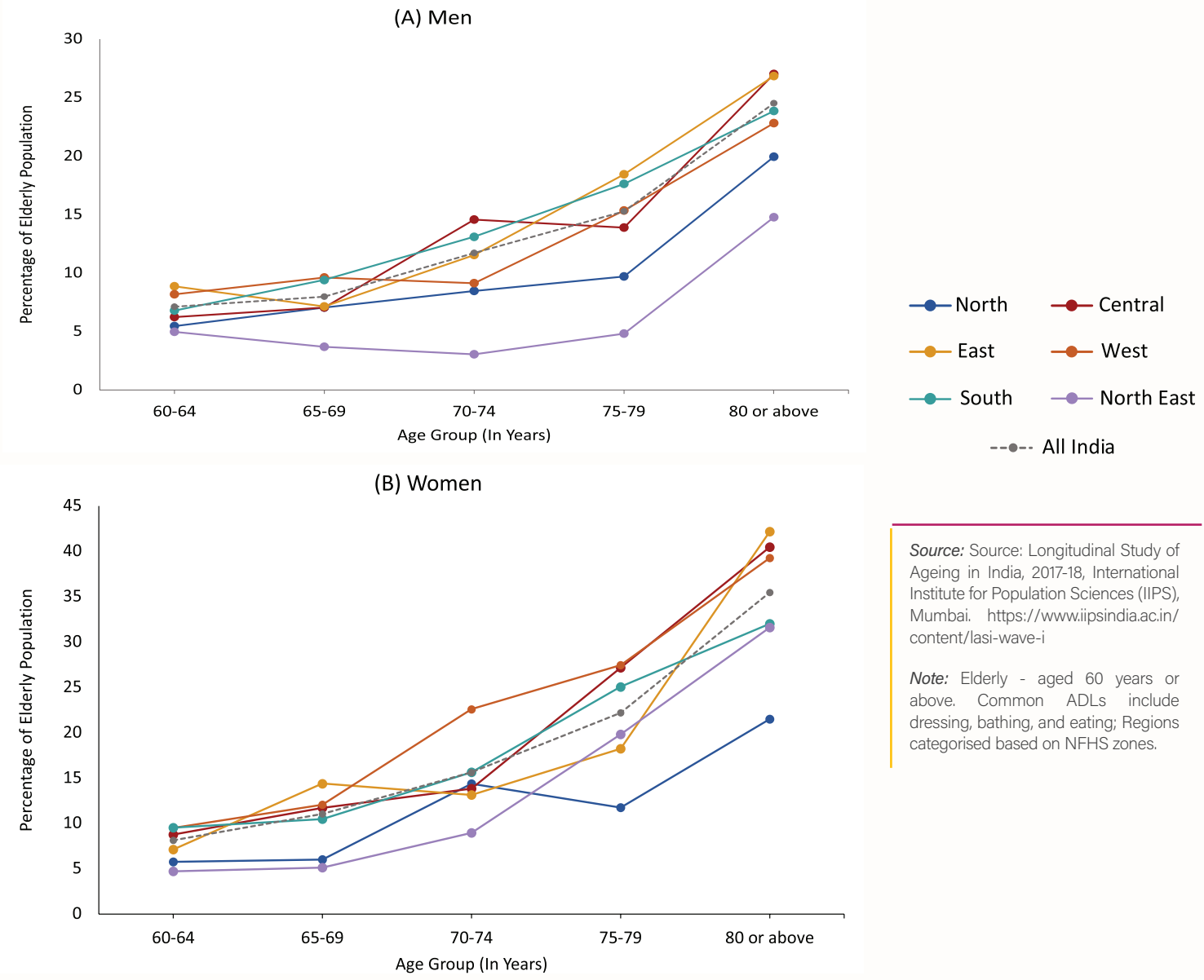
Note: Elevated depressive symptoms were defined as a score of ≥4 out of 10 depressive symptom items (Trouble concentrating, Feel depressed, Low energy, Feel afraid, Low satisfaction, Loneliness, Bothered, Everything an effort, Hopeless, Unhappy). Negative symptoms scored 1 if experienced often (≥3 days/week); positive items were reverse-scored. Elderly include individuals aged 60 years of above.

2.2.3 Functional Health of Older Persons

The ability to physically function worsens with increasing age. Functional decline represents one of the most immediate and visible challenges facing India's ageing population. The ability to perform Activities of Daily Living (ADLs) serves as a critical indicator of independence, quality of life, and care needs. Functional weakening is measured by the difficulty in performing three basic ADLs, such as dressing, bathing, and eating. Such limitations may be the consequence of complications associated with NCDs, mental illness, or sudden injury. India exhibits functional decline trajectories with clear regional and gender patterns in ADL limitations among the elderly, showing sharp increases in functional limitations with age and dramatic spikes among "superagers" (aged 80 and above) (Figure 2.4). Regional patterns reveal that elderly males from the north-eastern region are the least vulnerable to basic ADL limitations, with the lowest prevalence across all age groups. The variation across regions widens with age, with central, eastern, western, and southern India having a relatively higher proportion of superagers (80+) years elderly with at least one basic ADL limitation. Such patterns imply that regional tailoring is required to target support and nursing care solutions for the elderly from the policy standpoint.

In states with advanced demographic transitions, the prevalence of limitations in common ADLs (dressing,

Figure 2.5: Share (%) of elderly population reporting limitation in at least one common activities of daily living (ADL) across regions, India, LASI, 2017-18



Source: Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

Note: Elderly - aged 60 years or above. Common ADLs include dressing, bathing, and eating; Regions categorised based on NFHS zones.

Table 2.2: Share (%) of elderly population reporting all three common ADL Limitations across states, India, LASI, 2017-18

	Men (Age in years)			Women (Age in years)		
State	60 to 69	70 to 79	80 or above	60 to 69	70 to 79	80 or above
A & N Islands	2.1	5.1	23.1	4.8	5.6	31.2
Lakshadweep	1.0	6.9	20.9	3.3	6.8	16.0
Delhi	1.6	1.9	19.1	1.5	5.3	13.9
Arunachal Pradesh	0.9	1.6	16.0	1.0	4.2	18.7
West Bengal	2.4	6.3	14.7	1.3	6.0	33.4
Mizoram	0.0	2.5	14.2	1.5	4.1	17.9
Kerala	2.4	3.0	14.2	2.3	4.7	12.2
Sikkim	5.1	8.0	13.6	8.7	8.2	16.0
Madhya Pradesh	2.1	11.3	12.3	1.7	13.2	17.4
Jammu and Kashmir	3.3	3.8	12.3	3.4	10.5	18.6
Punjab	3.6	0.6	11.3	0.7	3.0	1.6
Haryana	1.1	2.9	11.0	2.0	3.3	10.4
Uttar Pradesh	1.1	2.2	10.4	1.5	3.7	17.2
Nagaland	0.0	0.0	10.1	0.6	0.0	2.5
Jharkhand	0.6	3.2	9.2	1.0	3.4	18.0
Meghalaya	0.0	0.0	8.9	0.8	4.0	23.4
Maharashtra	1.9	3.3	8.9	1.3	5.9	24.8
Himachal Pradesh	2.7	2.1	8.8	7.3	13.5	13.0
Tamil Nadu	2.0	2.3	8.3	1.3	2.0	10.9
Bihar	0.9	3.0	7.7	0.7	1.8	13.4
Tripura	0.0	0.0	6.3	0.4	1.9	3.8
Manipur	0.1	0.8	6.2	0.3	0.9	4.5
Andhra Pradesh	2.3	7.3	6.1	2.8	9.0	18.0
Assam	1.6	1.4	5.8	1.6	2.7	15.6
Odisha	0.7	3.6	5.1	0.7	6.2	7.3
Chhattisgarh	2.4	4.7	4.2	1.4	4.3	13.5
Telangana	1.6	4.9	3.8	1.4	4.5	16.6
Gujarat	1.3	5.1	3.6	1.6	3.8	4.4
Chandigarh	0.6	1.5	3.6	0.1	5.3	0.0
Rajasthan	1.4	1.6	2.9	1.2	3.1	2.6
Karnataka	1.8	1.0	0.2	1.0	0.6	4.4
Dadra and Nagar	1.3	2.3	0.0	2.0	1.4	0.0
Daman and Diu	0.0	1.1	0.0	3.2	0.3	37.4
Goa	2.9	6.1	0.0	2.4	10.0	13.4
Puducherry	1.2	4.3	0.0	0.6	5.2	15.5
Uttarakhand	3.4	1.7	0.0	3.5	7.5	19.7
All India	**1.7**	**3.7**	**8.7**	**1.5**	**4.6**	**15.4**

Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

Note: Common ADLs include dressing, bathing, and eating.

Table 2.3: Share (%) of male elderly population reporting limitation to Instrumental activities of daily living (IADLs) across states, India, LASI, 2017-18

State	Cooking		Shopping		Making Calls		Taking Medication		House Work	
	60-79	80 or above	60-79	80 or above	60-79	80 or above	60-79	80 or above	60-79	80 or above
Karnataka	22.5	67.7	19.4	61.8	29.3	53.5	11.2	16.5	25.5	69.4
Jammu and Kashmir	25.6	66.9	19.7	59.2	27.6	61.2	21.2	33.0	25.3	57.7
Andhra Pradesh	19.5	57.5	16.9	55.1	24.0	55.4	9.1	34.0	22.3	57.5
Himachal Pradesh	9.6	49.0	11.4	52.6	10.5	59.6	8.7	31.1	17.6	55.4
Jharkhand	22.6	48.7	17.8	43.2	19.6	44.2	8.1	30.2	14.3	50.4
Haryana	13.9	48.2	13.6	51.2	20.0	49.5	5.6	21.8	17.3	58.4
Lakshadweep	5.0	46.0	5.9	46.0	6.2	34.9	5.9	56.3	16.2	61.0
Bihar	17.4	45.2	18.6	56.5	25.6	65.3	13.8	40.1	18.4	57.0
Assam	11.7	44.4	17.1	43.5	16.1	42.5	17.3	33.2	14.7	41.8
West Bengal	19.3	40.3	15.1	61.8	19.8	44.5	9.3	33.2	26.1	61.0
Sikkim	15.6	40.2	13.0	35.6	17.3	22.3	11.9	24.9	17.0	54.2
Tamil Nadu	21.2	39.6	14.9	34.4	16.0	34.3	10.1	20.5	25.7	59.2
Kerala	5.6	39.6	12.0	46.1	8.1	35.9	5.1	29.6	17.1	53.8
Telangana	21.8	33.4	15.1	31.9	34.1	42.8	8.2	16.6	21.1	41.2
A & N Islands	13.7	31.6	11.4	33.1	6.9	36.7	6.5	21.7	11.9	46.2
Madhya Pradesh	12.9	31.0	18.9	33.2	21.7	27.3	12.5	27.6	22.4	29.6
Chandigarh	7.0	30.9	8.5	64.6	3.0	27.7	2.6	12.2	8.7	62.1
Uttar Pradesh	10.0	27.6	11.8	38.0	17.2	46.8	9.7	28.5	13.7	33.8
Chhattisgarh	15.1	26.5	9.4	24.6	23.7	30.1	6.9	23.2	11.4	31.2
Arunachal Pradesh	7.5	25.3	4.5	20.4	6.9	25.7	3.6	17.3	4.3	24.4
Meghalaya	5.3	25.3	5.5	27.2	4.7	20.0	0.0	10.5	3.2	37.5
Punjab	14.3	25.1	7.2	33.9	22.9	55.6	5.5	18.9	11.3	33.0
Uttarakhand	6.9	24.6	11.5	22.6	15.4	28.3	8.2	17.3	13.7	24.6
Mizoram	8.0	24.3	5.8	34.0	5.6	19.8	2.7	8.9	13.8	59.6
Maharashtra	11.5	24.1	17.5	37.1	17.8	38.2	9.4	19.8	15.2	33.7
Nagaland	4.3	23.3	6.1	22.6	9.4	18.6	1.2	10.0	7.1	27.8
Rajasthan	2.8	21.2	6.9	28.4	8.1	35.9	6.4	28.4	6.9	31.4
Manipur	4.1	20.8	8.3	38.8	16.6	54.0	2.8	24.6	9.8	43.6
Delhi	7.0	20.8	9.2	39.2	7.3	38.1	8.2	30.4	17.7	35.6
Gujarat	4.4	20.1	9.6	33.6	8.7	35.9	5.4	19.4	9.6	33.7
Odisha	6.8	19.2	9.9	22.2	6.3	19.3	6.2	22.2	9.5	22.5
Dadra & Nagar Haveli	12.1	19.0	12.3	54.1	13.8	66.7	6.8	36.0	10.6	54.1
Puducherry	9.2	18.3	7.8	14.8	4.7	22.6	4.2	16.8	13.3	31.6
Tripura	3.1	14.7	4.2	16.0	18.0	33.0	2.2	11.6	7.0	33.5
Daman and Diu	2.9	6.9	14.8	32.5	11.2	53.8	6.8	16.4	9.3	18.1
Goa	6.6	5.8	9.0	16.5	3.5	5.2	4.1	8.2	16.7	29.0
All India	**13.4**	**34.6**	**14.3**	**41.9**	**17.9**	**43.7**	**9.5**	**27.7**	**17.2**	**43.4**

Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

Note: Elderly - aged 60 years or above

Table 2.4: Share (%) of female elderly population reporting limitation to instrumental activities of daily living (IADLs) across states, India, LASI, 2017-18

State	Cooking		Shopping		Making Calls		Taking Medication		House Work	
	60-79	80 or above	60-79	80 or above	60-79	80 or above	60-79	80 or above	60-79	80 or above
Assam	23.6	73.9	34.0	86.7	32.5	76.2	23.0	55.6	26.8	75.2
West Bengal	22.4	69.4	27.8	77.2	33.3	61.8	14.6	50.2	33.6	80.1
Jammu and Kashmir	36.6	67.5	55.3	82.7	64.0	80.8	34.0	61.3	41.2	77.5
Maharashtra	23.9	60.5	28.9	69.5	32.7	71.4	17.4	51.3	24.9	60.6
Himachal Pradesh	22.4	59.2	29.3	60.3	28.7	66.6	19.7	49.2	33.9	68.6
Jharkhand	25.2	55.6	30.3	68.1	39.8	57.4	21.1	37.6	22.7	60.5
Uttarakhand	13.5	52.7	25.8	57.4	28.9	67.8	17.6	50.1	29.2	69.8
Chhattisgarh	14.2	49.1	20.4	57.3	35.3	58.4	14.3	30.7	19.1	57.8
Andhra Pradesh	13.1	46.3	22.1	56.0	35.8	59.4	13.0	28.9	30.4	64.7
Tamil Nadu	16.7	45.7	23.2	53.6	30.9	59.2	16.4	33.2	37.4	60.2
Kerala	13.2	43.1	23.6	65.3	19.7	55.7	10.0	33.1	28.1	63.7
Uttar Pradesh	12.1	41.9	22.9	59.2	33.3	59.8	19.2	44.9	25.5	55.3
Madhya Pradesh	17.3	41.0	23.4	53.9	19.8	48.1	15.9	39.3	24.8	52.5
Bihar	21.2	40.6	28.4	52.3	43.2	56.7	24.0	48.3	31.1	54.3
Haryana	12.8	39.2	15.0	52.3	29.5	58.8	9.3	26.4	20.3	64.5
Delhi	20.0	38.8	18.0	51.3	27.0	35.0	20.6	27.2	14.4	47.2
Karnataka	18.5	37.6	33.8	55.5	42.8	46.4	19.7	27.8	51.4	56.1
Gujarat	9.4	29.8	20.1	50.5	20.4	53.7	11.8	12.7	16.1	36.5
Punjab	10.3	26.9	16.8	43.1	37.9	51.1	11.4	22.7	27.6	33.3
Odisha	12.7	25.3	12.7	23.2	13.8	20.8	10.8	21.4	13.5	22.9
Chandigarh	17.0	23.7	23.7	35.7	17.8	23.6	8.7	21.8	16.9	64.1
Sikkim	40.4	23.1	23.1	32.3	18.9	26.5	15.4	14.2	30.3	29.9
Telangana	49.5	23.0	23.0	58.9	49.3	73.3	8.2	35.9	27.5	58.0
Daman and Diu	22.6	22.5	22.5	43.5	22.5	33.3	14.1	44.7	20.2	68.8
A & N Islands	38.7	21.9	21.9	53.2	18.2	42.5	17.2	38.7	30.8	60.3
Goa	24.6	20.8	20.8	54.8	7.2	16.7	8.7	19.6	26.1	66.7
Lakshadweep	31.7	17.9	17.9	47.0	15.3	32.9	9.3	68.0	29.5	66.8
Puducherry	30.3	17.9	17.9	52.3	14.3	43.9	9.6	29.6	18.2	47.9
Manipur	36.3	17.7	17.7	50.0	27.0	41.9	7.4	13.5	16.4	36.1
Tripura	32.5	17.1	17.1	45.4	35.3	44.3	9.9	21.0	14.8	44.5
Rajasthan	6.8	16.6	17.2	36.8	22.8	48.5	16.5	35.4	15.8	35.7
Dadra & Nagar Haveli	26.1	14.4	14.4	75.1	28.6	82.5	11.2	53.0	14.9	64.5
Meghalaya	43.1	11.2	11.2	60.6	22.5	64.3	7.6	37.3	11.7	36.9
Mizoram	42.4	10.3	10.3	63.1	6.0	38.9	4.2	28.9	20.4	58.6
Arunachal Pradesh	46.6	9.5	9.5	46.6	8.3	41.5	5.4	37.0	7.0	43.0
Nagaland	17.5	5.3	5.3	37.3	5.9	24.3	1.7	11.3	6.8	24.9
All India	**16.6**	**44.7**	**24.4**	**57.6**	**31.4**	**56.6**	**16.9**	**39.0**	**27.4**	**56.2**

Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

Note: Elderly – aged 60 years or above

bathing, and eating) among the oldest old is substantially elevated. For example, in West Bengal, 33.4% of women aged 80 and above report all of these limitations, while in Maharashtra the figure reaches 24.8% (Table 2.2). At the national level, the percentage of elderly females with all three basic ADL limitations increases about four times from the 70-79 years (4.6%) group to the 80+ years (15.4%) cohort. This substantial gender disparity is a reflection of cumulative disadvantages throughout a woman's life, including lower lifetime nutrition, a higher burden of chronic diseases, and caregiving roles that often compromise their own health maintenance. As the populous northern states begin to experience their own demographic transitions, they can expect to face similar patterns of functional decline, requiring proactive development of long-term care infrastructure and a trained caregiving workforce to avert a future care crisis.

The likelihood of independent living diminishes notably with increasing age. The limitations in Instrumental Activities of Daily Living (IADLs), such as cooking, shopping, and managing money, represent a more subtle but equally critical challenge to independent living.

For all instrumental activities of daily living, the prevalence of limitation was about three to four-fold higher among superagers (80 years or above) than the 60-79 years age group (Table 2.3). Such patterns were more or less consistent across states and male and female older people. Interestingly, more than one-fourth of males (27.7%) and one-third of females (39.0%) elderly were reported to be unable to take medication by themselves (Table 2.4). Such high numbers indicate urgent policy intervention to promote formal nursing care for the oldest old cohort. More importantly, about half of the oldest old men (43.7%) and women (56.6%) showed difficulty in making calls. This is alarming and merits immediate policy attention to provide geriatric ambulatory services in case of health emergencies. This pronounced difficulty with using a mobile is a powerful indicator of the compounding effect of physical decline and the digital divide. As India has undergone a rapid digital transition, the inability to use modern communication technologies has left a substantial portion of the elderly population isolated from essential healthcare services, social support networks, and family connections. The COVID-19 pandemic starkly exposed this vulnerability, as many elderly individuals were unable to navigate digital platforms to access vaccinations or medical advice.

The elderly from relatively less affluent backgrounds in India have a higher prevalence of reporting limitations to Instrumental Activities of Daily Living (IADLs). The urban-rural divide is notable, with rural women facing consistently higher IADL limitation rates compared to their urban counterparts (Table 2.5). For example, in the 60-79 age group, 36.3% of rural women report difficulty making calls, compared to 21.8% of urban women. For both men and women, higher educational attainment (secondary or above) is associated with substantially lower IADL limitations. The patterning across wealth quintiles shows a consistent disadvantage for the poorest elderly, with elderly men aged 60-79 in the poorest quintile showing 16.0% limitations in cooking, compared to 12.7% in the richest quintile (Table 2.5). The data on IADL limitations provides a strong case for targeted interventions that go beyond traditional medical care to include social and technological support systems, such as digital literacy programs, community-based assistance programs, and policies that address the socioeconomic roots of functional decline.

A substantial proportion of India's elderly population requires intensive daily care. At the national level, of all the elderly males and females with ADL/IADL limitations, 33.7% and 42.6% of them, respectively, have five or more functional limitations (Figure 2.6). In terms of absolute headcount, these numbers swell to represent millions of individuals requiring substantial support. This finding is not an isolated statistic but a critical indicator of the imminent care crisis, as the traditional family-based support system is unable to accommodate this growing and high-need population.

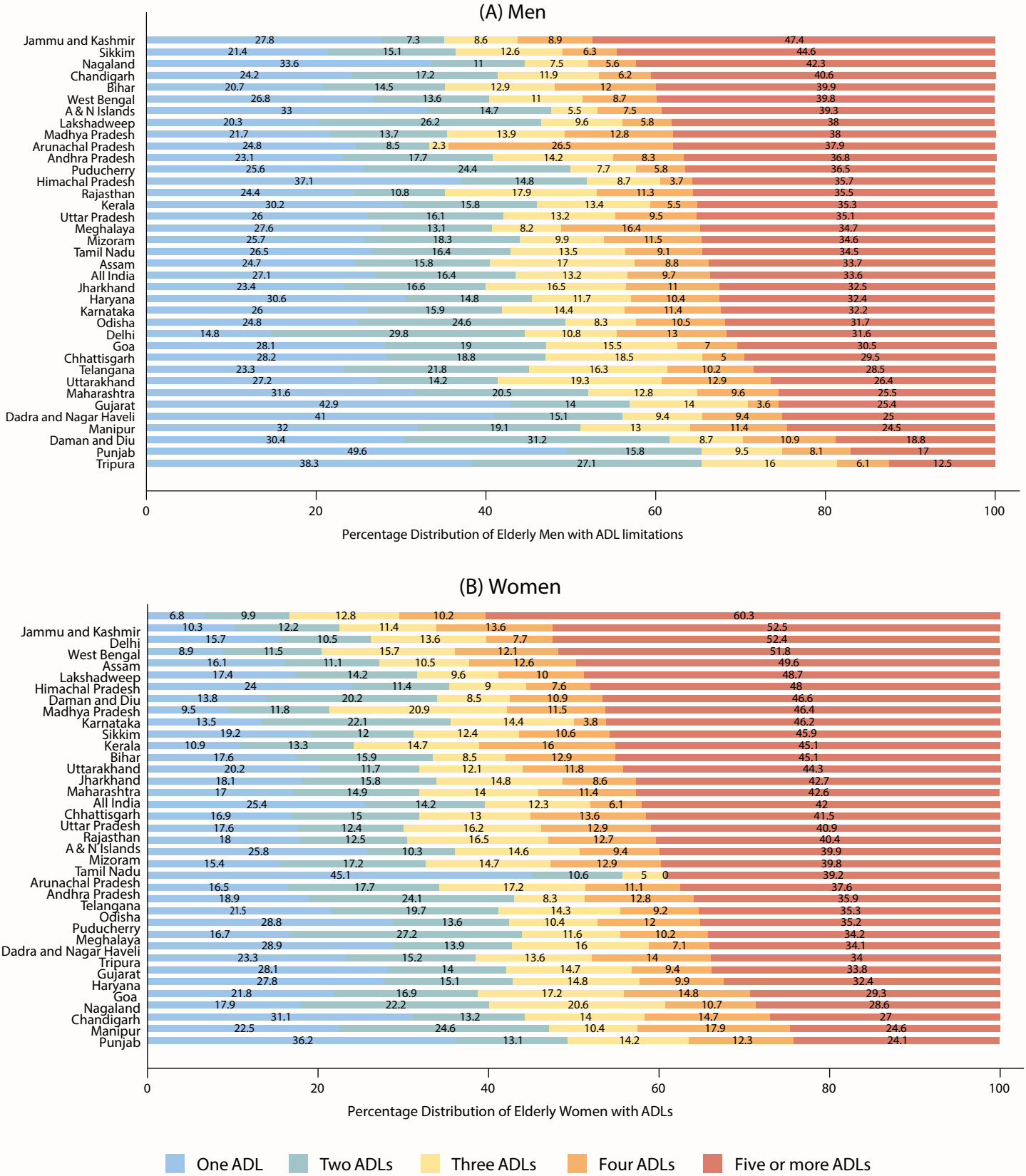
Regionally, in more than half of the Indian states, more than one-third of the elderly with ADL/IADL limitations had five limitations. Jammu and Kashmir demonstrates the highest dependency rates, with 47.6% of men and 60.3% of women with ADL limitations reporting five or more limitations.

Table 2.5: Share (%) of elderly population reporting limitation to instrumental activities of daily living (IADLs) across socioeconomic groups, India, LASI, 2017-18

Male										
State	Cooking		Shopping		Making Calls		Taking Medication		House Work	
Age (in Years)	60-79	80 or above	60-79	80 or above	60-79	80 or above	60-79	80 or above	60-79	80 or above
Residence										
Rural	14.6	35.2	15.3	42.6	22.0	50.0	10.9	30.0	18.5	44.6
Urban	11.0	32.1	11.4	37.7	9.3	24.2	5.7	18.8	14.2	39.3
Education Level										
Below Secondary	13.76	31.1	13.8	37.5	15.7	37.4	8.5	22.6	17.5	41.2
Secondary or above	9.5	29.6	8.3	33.2	5.6	19.9	3.9	17.0	10.8	31.6
Social Group										
Scheduled Castes	15.3	31.1	15.4	43.1	21.7	51.3	10.6	30.1	18.1	40.3
Scheduled Tribes	12.3	25.8	15.0	32.2	22.0	41.1	11.8	20.2	16.3	40.4
OBC	14.6	38.9	15.1	43.2	19.5	44.9	9.7	29.8	18.4	46.2
Others	11.4	30.6	11.8	38.9	13.1	36.7	7.3	22.2	14.1	40.6
MPCE Quintile										
Poorest	16.0	35.5	17.6	47.7	22.3	49.9	10.6	32.3	18.8	53.3
Poor	13.6	38.4	14.3	44.5	19.8	50.8	10.7	28.6	17.2	47.5
Middle	13.0	34.9	12.5	36.5	18.1	31.7	8.4	23.2	17.1	38.2
Rich	12.3	27.8	13.1	36.4	16.4	42.0	8.3	26.3	15.7	33.4
Richest	12.7	34.9	13.1	40.5	13.4	40.7	8.6	23.8	17.2	41.9
Female										
State	Cooking		Shopping		Making Calls		Taking Medication		House Work	
Age (in Years)	60-79	80 or above	60-79	80 or above	60-79	80 or above	60-79	80 or above	60-79	80 or above
Residence										
Rural	14.6	35.2	15.3	42.6	22.0	50.0	10.9	30.0	18.5	44.6
Urban	11.0	32.1	11.4	37.7	9.3	24.2	5.7	18.8	14.2	39.3
Education Level										
Below Secondary	13.76	31.1	13.8	37.5	15.7	37.4	8.5	22.6	17.5	41.2
Secondary or above	9.5	29.6	8.3	33.2	5.6	19.9	3.9	17.0	10.8	31.6
Social Group										
Scheduled Castes	15.3	31.1	15.4	43.1	21.7	51.3	10.6	30.1	18.1	40.3
Scheduled Tribes	12.3	25.8	15.0	32.2	22.0	41.1	11.8	20.2	16.3	40.4
OBC	14.6	38.9	15.1	43.2	19.5	44.9	9.7	29.8	18.4	46.2
Others	11.4	30.6	11.8	38.9	13.1	36.7	7.3	22.2	14.1	40.6
MPCE Quintile										
Poorest	16.0	35.5	17.6	47.7	22.3	49.9	10.6	32.3	18.8	53.3
Poor	13.6	38.4	14.3	44.5	19.8	50.8	10.7	28.6	17.2	47.5
Middle	13.0	34.9	12.5	36.5	18.1	31.7	8.4	23.2	17.1	38.2
Rich	12.3	27.8	13.1	36.4	16.4	42.0	8.3	26.3	15.7	33.4
Richest	12.7	34.9	13.1	40.5	13.4	40.7	8.6	23.8	17.2	41.9

Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

Figure 2.6: Distribution (%) of the elderly with ADL/IADL limitations by number of ADL/IADL limitations across states, India, LASI, 2017-18



Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

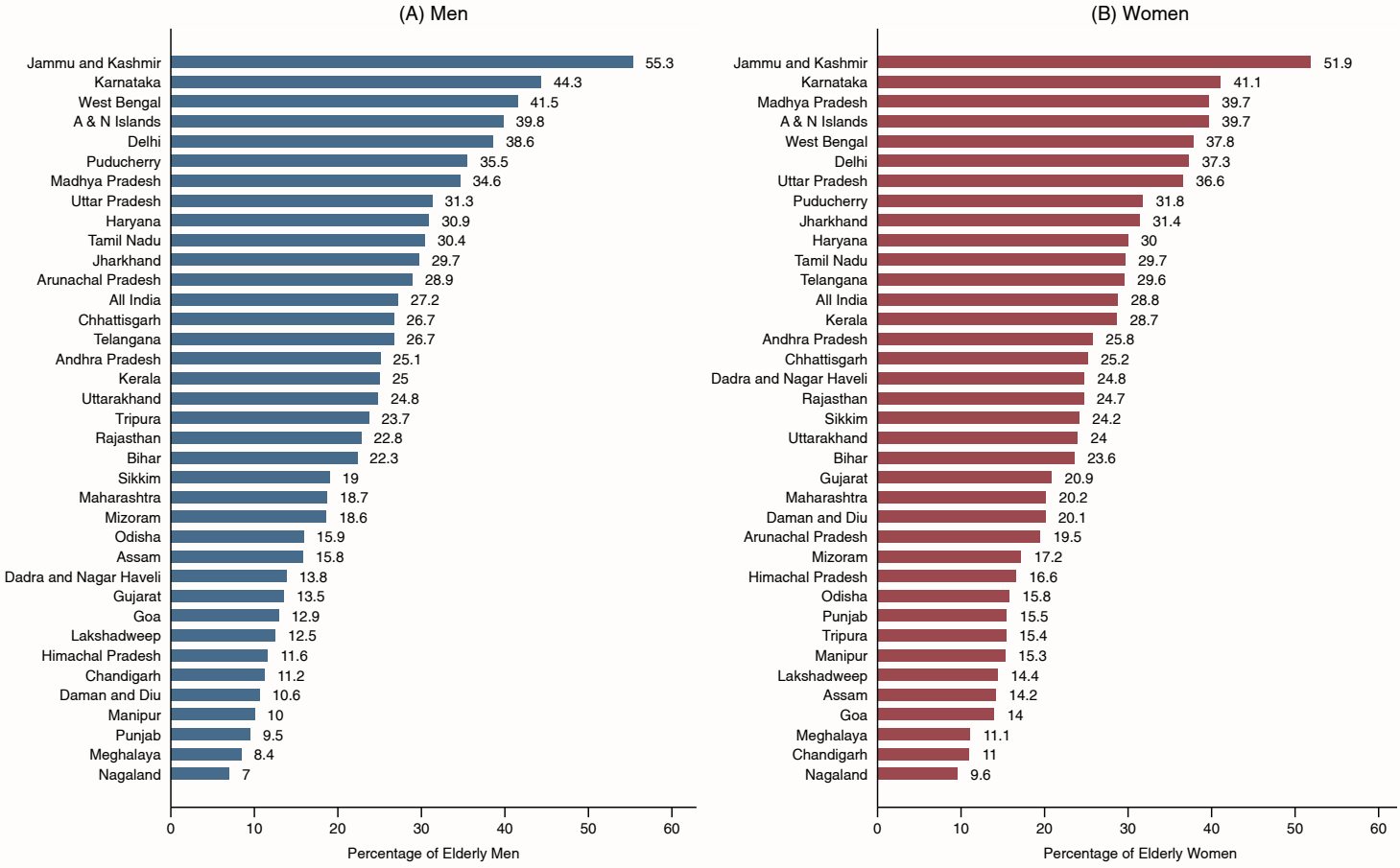
Note: ADL/IADL limitations include dressing, walking, bathing, eating, getting in or out of bed, using the toilet, cooking and serving, shopping making calls, taking medication, housework, managing money, finding address. Elderly include individuals aged 60 years of above.

In contrast, states like Punjab show relatively lower rates of multi-ADL limitations (17.0% for men and 24.1% for women), which may be attributed to better nutritional status and healthcare access throughout the life course. The profound gender disparity in multi-ADL limitations is consistent across all states, with women consistently showing a higher prevalence of substantial care needs. Thus, women, while living longer, often do so with a greater burden of chronic disease and a longer period of dependency. These patterns indicate the need for expanded formal care systems to supplement traditional family-based support that can provide affordable and accessible care to the millions of elderly individuals with substantial care needs.

2.2.4. Health Seeking Behaviour

Preventive health checkups are not popular among the Indian elderly. Elderly women (28.2%) have a slightly higher preference for preventive checkups than elderly men (27.2%) There is an overall low utilisation of preventive checkups, with only under 30% of elderly Indians undergoing them regularly, despite the critical importance of early screening for managing chronic diseases and maintaining functional independence (Figure 2.7). Reaching 80% preventive care coverage requires scaling services 7-fold. This low uptake could be due to healthcare systems that are predominantly oriented toward acute, episodic care rather than proactive health maintenance. While some states show slightly higher utilisation, the overall numbers are consistently low. For example, Jammu and Kashmir has the highest rate of preventive checkups at 55.3%, followed by Karnataka and West Bengal. Other states, such as Nagaland, Chandigarh and Meghalaya show much lower rates of preventive checkups. The lack of health insurance, as a primary barrier to access, is the key factor limiting the uptake of these services, particularly for the poorest populations. This pattern of under-prioritization of preventive care is not unique to India but is a challenge faced by many developing nations. International frameworks and global reports highlight that progress towards universal health coverage is faltering, and out-of-pocket health spending is pushing vulnerable populations into poverty, a trend particularly affecting those in poorer households and with older family members.

Figure 2.7: Preventive checkups (%) among the elderly across states, India, LASI, 2017-18



Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

Note: Figure represents percentage of elderly who visited healthcare facility for a preventive checkup. Elderly include individuals aged 60 years or above.

2.3 Healthcare Access and System Preparedness

2.3.1 Barriers to Healthcare Access

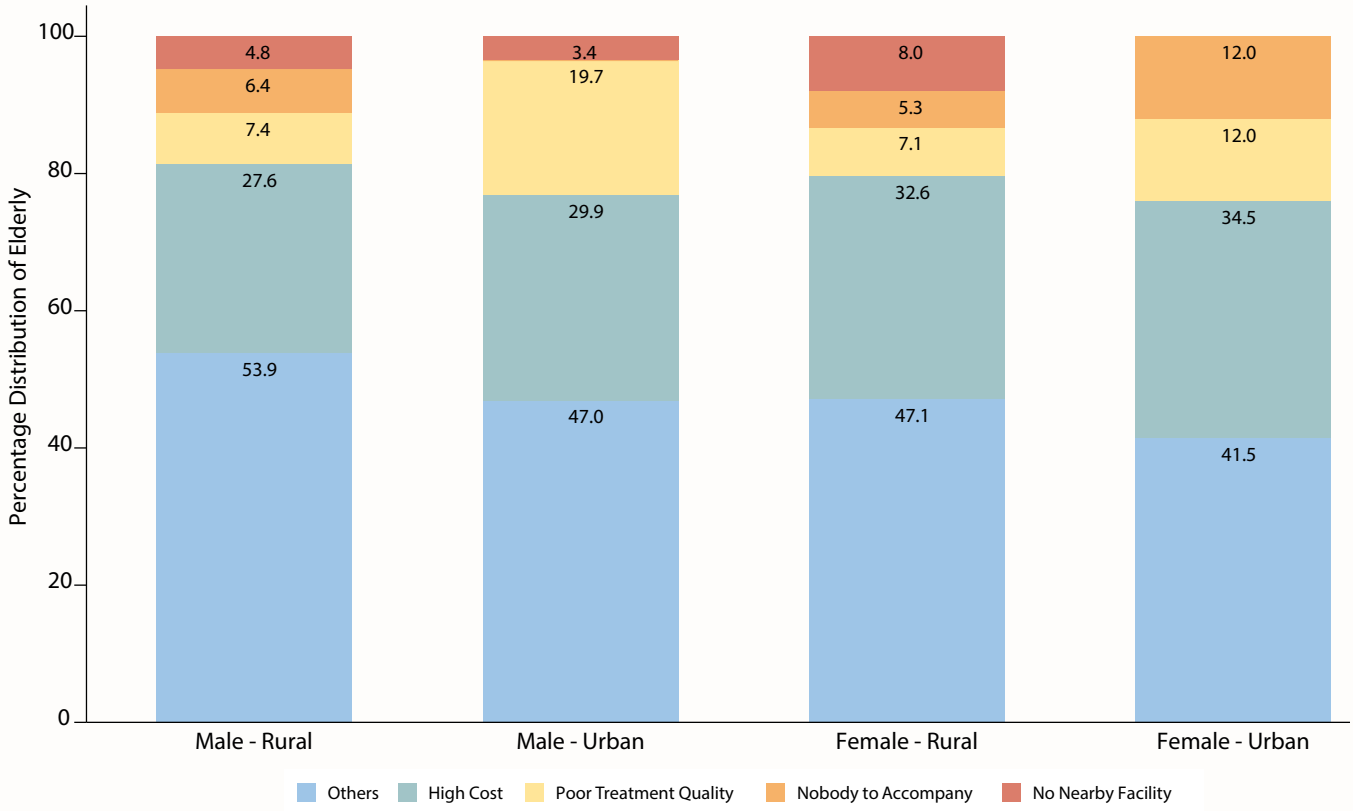
High Treatment cost is the most reported barrier to healthcare access by the Indian elderly. Overall, 53.9% and 47.0% of male elderly people pointed to high treatment cost as the most important reason for non-utilisation of healthcare services (Figure 2.8). In less economically developed states, particularly in rural areas, the primary barrier to healthcare access is financial. In Jharkhand, 84.7% of rural men cite "High Cost" as a primary barrier, while in Assam the figure stands at 76.1%. These figures demonstrate a healthcare system where basic access remains the main challenge, with cost acting as an insurmountable obstacle for large proportions of the elderly population. This concentration of cost barriers indicates inadequate social protection coverage and significant gaps in providing affordable care options.

In more economically advanced states, a different pattern emerges. In rural Tamil Nadu, a lower percentage of men cite cost as a barrier, while 51.3% report "Poor Treatment Quality" as a significant impediment. This indicates a paradoxical shift, like healthcare challenges; as basic access improves, quality concerns become more prominent. This transition suggests that populations with greater health literacy and access become more discerning, demanding not just the availability of care but its effectiveness and appropriateness. For policymakers, this means that the focus must evolve from simply increasing the number of facilities to ensuring the quality of care they provide.

The gender-specific barrier of "Nobody to Accompany" is a significant factor, especially for rural women. This seemingly minor barrier is a reflection of deep-seated social norms that restrict an elderly woman's autonomy and mobility, making her dependent on family members to seek medical care. This barrier, combined with the general gender disparity in health outcomes, underscores the need for policies that are not only financially and geographically accessible but also culturally sensitive and designed to empower elderly women.

Historically, India has relied on informal, family-based care, but as family structures change, this traditional support system is eroding. The research shows that a strong association exists between social support and poor health outcomes among the elderly.[13,14] This is where India's

Figure 2.8: Healthcare access barriers (%) among the elderly by sex and place of residence, India, LASI, 2017-18



Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i
Note: Figure represents elderly who did not visit healthcare facility in the past one year. 'Others' includes "Needed to work", "Didn't want to give up a day's work", "Family member(s) decided it wasn't required", and "Other". Elderly include individuals aged 60 years or above.

trajectory diverges sharply from other rapidly ageing Asian nations like Japan and South Korea, which faced similar demographic challenges but have successfully transitioned to comprehensive, state-supported long-term care systems. While private care providers are emerging in India's urban centers, they remain largely inaccessible to the majority of the population due to cost, leaving a massive care gap for the millions of elderly individuals with high-dependency needs. The findings warrant a timely call to action, demanding a more proactive, publicly supported system that can provide affordable and accessible care to the vulnerable elderly individuals.

2.3.2. Healthcare Utilisation

About 50% of elderly with no healthcare utilisation belong to the bottom two MPCE quintiles (Figure 2.9). The non-utilisation of healthcare by the poorest segments of the population masks a larger, invisible crisis of delayed care. Chronic, progressive conditions will inevitably advance to more severe, debilitating, and ultimately more expensive stages, leading to increased functional decline and greater dependency on an already overwhelmed care system. Literature consistently shows that low socioeconomic status and financial insecurity increase vulnerability to poor health and psychological distress, not just in India but even in developed nations like the United States.[15]

2.3.3. Healthcare Workforce and Infrastructure

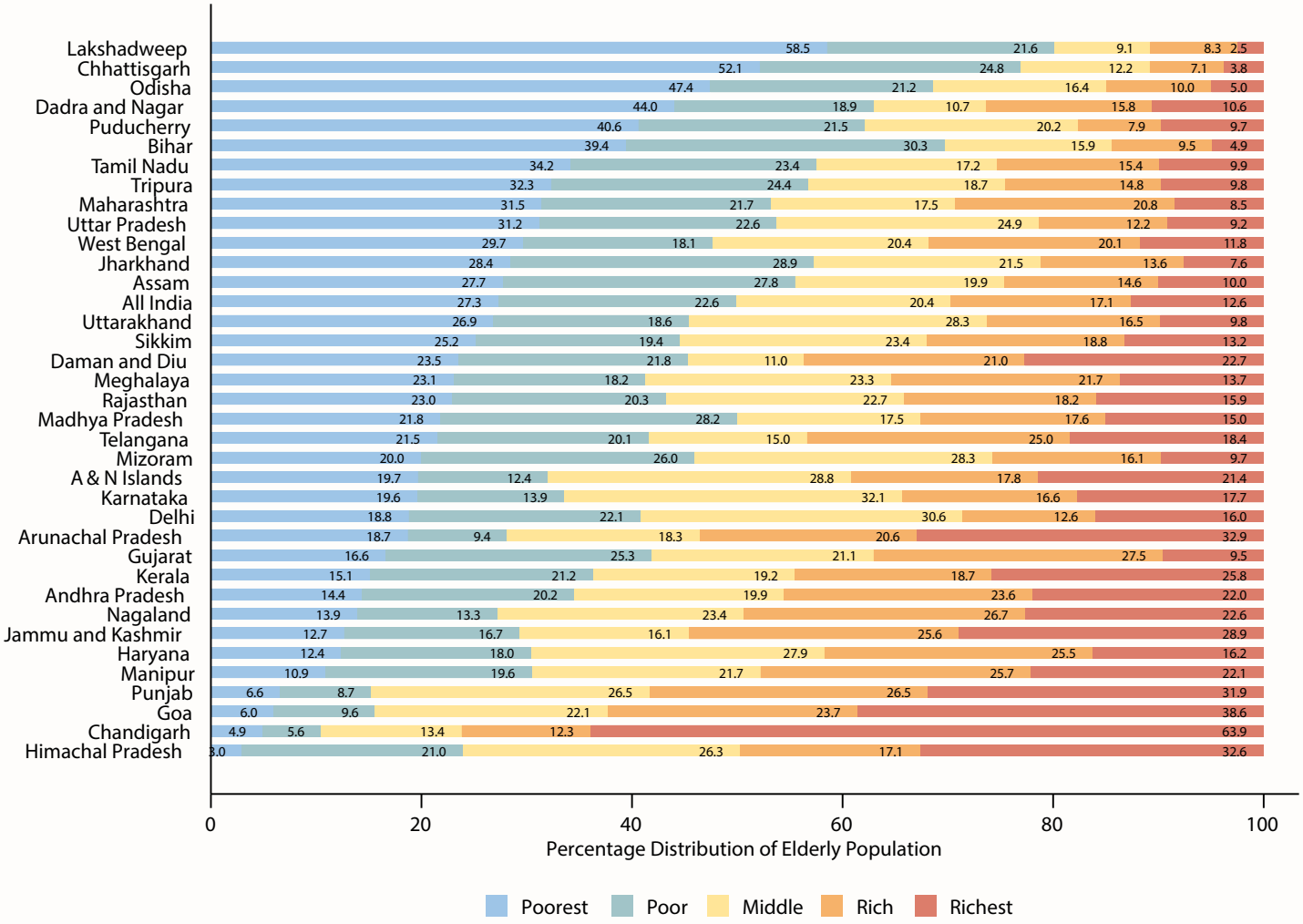
Timely policy attention to increase specialized geriatric care is the fundamental need of the hour. According to the UK Royal College of Physicians, which advises one geriatrician for every 50,000 people, India's ageing population in 2020 would have required 27,600 specialists. Despite these massive requirements, India currently has only a few hundred practicing geriatricians. This shortage extends beyond absolute numbers to geographic distribution, with most specialists concentrated in urban areas and affluent regions. The nursing shortage compounds healthcare workforce inadequacy. India's nurse-to-population ratio of 1:670 falls well below WHO recommendations of 1:300,[16] with the situation further deteriorated by migration of trained nurses to developed countries offering better compensation and working conditions. For geriatric care specifically, the shortage is even more acute as few nurses receive specialized training in elderly care needs, chronic disease management, or end-of-life care.

Healthcare infrastructure needs to be adequately adapted for elderly care needs. Healthcare facilities have to ensure age-friendly design features, specialized equipment for elderly patients, or integrated care models addressing multiple chronic conditions simultaneously. The predominant acute care orientation of healthcare systems poorly serves elderly populations who require ongoing chronic disease management, preventive care, and coordinated services across multiple specialties.

2.4. Policy Directions for Healthy Ageing in India

Affordable healthcare access, and promoting life-long healthy routines (balanced diet, physical activity, routine preventive checkup are instrumental to healthy ageing in India. It is high time for India to ensure Universal Health Coverage (UHC) as a top health system-level priority, extending all essential healthcare services to the elderly from all population subgroups, particularly from socioeconomically vulnerable backgrounds. India must shift from its fragmented approach to a proactive, integrated, and publicly supported system. This requires establishing robust social insurance programs, including a comprehensive long-term care framework, that are accessible and affordable to all populations, not just the affluent urban segments. In this regard, "AB-PMJAY (Ayushman Bharat - Mantri Jan Aarogya Yojana)" by the Government of India (GOI) deserves applause for its coverage target of providing health insurance coverage of INR 15 Lakh to approximately 10.7 crores poor and vulnerable families. While the program provides cashless treatment facilities across a wide range of network facilities (through digital mode), several issues, such as low private sector participation, awareness and outreach, infrastructural gaps, and fraud (misuse), remain big concerns. Further, flagship GOI programs like the "National Program for Healthcare for the Elderly (NPHCE)" have placed dedicated geriatric OPD and care services in district hospitals (CHCs and PHCs), focusing on preventive, curative, and rehabilitative services. However, concerns regarding inadequate infrastructure, substandard quality, and low uptake need to be addressed in mission mode. Finally, lessons from state-specific insurance programs like Tamil Nadu CM's Comprehensive Health Insurance Scheme (Tamil Nadu), *Mahatma Jyotiba Phule Jan Arogya Yojana* (MJPJAY, Maharashtra) can be learned to improve healthcare utilisation uptake. Finally, it is imperative to

Figure 2.9: Distribution of the elderly with no healthcare utilisation by MPCE quintile across states, India, LASI, 2017-18



Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

Note: No healthcare use is defined as the percentage of people who have not visited any healthcare facility in the past 12 months.

promote healthy lifestyle practices among young and older adults to promote healthy ageing in the upcoming decades. This would not only mitigate the substantial burden on families but would also lower the economic burden on the public sector for providing healthcare to the elderly Indians with high-dependency needs.

Improving Primary healthcare points and diagnostic facilities can effectively manage the burden of NCDs among the Indian elderly. Expanding infrastructure in rural areas is particularly critical, as reported lower rates of NCDs often reflect underdiagnosis rather than actual low prevalence, masking the true scale of the problem. While the government had operationalized 150,000 Health and Wellness Centres under the *Ayushman Bharat* to broaden the reach of primary care, inconsistencies in the quality and availability of diagnostic services and trained personnel have notably limited its impact. Investing in better-equipped PHCs and mobile diagnostic units is an essential step to ensure timely detection, especially among hard-to-reach populations that remain outside the formal care net.

Mental healthcare services should be linked to the primary healthcare facilities, especially in rural India. Although the government launched the National Mental Health Programme (NMHP) in 1982 (now the District Mental Health Programme (DMHP)), the treatment gap for mental disorders in India exceeds 60%.[17] This alarming mismatch between requirement and service delivery is compounded by persistent stigma in rural areas where awareness and access are weakest. Integrating community-based screening and counselling services could normalize help-seeking,

reduce social barriers, and ensure support for resilient ageing trajectories.

Technology-based solutions are key to increasing healthcare utilisation uptake. Digital innovations can notably improve healthcare access by enabling rapid screening and effective treatments. For instance, AI-powered computer-aided detection (AI-CAD) software has transformed Tuberculosis (TB) screening, reducing the time taken for detection to mere seconds. Similarly, telemedicine platforms such as the *eSanjeevani*, launched under the Ministry of Health and Family Welfare, have opened avenues for expanding digital healthcare. However, improving digital literacy among the elderly and making technology-based solutions more affordable and accessible is key. Equally important is recognizing that technology must complement but not replace the healthcare workforce.

Explicitly targeted policy interventions are required for the healthcare needs of older women to address the gender gaps. Having spent much of their time as primary caregivers, elderly women in India bear a distinct disadvantage in later life. Higher survival rates relative to men, along with a greater likelihood of widowhood, leave many navigating old age without spousal or institutional support. Their tendency to neglect personal healthcare needs renders them especially vulnerable to illness and unmet care. Targeted policy interventions and gender-sensitive healthcare services by partnering with self-help groups, women's collectives, and local governance bodies could provide a safe environment and actively encourage health-seeking behaviour among elderly women.

Promoting formal nursing, ambulatory, and support care is essential for the elderly with functional impairment and is also crucial to the mental health of caregivers. Changing family structures have reduced the sustainability of household-based caregiving, worsening the burden of the elderly with care requirements as well as their caregivers. While the Integrated Programme for Senior Citizens (IPSrC) has expanded the coverage of old-age homes and day-care centres, coverage remains limited to urban pockets, providing only shelter rather than skilled support. More systematic efforts towards geriatric nursing in terms of formal nursing, ambulatory services, and home-care services could notably reduce the dependence on overburdened families in the backdrop of declining informal care systems.

Timely Efforts beyond healthcare delivery services are critical for healthy ageing in India. Beyond healthcare delivery, preventive strategies targeting lifestyle and behavioural risk factors are crucial for healthy ageing. Global as well as Indian evidence points towards dietary patterns, physical activity, avoidance of tobacco and alcohol consumption as key elements that delay the onset of illness and disability. This highlights the importance of recognizing that these aspects need policy attention. National initiatives like the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases, and Stroke (NPCDCS) address risk factor screening but often lack systematic follow-up and community-based health promotion. Behavioural nudges to reduce risky habits, nutrition education tailored to the elderly, and investments in elder-friendly community infrastructure that promotes physical activity could, at a policy level, generate meaningful improvements in healthy ageing.

2.5 Conclusion

The future of healthy ageing in India warrants a shift from fragmented efforts to a systematic approach integrating curative, preventive, and supportive care. Strengthening primary healthcare, mental health support, and digital innovations with gender-sensitive services and formal caregiving systems are central. Preventive strategies to curb lifestyle risks and promote active ageing, alongside pensions and insurance, are essential to secure dignity, independence, and healthy ageing.

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03 Chapter
Work, Retirement, and Economic Security

3.1 Labor Market of Older People in India

The rate at which older people participate in the labour market in India shows considerable diversity due to differences in factors such as rural versus urban location, educational attainment, health status, gender, and the type of work available.[1] In rural areas, a larger share of older adults continues to work in agriculture and informal sectors out of necessity, as social security coverage is limited.[2] In contrast, urban areas offer more formal employment but also have higher retirement rates due to structured pension systems and age-related health issues. Additionally, men are more likely to remain in the workforce compared to women.[3] Economic necessity, lack of pensions, health constraints, and societal expectations all contribute to this varied participation across different groups.[4]

3.1.1 Overview of Workforce Participation by Gender

Labour force participation is higher among the 50–60 age group and declines sharply for those aged 60 and above. Labour force participation is significantly higher among the 50–60 age group, around 90% for men and 45% for women, while it declines sharply for those aged 60 and above **(Figure 3.1).** The data clearly shows that older adults tend to withdraw from work as they age. For men, participation falls to around 50% or lower after 60, while women's participation drops even more steeply, to 14%. This decline reflects a combination of health issues, societal expectations, and limited opportunities in later life. The sharp fall suggests the absence of supportive policies to encourage productive engagement and the need for financial security mechanisms to sustain livelihoods post-retirement.

Male participation remains relatively high in certain states, suggesting economic necessity or informal work opportunities. Male participation remains relatively high in states like Himachal Pradesh (70.6% even above 60%), Bihar (53.9%), and Madhya Pradesh (nearly 56.2%), suggesting economic dependence on continued work or informal employment. In states with weaker formal pension coverage, older men are compelled to remain active in the labour market. These regions highlight the urgent need for pension reforms, skill development, and rural employment schemes that can provide older adults with viable alternatives to physically demanding work.

Southern states show lower participation among older males. Southern states like Tamil Nadu (42.4% for men above 60) and Karnataka (37%), and Haryana (around 30.8%) show much lower participation among older males, likely due to better pension coverage and healthcare services. States with stronger governance and welfare systems enable older men to retire earlier without financial hardship. The data indicate that participation rates among men above 60 in these states are significantly lower.

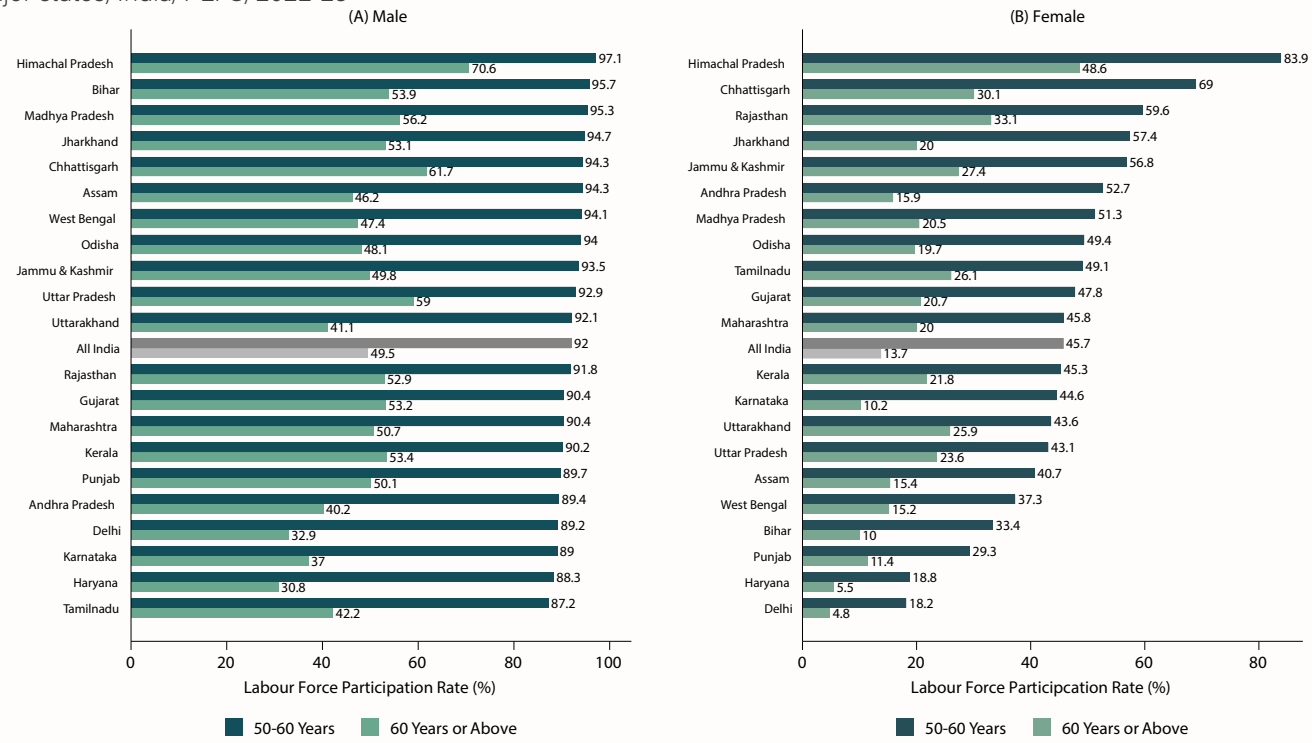
Female participation rates are much lower compared to those of males. Female participation rates are much lower across all states, with participation generally below 30% after age 60, except in Himachal Pradesh (47%), where participation is comparatively higher. Older women face structural barriers that limit their ability to participate in the workforce. In most states, women's participation after 60 drops, highlighting severe exclusion. However, Himachal Pradesh, Rajasthan, and Chhattisgarh are notable outliers, suggesting that local work environments, rural employment options, or community-based roles may encourage female engagement. These examples point to the need for policies that specifically address gender-based constraints and provide opportunities tailored to women's capabilities. States like Delhi (around 3–5% for women above 60) and Haryana (about 5%) show very low participation among elderly women, indicating social constraints, caregiving roles, and limited employment avenues.

3.1.2 Trends by Age

Employment rate by age group across different states in India, separately for males and females **(Figure 3.2).** Across all states, the employment rate follows a similar pattern, rising steadily from the 15–19 age group, peaking around the 30–49 age group, and declining thereafter for the 50–59 and 60+ age groups.

Age-wise trend in LFPR has an inverted U shape. Across all states, employment rates follow a consistent pattern by age group. For males, employment starts from about 40–50% in the 15–19 age group, rises sharply to 80–95% in the 30–49 age group, and then declines to 50–70% after 50, falling further in the 60+ age group to 20–40%. For females, participation starts much lower, often around 10–20% in the 15–19 age group, peaks at 30–40% in the 30–49 age group, and drops to 5–15% after 50, reaching single digits (3–10%) in the 60+ age group. This life-cycle pattern reflects the role of age in influencing economic activity, with health, retirement norms, and social expectations playing a significant role in reducing participation at later ages.

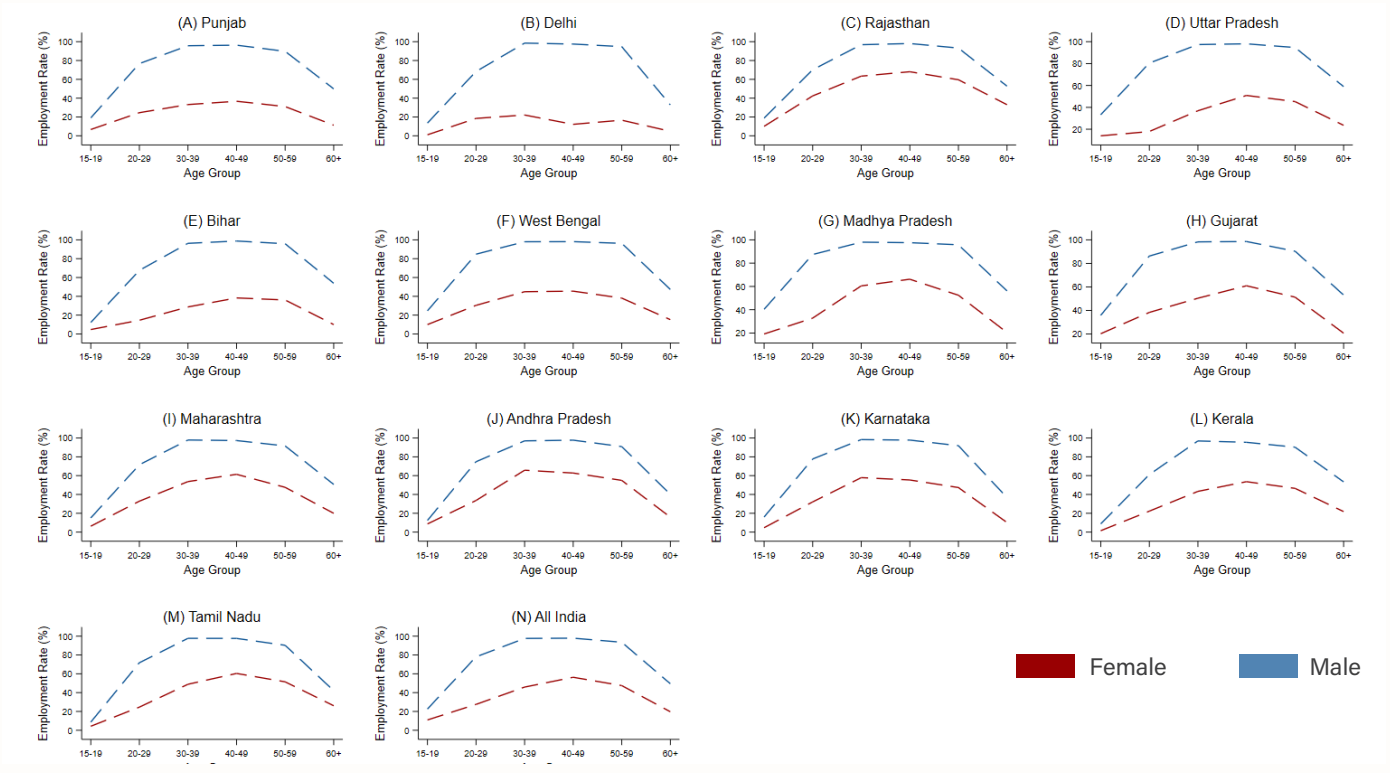
Figure 3.1: Labour force participation rate (%) among individuals aged 50 years or above by age group and by sex across major states, India, PLFS, 2022-23



Source: Periodic Labour Force Survey 2022-23 https://www.mospi.gov.in/publication/annual-report-periodic-labour-force-survey-plfs-july-2022-june-2023

Note: Labour Force Participation Rate, defined as percentage of persons employed and seeking employment in the total population.

Figure 3.2: Worker population ratio (%) among individuals aged 15 years or above by age and sex across major states, India, 2022-23



Source: Periodic Labour Force Survey 2022-23 https://www.mospi.gov.in/publication/annual-report-periodic-labour-force-survey-plfs-july-2022-june-2023

Note: WPR – Worker Population Ratio, defined as the percentage of persons employed in the total population.

Table 3.1: Share of employment (%) for individuals aged between 20 and 80 years by sector and age groups for major States, India, LASI, 2017-18

State	Agriculture, forestry, & mining	Manufacturing	Other Industries	Other services	Public Services	Real estate & other business activities	Transportation, IT, & finance	Wholesale & retail trade
20 to 39 years								
Andhra Pradesh	45.4	2.7	3.0	1.5	0.8	2.2	0.0	3.1
Assam	24.6	2.7	5.7	3.5	0.0	0.0	0.0	1.1
Bihar	18.9	0.0	3.6	4.3	0.0	3.0	0.0	1.5
Chhattisgarh	30.6	4.2	0.0	8.0	0.0	1.5	0.0	0.0
Delhi	1.4	0.0	9.5	1.8	0.0	0.0	0.0	1.6
Gujarat	29.8	8.4	21.4	3.5	0.0	0.0	0.0	6.0
Haryana	13.7	0.0	12.8	0.0	0.0	3.7	0.0	3.7
Himachal Pradesh	51.4	7.1	0.0	0.0	0.0	3.4	0.0	4.3
Jammu & Kashmir	0.0	0.0	6.3	0.0	0.0	0.0	0.0	0.0
Jharkhand	28.0	1.0	6.8	1.0	0.0	2.2	0.0	3.4
Karnataka	33.5	3.8	43.7	1.4	0.0	0.0	0.7	1.9
Kerala	0.0	0.7	12.3	1.9	0.0	1.9	0.0	3.8
Madhya Pradesh	12.8	0.0	3.1	1.6	14.9	0.0	0.0	6.3
Maharashtra	43.6	2.1	5.3	9.8	3.3	0.3	0.0	5.3
Odisha	24.4	0.8	5.0	3.2	0.0	2.5	0.0	0.0
Punjab	10.9	0.0	4.7	5.2	0.0	0.0	0.0	1.8
Rajasthan	25.4	5.0	3.6	8.6	0.0	4.6	0.0	0.0
Tamil Nadu	28.0	7.3	4.9	3.4	0.0	4.6	0.0	9.3
Uttar Pradesh	12.1	0.6	6.4	2.8	0.0	0.0	2.1	0.0
Uttarakhand	20.6	0.0	0.0	0.0	0.0	3.7	0.0	0.0
West Bengal	10.0	5.6	5.8	8.8	0.0	2.6	0.6	6.2
All India	25.6	3.4	11.9	4.5	1.2	1.4	0.3	3.8
40 to 59 years								
Andhra Pradesh	40.8	3.0	5.6	4.3	1.8	5.3	2.8	4.5
Assam	28.9	4.9	11.8	4.6	0.6	3.2	1.5	4.8
Bihar	32.8	1.6	5.5	5.6	1.4	2.9	0.9	5.8
Chhattisgarh	51.5	0.7	9.8	2.4	0.9	5.2	1.2	2.6
Delhi	0.0	4.8	12.8	7.6	2.9	6.3	5.9	8.9
Gujarat	34.1	4.7	9.4	4.1	1.6	1.9	3.4	5.0
Haryana	24.5	2.5	9.2	2.7	1.3	4.9	2.4	3.7
Himachal Pradesh	52.0	1.5	8.3	3.1	3.4	3.6	1.3	1.4
Jammu & Kashmir	8.7	2.4	7.3	0.4	1.3	2.9	2.9	5.0
Jharkhand	36.1	2.7	6.2	6.4	0.6	4.7	1.3	4.5
Karnataka	24.3	2.5	17.8	3.4	7.7	2.7	3.1	3.4
Kerala	6.1	3.0	9.3	4.9	1.3	5.4	7.7	4.1

State	Agriculture, forestry, & mining	Manufacturing	Other Industries	Other services	Public Services	Real estate & other business activities	Transportation, IT, & finance	Wholesale & retail trade
40 to 59 years								
Madhya Pradesh	36.4	1.6	5.5	6.7	2.1	6.4	1.9	4.4
Maharashtra	42.5	4.2	8.7	3.9	1.3	2.3	3.3	5.5
Odisha	41.6	1.2	7.0	2.7	0.7	4.5	1.3	4.0
Punjab	16.0	2.3	7.4	2.6	1.2	5.7	1.7	3.9
Rajasthan	38.0	2.3	8.3	2.8	0.7	5.0	2.0	5.1
Tamil Nadu	35.6	3.1	6.7	6.3	1.4	5.2	3.3	7.0
Uttar Pradesh	34.6	1.4	8.9	3.0	0.9	2.9	1.9	2.6
Uttarakhand	22.8	2.1	10.1	7.4	1.9	4.5	3.8	4.0
West Bengal	23.6	3.9	7.1	6.1	0.8	3.5	3.7	9.0
All India	33.1	2.8	8.8	4.4	1.9	3.8	2.6	5.0
60 to 79 years								
Andhra Pradesh	32.5	1.5	3.6	3.3	0.6	3.6	1.2	2.6
Assam	19.4	1.3	3.1	4.5	0.2	0.8	0.2	2.9
Bihar	27.5	0.6	2.8	2.2	0.2	1.5	0.5	3.1
Chhattisgarh	32.1	0.5	3.1	1.8	0.3	0.9	0.5	2.0
Delhi	0.1	1.8	5.5	3.3	0.9	1.7	2.5	6.7
Gujarat	20.9	2.0	6.1	1.9	1.5	0.4	1.2	4.4
Haryana	12.2	0.7	2.5	0.5	0.4	2.2	0.1	2.8
Himachal Pradesh	35.9	0.8	2.2	1.5	0.3	1.4	0.1	2.3
Jammu & Kashmir	8.2	1.8	1.5	0.6	0.1	1.7	0.6	2.2
Jharkhand	31.1	0.8	1.9	2.2	0.3	2.2	0.7	2.7
Karnataka	30.8	0.8	4.1	1.2	0.2	0.5	1.2	2.2
Kerala	6.1	1.1	4.4	1.9	0.2	2.7	1.7	4.9
Madhya Pradesh	27.3	0.5	2.8	1.9	0.5	4.7	0.4	1.7
Maharashtra	30.6	1.2	3.3	2.6	0.5	0.4	2.0	3.3
Odisha	31.2	0.2	3.1	1.1	0.2	1.1	0.6	3.1
Punjab	11.1	1.0	2.6	1.7	0.6	2.4	0.5	2.0
Rajasthan	25.5	0.8	3.6	1.6	0.3	2.5	0.2	1.9
Tamil Nadu	26.2	2.1	3.7	3.6	1.0	1.9	1.0	5.0
Uttar Pradesh	24.7	0.4	4.3	1.6	0.4	1.3	0.3	3.1
Uttarakhand	20.1	0.8	3.5	2.6	0.1	1.8	0.5	2.3
West Bengal	19.2	2.4	3.1	2.9	0.5	1.6	0.9	6.7
All India	**25.5**	**1.1**	**3.5**	**2.1**	**0.5**	**1.6**	**0.8**	**3.3**

Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

High male employment states- In states such as Punjab, Rajasthan, Uttar Pradesh, and Bihar, male employment rates are consistently high. For instance, in Punjab, about 95% of men in the 30–49 age group are employed, and even in the 60+ group, more than 50% continue working. Similarly, Bihar and Uttar Pradesh record male participation above 80% in prime working years and around 30–40% after age 60. This suggests limited retirement benefits and greater reliance on continued work for economic survival, especially in rural or agrarian areas.

Low female participation states- In contrast, states like Delhi, Maharashtra, and Karnataka report some of the lowest female employment rates. For example, in Delhi, female participation rarely exceeds 20%, even at peak ages, and drops to below 5% after age 60. Maharashtra and Karnataka also show female rates around 20–30% in the 30–49 group, falling to 10% or lower for those above 60.

Moderate participation states- States like Kerala and Tamil Nadu exhibit moderate employment trends. In Kerala, male employment peaks at 85–90%, but female participation in the same age group is around 30–35%, declining to 10–15% after age 60. Tamil Nadu shows a similar pattern, with female participation peaking at 25–30% before dropping below 10% in later years. These states benefit from better education and healthcare, but still face gender disparities.

Age-related decline across all states is not uniform. The decline in employment is universal across states and genders, but the extent varies; however, the gap narrows considerably for those 60 years and above. In Punjab, male employment drops from 95% at age 30–49 to around 55–60% at 60+, a fall of nearly 40 percentage points. Female participation in the same state drops from 30–35% to 10% or lower. In Delhi, the decline is sharper, with male employment falling from 80% to about 40%, while female participation drops from 20% to less than 5%. This sharp decline signals health issues, family obligations, and retirement norms pushing older individuals out of the workforce, with women disproportionately affected.

3.1.3 Type of Employment

Agriculture, forestry, and mining are the primary sectors employing older adults across age groups, especially in rural states. Among the 20–39 years group, Andhra Pradesh (45.4%), Himachal Pradesh (51.4%), and Maharashtra (43.6%) have the highest share of workers in agriculture. For the 40–59 years group, Chhattisgarh (51.5%), Himachal Pradesh (52.0%), and Maharashtra (42.5%) continue to show heavy dependence on agriculture. Even in the 60–79 years group, older adults in Himachal Pradesh (35.9%), Andhra Pradesh (32.5%), and Odisha (31.2%) remain significantly engaged in agriculture.

Manufacturing plays a minor role across states and age groups, with most states reporting shares below 5%. In the 20–39 group, only Gujarat (8.4%), Tamil Nadu (7.3%), and Himachal Pradesh (7.1%) show slightly higher shares, while many states like Bihar, Punjab, and Delhi report 0% or near-zero participation. In the 40–59 group, Delhi (4.8%) and Gujarat (4.7%) lead, whereas Kerala (3.0%) and West Bengal (3.9%) remain moderate. Among the 60–79 group, participation is negligible across states, with Tamil Nadu (2.1%) and West Bengal (2.4%) reporting the highest shares. Manufacturing's low share reflects limited industrial employment opportunities for older workers, especially after age 60, and suggests a need for policies encouraging skill training and transition into lighter industries.

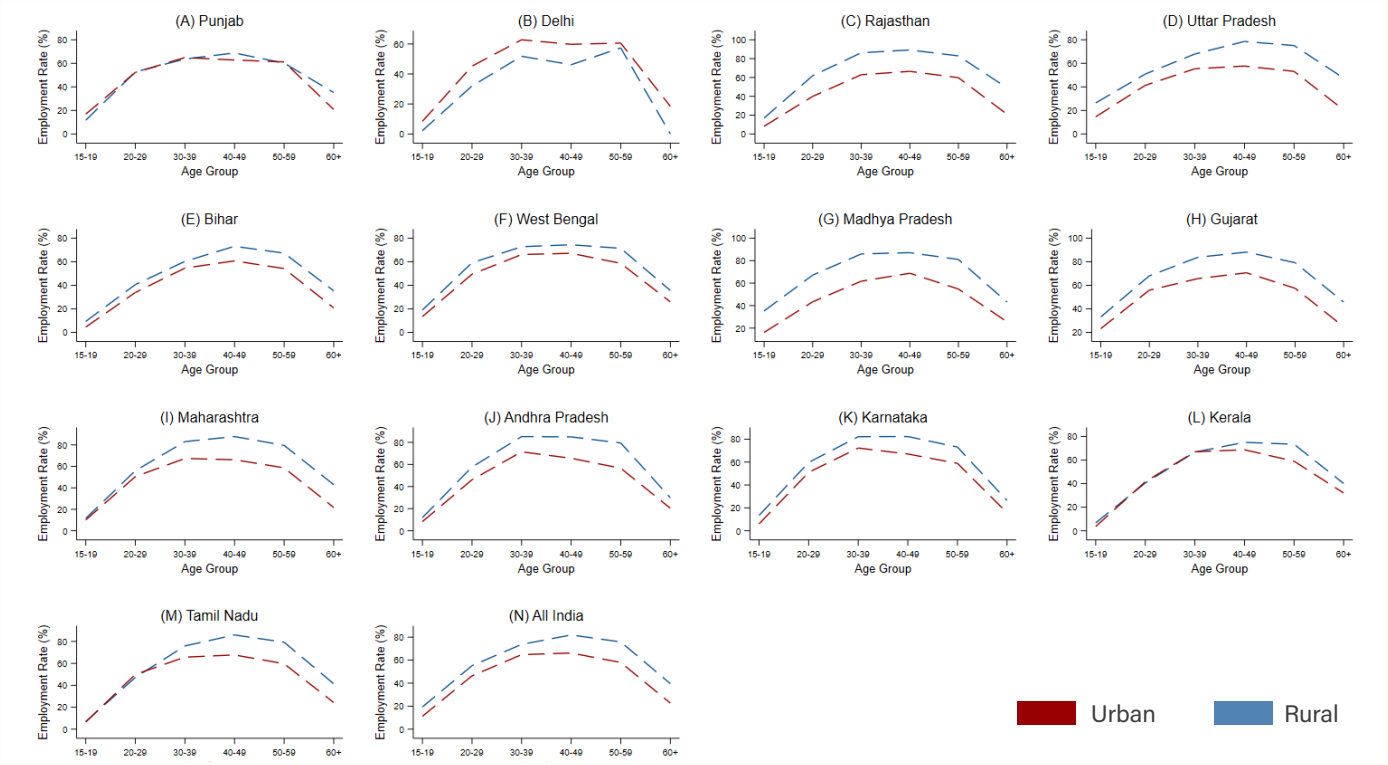
Sectors such as "other industries," "other services," and "wholesale and retail trade" show moderate participation, with some states leveraging these sectors more effectively. For the 20–39 group, Karnataka (43.7%) and Gujarat (21.4%) have the highest share in "other industries," while Maharashtra (9.8%), Rajasthan (8.6%), and West Bengal (8.8%) lead in "other services." Wholesale and retail trade has a moderate presence, with Tamil Nadu (9.3%), Delhi (1.6%), and Gujarat (6.0%) among the top contributors. Among the 40–59 group, the share of services remains moderate with Delhi (12.8%) and Karnataka (17.8%) in "other industries," and Kerala (7.7%) and Delhi (5.9%) in "transportation, IT, and finance." In the 60–79 group, service-sector participation drops sharply, though sectors like "wholesale and retail trade" remain relevant in states such as Delhi (6.7%), West Bengal (6.7%), and Kerala (4.9%), indicating that some older workers remain in small-scale service-oriented roles.

Public services and formal sectors like "real estate and business activities" and "transportation, IT, and finance" have minimal engagement with older adults. For the 20–39 group, public services hover around 0–2% in most states, with Madhya Pradesh (14.9%) as a rare exception. The 40–59 group shows some improvement in public services, notably Delhi (2.9%), Karnataka (7.7%), and Kerala (1.3%), but the overall contribution remains under 8%. In the 60–79 group, participation declines again, with most states reporting below 1% in public services.

3.1.4 Urban and Rural Differences

Figure 3.3 presents the work population ratio across different age groups in various states of India, comparing rural and urban populations. A clear and consistent pattern is visible across states: employment rises from the 15–19 age group, peaks around 30–49, and declines after age 50, particularly in the 60+ group. In states like Andhra Pradesh, Maharashtra, Rajasthan, Madhya Pradesh, and Gujarat, rural employment rates are significantly higher than urban rates across most age groups, with rural participation reaching 80–95% in prime working years and still remaining above 50% in older age groups. States like Delhi show lower rural employment compared to others. The All-India graph confirms this broader trend, with rural employment peaking near 85–90%, while urban employment is around 65–70%, declining sharply after age 50. In most states, the gap between rural and urban employment is small or nearly non-existent at younger ages, such as in the 15–19 and 20–29 age groups, where both rural and urban populations are equally engaged in work due to economic necessity, early entry into the workforce, and fewer retirement provisions. However, this gap widens with age, becoming most noticeable in the 50–59 and 60+ age groups.

Figure 3.3: Worker population ratio (%) among individuals aged 15 years and above by residence and age group across major states, India, PLFS 2022-23



Source: Periodic Labour Force Survey 2022-23 https://www.mospi.gov.in/publication/annual-report-periodic-labour-force-survey-plfs-july-2022-june-2023

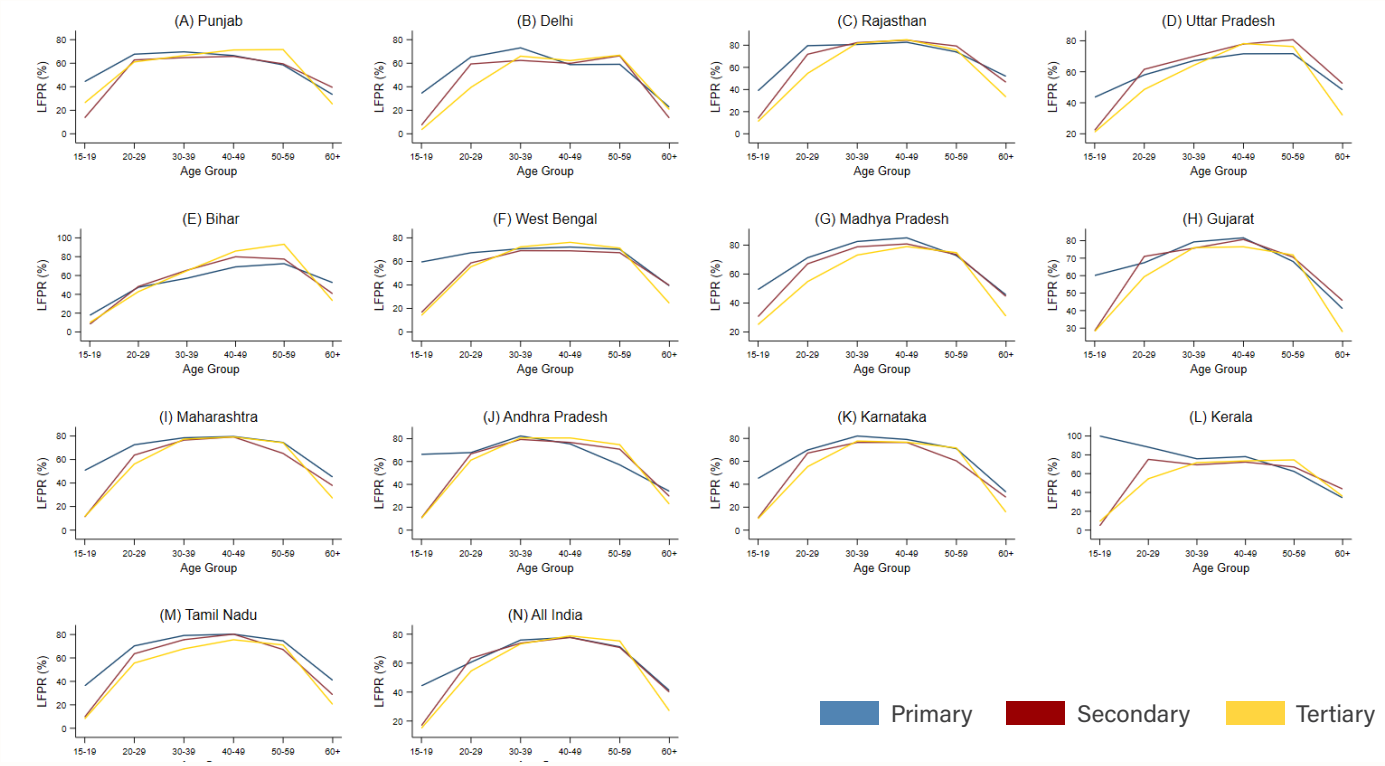
Note: WPR – Worker Population Ratio, defined as the percentage of persons employed in the total population.

3.1.5 Educational Differences

The graphs display the labour force participation rate (LFPR) by age group across states in India, with three different lines representing primary, secondary, and tertiary. Across most states, the LFPR shows a similar pattern: it increases from the 15–19 age group, peaks between 30–49 years, and declines after 50, especially in the 60+ category. A key observation is that in many states, the LFPR for the 15–19-year age group is higher in the primary sector.

In all states, the share of females who have post-secondary and higher education is substantially higher than male participation **(Figure 3.5).** In Karnataka, female participation is 79%, while male participation is 62.5%. Similarly, in Bihar, female with Post-Secondary and Higher Education is 80.5% compared to male participation at 58.6%. States with the highest female participation Rajasthan (83.4%), Bihar (80.5%), Chhattisgarh (80.3%), record the highest female who have post-secondary and higher education rates in the 45–60 age group. States with the lowest participation. In contrast, Kerala (29.8%), Himachal Pradesh (26.7%), Tripura (27.9%), and Punjab (39.4%) have the lowest female participation.

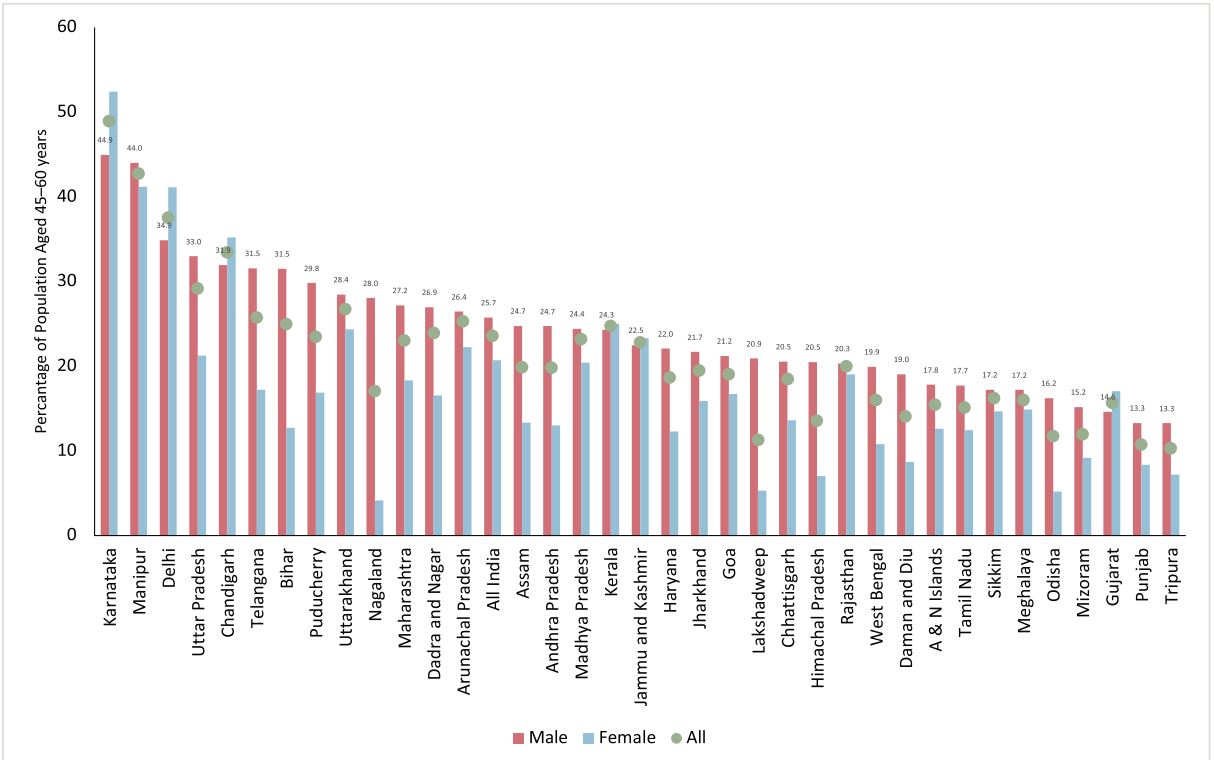
Figure 3.4: Labour force participation rate (%) among individuals aged 15 years or above by age group and educational attainment for major states, India, PLFS, 2022-23



Source: Periodic Labour Force Survey 2022-23 https://www.mospi.gov.in/publication/annual-report-periodic-labour-force-survey-plfs-july-2022-june-2023

Note: LFPR – Labour Force Participation Rate, defined as percentage of persons employed and unemployed in total population. ; 'Primary' includes 'below primary' and 'primary'; 'Secondary' includes 'middle' and 'secondary'; 'Higher' includes 'higher secondary', 'diploma/certificate course', 'graduate', and 'postgraduate and above'

Figure 3.5: Share of the population aged 45–60 years with post-secondary or higher education across major states, India, LASI, 2017-18

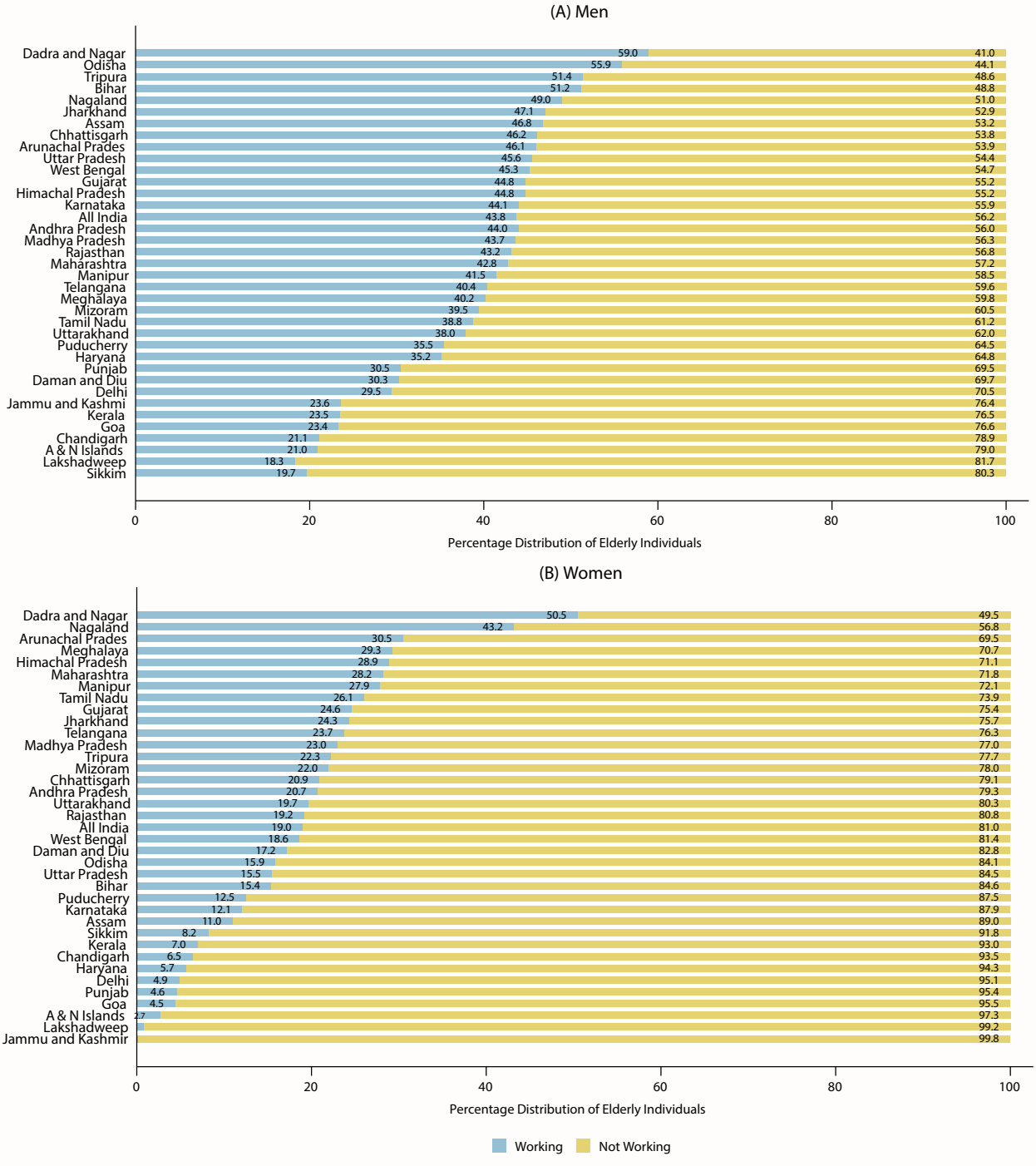


Source: Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai.

3.2 Work and Retirement Life of the Elderly in India

Figure 3.6 presents the percentage distribution of working status among the elderly population across different states in India. Almost 43.8% of the male elderly were reported to be currently working, whereas this number was much lower for female elderly (19.0%) in India. A higher proportion of male elderly were reported to be working in the states of Odisha (55.9%), Bihar (51.2%), Jharkhand (47.1%), Assam (46.9%), Chhattisgarh (46.2%), Uttar Pradesh (45.9%), West Bengal (45.3%), and Gujarat (44.8%). States like Sikkim (19.7%), Goa (23.4%), Kerala (23.5%), and Delhi (29.5%) reported a relatively lower proportion of elderly males working. State variation in the current working status of female elderly showed a different pattern. Most of the states had below 25% of currently working female elderly. States of Nagaland (43.2%), Arunachal Pradesh (30.5%), Meghalaya (29.3%), and Himachal Pradesh (28.9%) reported relatively higher proportions of elderly women currently working.

Figure 3.6: Distribution (%) of the elderly by current working status across states, India, LASI, 2017-18



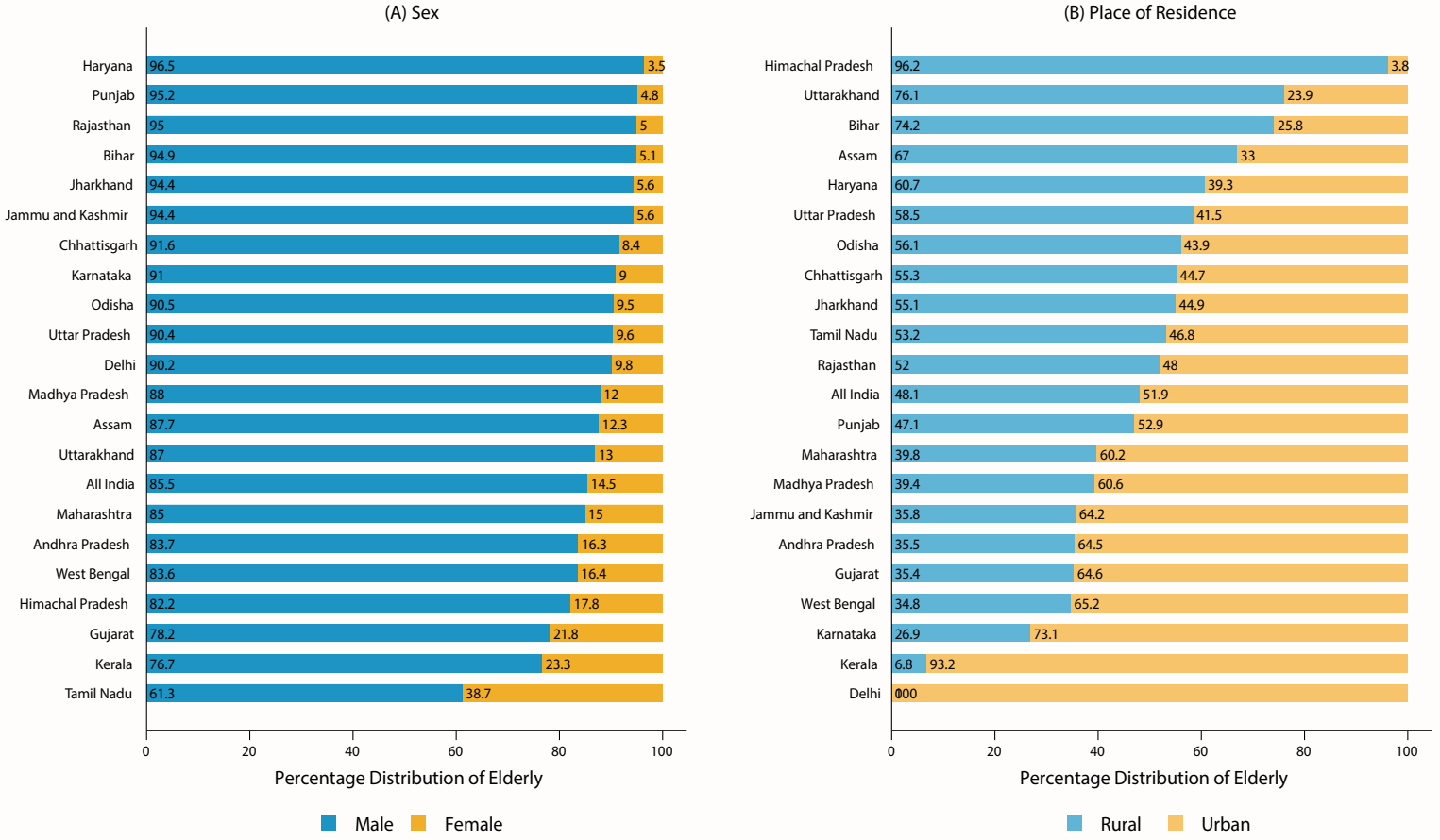
Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai.

Note: 'Working' refers to elderly percentage of elderly who have worked for at least 3 months in their lifetime and those who are currently working.

3.3 Economic Security

Figure 3.7 illustrates that, in most states, elderly males receive a higher share of pensions compared to elderly females. In Haryana (96.5% male), Punjab (95.2%), and Rajasthan (95%), pensions are overwhelmingly received by elderly men. In Tamil Nadu (61.3% male), a more skewed distribution for women is observed. At the all-India level, 85.5% of pensions are received by males, while only 14.5% go to females. Moreover, in states like Himachal Pradesh (96.2% rural), Uttarakhand (76.1% rural), and Bihar (74.2% rural), most pensions are being received by elderly individuals in rural areas. This reflects the rural concentration of elderly populations as well as possibly higher reliance on government support in rural regions. At the national level, pensions are fairly evenly distributed, with 48.1% of pensions going to rural elderly and 51.9% to urban elderly, though state-level disparities are significant.

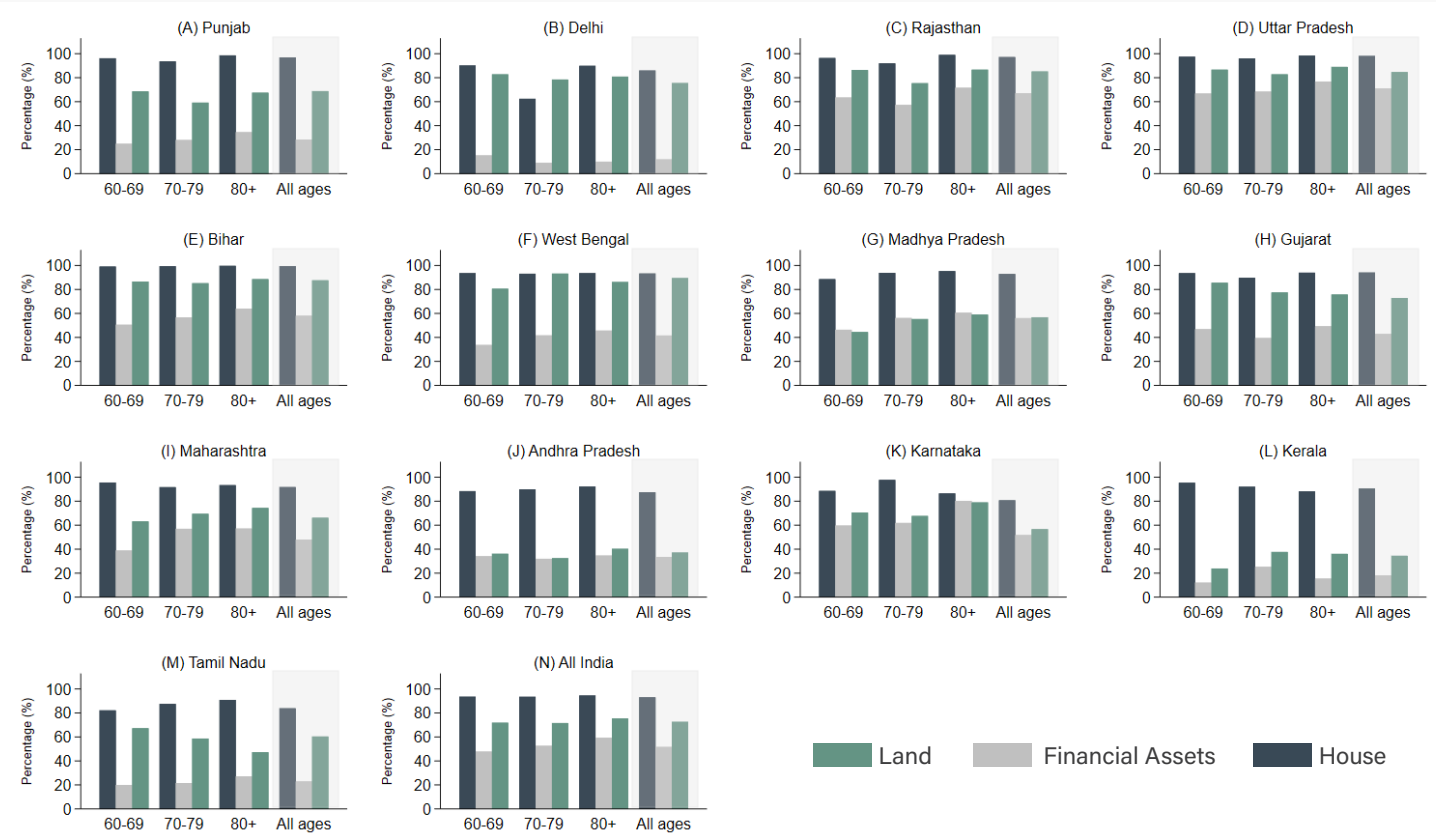
Figure 3.7: Distribution % of the elderly receiving pensions (currently/expected) by sex and residence across major states, India, LASI, 2017-18



Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai.

Figure 3.8 depicts the ownership of assets—land, financial assets, and housing—among elderly individuals across different age groups (60–69, 70–79, 80+) and for all ages combined, segmented by state. A striking observation across most states is that housing remains the most widely owned asset among the elderly. This suggests that homes form the primary source of security and stability for elderly individuals, irrespective of their age. Ownership of land shows greater variation across states. States such as Andhra Pradesh, Karnataka, Kerala and Tamil Nadu show relatively lower land ownership, reflecting urban lifestyles and limited agricultural involvement. Financial assets—such as savings, pensions, and investments—are less uniformly distributed. States like Delhi, Kerala, and Tamil Nadu show relatively lower ownership of financial assets. The All-India data confirms that while housing is the most common asset—owned by about 80–85% of elderly individuals—land ownership is present in about 50–55%, and financial assets are owned by roughly 30–40%, with variations across age groups.

Figure 3.8: Percentage of the elderly ownership of home, land, and financial assets across major states, India, LASI, 2017-18



Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai.

Note: Financial assets include savings accounts, postal accounts, certificates of deposits, stocks, mutual funds, bonds, kitty parties, chit funds, bishi, saving schemes like life insurance, Unit Trust of India, or Public Provident Funds.

3.4 Policy Considerations for Productive Ageing

To promote active and productive ageing, policymakers in India have to adopt a targeted approach while accounting for diversity and heterogeneity across elderly population groups.[5] Providing decent work conditions to the Indian elderly requires a better understanding of intricacies related to physical health, financial needs, and economic security across male and female elderly, rural and urban elderly, regional-wide disparities, etc. This is because work can be strenuous for some elderly groups and deteriorate their wellbeing,[6-7] whereas for other elderly groups, it might enhance their ageing process. Hence, deeper nuances related to such disparities should be considered from a policy standpoint.

There is an urgent need to address the financial security and economic independence of older adults and the elderly in the informal sector. Governments can do more to ensure the economic security of the elderly involved in the agricultural sector. Promoting technological innovation and mechanization in agriculture can significantly help the elderly cohort to take up the age-friendly tasks that require less physical strain. Further, helping farmers with agricultural credit policies merits urgent attention to ensure their economic security. Agriculture, forestry, and mining are the primary sectors employing older adults across age groups, especially in rural states. For the 40–59 years group, Chhattisgarh (51.5%), Himachal Pradesh (52.0%), and Maharashtra (42.5%) continue to show heavy dependence on agriculture. In the 60–79 years group, older adults in Himachal Pradesh (35.9%), Andhra Pradesh (32.5%), and Odisha (31.2%) remain significantly engaged in agriculture. Manufacturing plays a minor role across states and age groups.

Retirement and pension policies need to be reviewed periodically to account for improving longevity and

the capacity to work. It is imperative to review the retirement age policies and pension revisions from time to time. While increasing longevity can be an attractive avenue to revise the retirement age, policies should take into account the health and capacity to work and perform as well. Further, policies related to pension coverage should focus on timely reviewing the scope of increasing the coverage, targeting the elderly from vulnerable households.[8]

Labour force participation declines sharply after 60 years. Labour force participation is significantly higher among the 50–60 age group, around 90% for men and 45% for women, while it declines sharply for those aged 60 and above. The data clearly shows that older adults tend to withdraw from work as they age. For men, participation falls to around 50% or lower after 60, while women's participation drops even more steeply, to 14%. This decline potentially reflects a combination of health issues, societal expectations, and limited opportunities in later life.

Innovations to facilitate the older population in job search and matching can be considered as an important pathway to economic support. It is difficult in older age to find work, especially with the digital divide, the generation gap, and the continuously changing job market demand. Providing a platform that specifically caters to the needs of the elderly for searching decent work and jobs can help them immensely. Further, formalizing the job market (search) for the elderly can also help to track the age-based discrimination. It can also be used to reflect and strengthen the skills of the elderly and provide them with training based on the needs of older people.

Investing in education and skill development is the key to an economically secure and independent future for the ageing population in India. Policies promoting a lifelong approach to learning and acquiring skills are warranted to keep up the employability among older adults and the elderly.[9] With the increasing pace of ageing, older adults and the elderly in India will have educational requirements, but the skills needed to perform the job need continuous updating. This can be achieved through training programs and provisions to periodically review and upskill while on the job. Increasing investments are required to provide skill-based education and financial literacy, especially to children and the younger cohort from destitute and vulnerable households, to financially secure the future of the population ageing in India.[10,11]

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04 Chapter
Family, Community, and Social Life

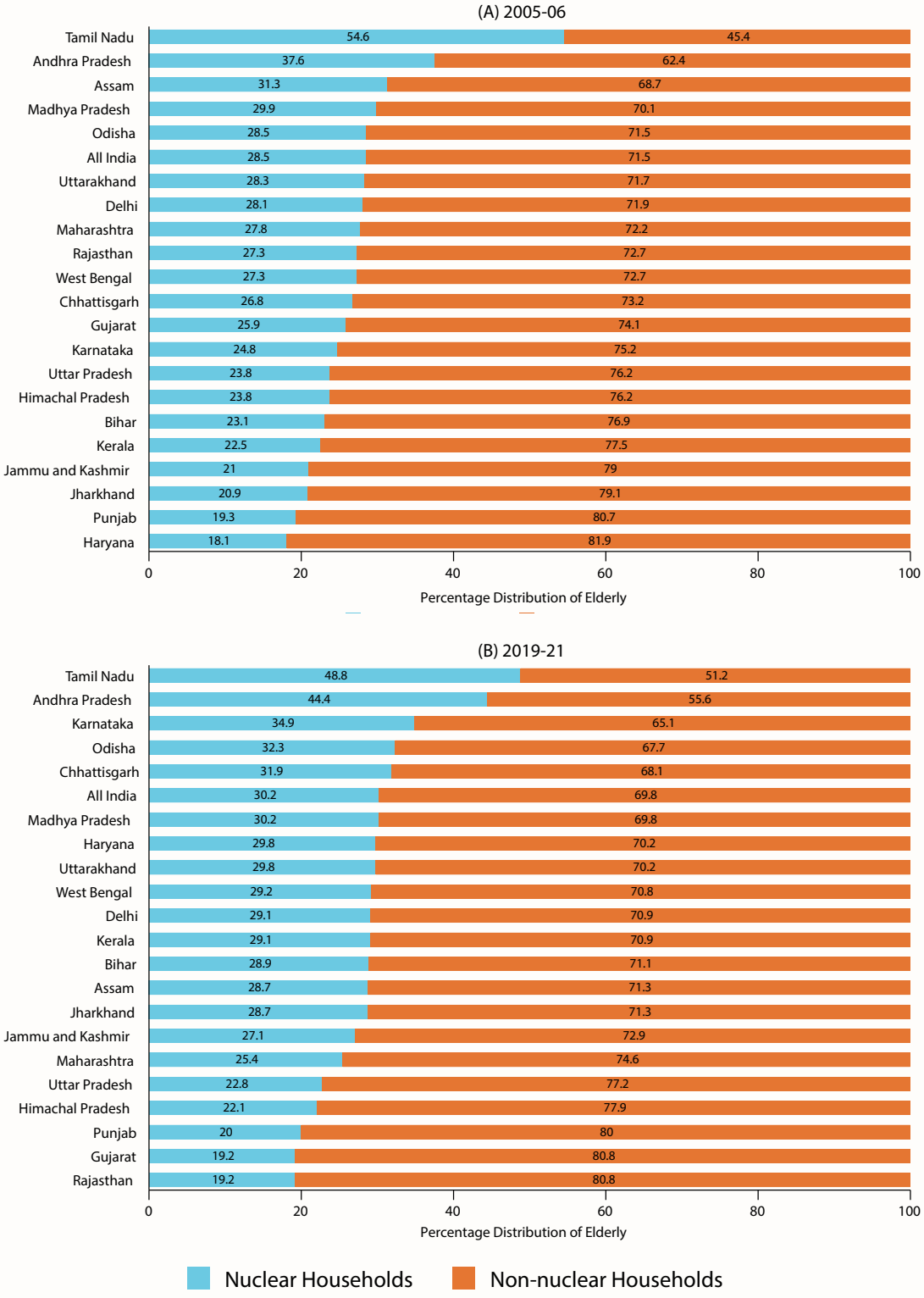
Elderly Individuals, in general, have more time to spend in their home and community. After retiring and separating from work and responsibilities, the elderly in general can spare more time to engage with the family and community, and build social ties. At the later stages of life, family ties, interpersonal relationships, and social engagement become much more crucial in determining the self-assessment of life evaluation and overall wellbeing. The quality of relationships and participation in community and social events has a profound influence on mental health in the later stages of life. For the oldest-old cohort, family support is crucial for long-term care (LTC) as the likelihood of functional impairment increases drastically after the age of 75 years. In general, regular community engagements also give a sense of purpose to the older cohort, thereby promoting active and healthy ageing. The WHO framework on healthy ageing emphasizes that intrinsic capacity (the composite of physical and cognitive abilities) declines with age, and external support provided by family and social networks gains precedence to maintain functional ability and dignity in old age[1]. Social science theory reinforces this by emphasizing the socially embedded nature of ageing with individual trajectories unfolding through "linked lives" in which family networks profoundly shape wellbeing[2]. The concept of "age differentiation" highlights how transitions such as entering retirement and widowhood imply heightened dependence, making family networks especially critical[3]. In the same vein, the Convoy Model of Social Relations underscores intensifying family reliance as a consequence of narrowing social networks[4]. Similarly, Socioemotional Sensitivity Theory demonstrates the increasing prioritization of meaningful relationships and hence, family bonds among the elderly[5].

In the Indian context, the family-based care and social support structure remains strong and dominant in most parts of the country. In the last decade or so, India has witnessed substantial improvement in terms of infrastructure, rapid urbanization, increasing rural to urban migration, and a swelling number of nuclear urban families. Despite this, the family relationships and support mechanisms were observed to be robust in India. In India, families provide not only companionship, identity, and belonging but also shape access to care, social integration, and dignity.[6,7] Research from developed nations consistently demonstrates that both the existence and quality of familial bonds are vital for health and wellbeing.[8-10] Traditionally, Indian family systems ensured economic security, caregiving, and social identity, especially during later life. Endowments of household members have been generally enjoyed by the dependents as well. Therefore, the household and family are considered to be one of the most important determinants of wellbeing. However, the recently observed phenomenon of changing family structure will have important implications for the elderly LTC in the future. Increasing age at marriage, growing preferences for not getting married, and swelling divorce rates in urban regions indicate a future demand for more formal and paid LTC facilities at later stages of life. In this regard, research has shown that social isolation and loneliness are important risk factors for mortality, depression, cognitive decline, and cardiovascular disease in later life. Widowhood, peer loss, and limited mobility further magnify these risks in old age.

The elderly in most parts of India prefer paid or volunteer work at later stages of life. It is important from a policy standpoint to promote healthy and active ageing with purpose and dignity. Decreased ability to participate and engage in social activities, and to contribute to the usual family consumption expenses (mainly due to the early onset of chronic conditions), are potential drivers of isolation and loneliness among the elderly. Elderly day care centers that involve some social activity and volunteer work are critical intervention pathways to keep the older cohort socialized and busy with a better sense of purpose.

This chapter utilizes the sample survey datasets to highlight the family relationships and social life of the elderly in India. It examines the living arrangements of the elderly in India in terms of household size and accompanying household members. The chapter highlights the nature of long-term cases for the elderly across India's regions and states. This section also delves into the social life of the Indian elderly through types of social activity, frequency of social engagements, religious and spiritual inclination, and their levels and patterns across population subgroups.

Figure 4.1: Distribution (%) of the elderly by household structure across major states, India, NFHS, 2005-2021



Source: International Institute for Population Sciences (IIPS) & Macro International. (2007). National Family Health Survey (NFHS 3), India, 2005–06; International Institute for Population Sciences (IIPS) & ICF. (2021). National Family Health Survey (NFHS 5), India, 2019–21. https://dhsprogram.com/

Note: Elderly – aged 60 years or above

4.1. Family Structure and Living Arrangements

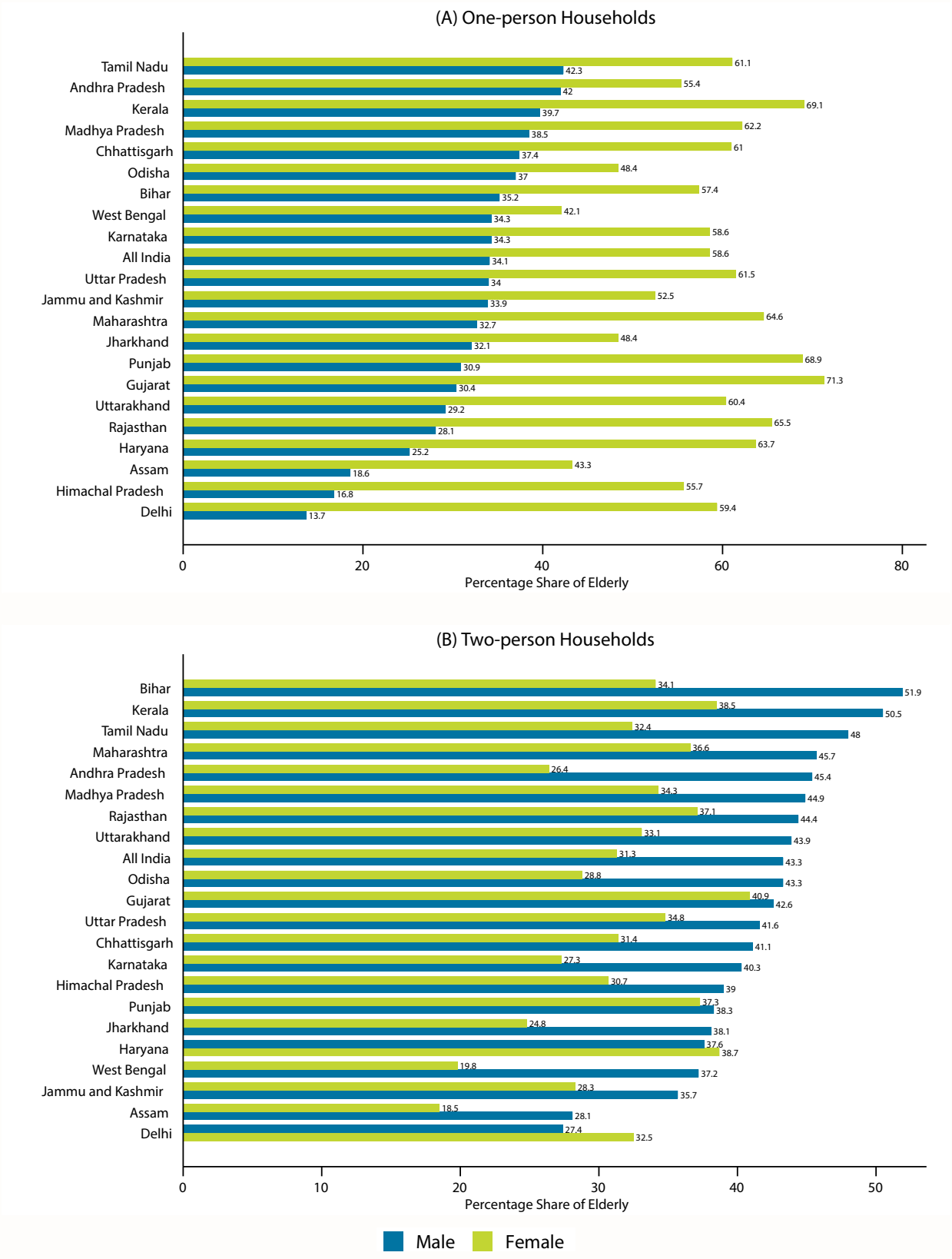
The elderly in most states of India continue to live in a joint family. Despite the ongoing discussion on nucleation of households[11], the joint household system continues as the dominant living arrangement among the elderly in India. NFHS data from 2006 and 2021 **(Figure 4.1)** reveal no notable change in the last 15 years, and about 70% of the elderly in India continue to live in joint family systems. Northern states that are yet to witness the fourth stage of demographic transition have a joint family system dominating the elderly living arrangement. For instance, more than 80% of the elderly from states like Gujarat, Punjab, Rajasthan, and Uttar Pradesh were from joint families. On the other hand, in demographically advanced states, nuclear households were more prevalent, particularly in the southern states of Andhra Pradesh (51.2%) and Tamil Nadu (55.6%). The type of living arrangement is an important marker of elderly support and highlights a dual narrative. In economically weaker and populous states, the persistence of joint family systems is the reflection of resource constraints, employment-driven migration of the younger group, and sociocultural beliefs. Further, state-specific interventions also matter, for example, state top-up assistance under the National Social Assistance Programme (NSAP) is only ₹100 in Uttar Pradesh (₹300 in Rajasthan) as compared to ₹1000 and ₹800 in Andhra Pradesh and Tamil Nadu respectively[12]. Interestingly, the southern states have actively developed institutional care ecosystems to supplement family support, such as the "Destitute Pension Scheme" in Tamil Nadu[13].

More than half of female, one-person households belong to elderly. The findings suggest a stark gender difference in living arrangements among the Indian elderly. Elderly women are much more prone (58.6%) to live alone compared to elderly men (34.1%) **(Figure 4.2).** The trend reverses in the case of two-person households, with elderly men making up 43.1% compared to 31.3% elderly women. This observation suggests two demographic realities. The first factor is rising life expectancy, and the second is increasing widowhood, both among women. The implications are profound. The loss of a spouse reduces household protection and financial security, entrenched gender inequalities limit access to resources and decision making, and declining health and mobility undermine independence. Indicative of a clear feminization of ageing, India is witnessing a growing share of widowed elderly women, which demands the cushion of formal care. Across states, a notably higher proportion (about two-thirds) of the elderly women from Kerala, Tamil Nadu, Punjab, Gujarat, Rajasthan, and Haryana were reported to stay alone. Southern states of Andhra Pradesh, Tamil Nadu, and Kerala have also had a relatively higher percentage of male elderly living alone.

The vulnerabilities of solitary living are compounded when considered through the income lens. More than half of elderly men and women (57.6% and 67.2% respectively) living alone fall within the bottom two MPCE quintiles **(Figure 4.3).** The pattern is especially pronounced in states like Chhattisgarh, Madhya Pradesh, Bihar, and Jharkhand. The picture is virtually the opposite in Delhi, Kerala, and Punjab, where one-half to three-fourths fall within the richest two quintiles. Furthermore, the figure clearly suggests that elderly females living alone are more economically vulnerable than elderly males living alone.

Findings on living arrangements present a striking paradox. In economically backward states, solitary living signals vulnerability. Along with inadequate social security nets, these are often cases of elderly parents left alone after the out-migration of younger family members for work. In the case of elderly women, widowhood adds another dimension of risk. In socioeconomically better-off states, solitary living is rather a sign of independence. Upon recognition that families cannot shoulder the full burden of elderly care effectively, the transition towards nuclear households in such states reflects growing independence rather than vulnerability. It is rather a representation of better pensions, better access to services, and reduced dependence on external kin. Many elderly people are living alone by choice while still maintaining family ties, reflecting enhanced agency rather than marginalization. From a policy perspective, this calls for more context-based interventions. In the former group, income security must be prioritized. Community-based interventions, including day-care services, home-based care, and more, could mitigate vulnerability. The latter group could benefit more from interventions oriented towards enhancing autonomy. Recreation centres and volunteering opportunities could improve social connections.

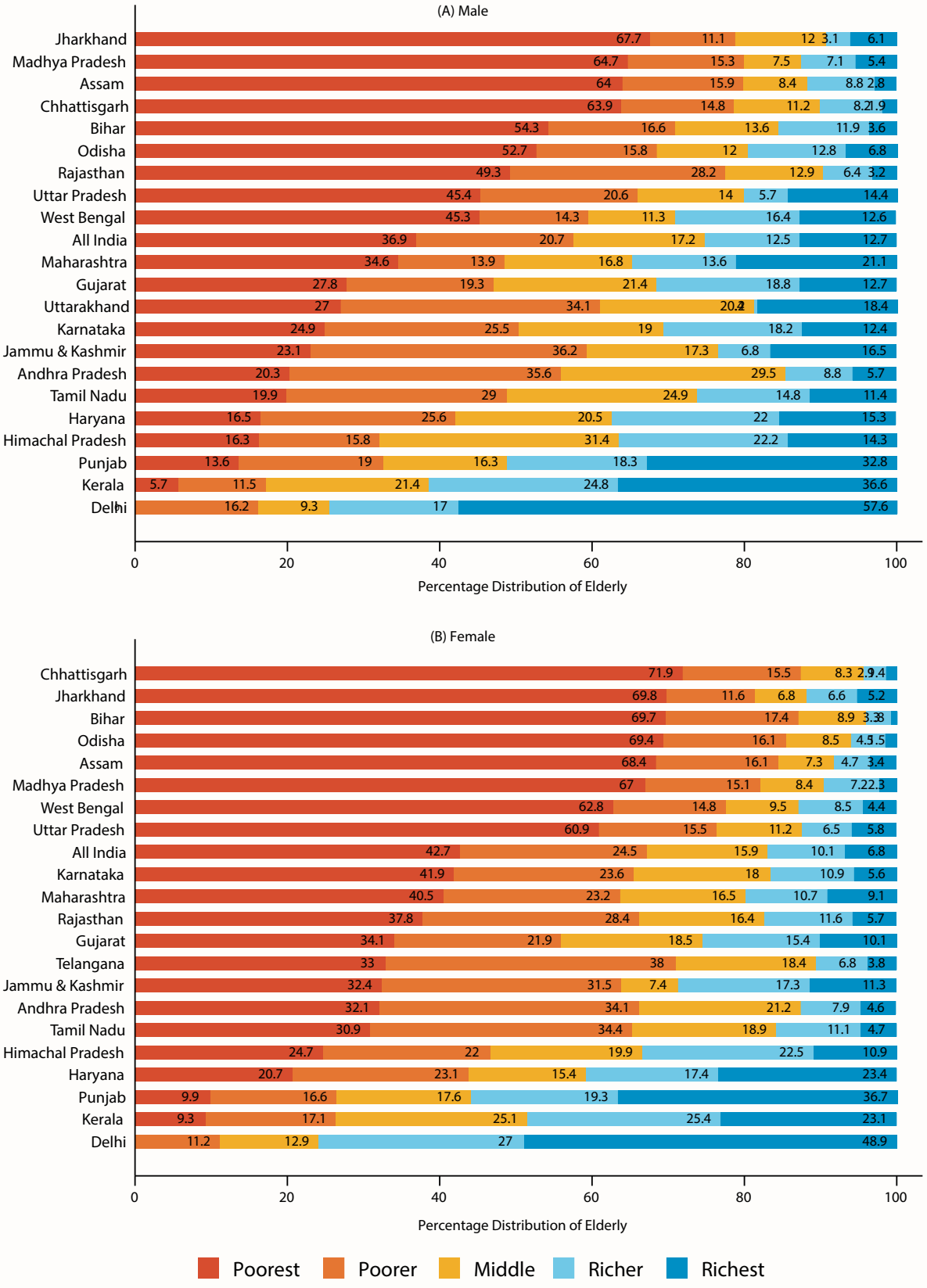
Figure 4.2: Share (%) of the elderly in one-person and two-person households by sex across major states, India, NFHS, 2019-21



Source: International Institute for Population Sciences (IIPS) & ICF. (2021). National Family Health Survey (NFHS 5), India, 2019–21. https://dhsprogram.com/

Note: Elderly - individuals aged 60 years or above

Figure 4.3: Distribution (%) of alone living elderly by MPCE quintiles across states, India, NFHS, 2019-21



Source: International Institute for Population Sciences (IIPS) & ICF. (2021). National Family Health Survey (NFHS 5), India, 2019–21. https://dhsprogram.com/

Note: Elderly – 60 years or above

4.2. Family and Long-Term Care

Changing healthcare needs of older persons in India will have important implications for long-term care of the elderly. With the increasing prevalence of ADL limitations, the elderly cohort is projected to need more and more support for common activities of dressing, bathing, cooking, and housekeeping. Such support is required for long-term, and therefore, will be hard to provide with a continually changing family structure. Overlooking the demand-supply gap may result in an increasing proportion of older persons with unmet long-term care needs in the future.

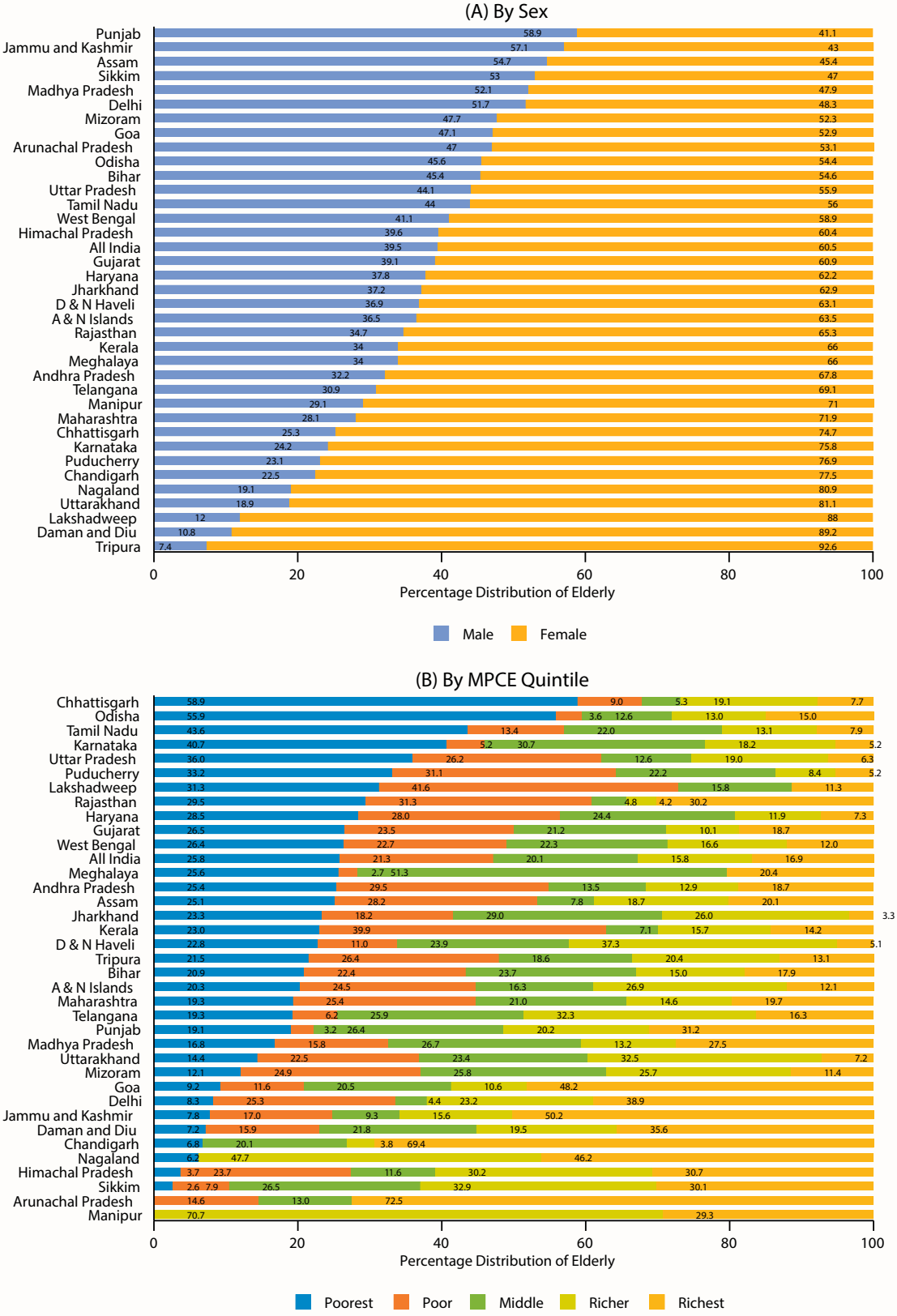
In India, elderly care demand is mostly met by family members. As per the Asian Development Report on ageing, almost all LTC of the elderly in India is informally provided by immediate family members or relatives. It is also worth noting that informal caregivers in the family are mostly older adults and predominantly women. In most parts of India, such responsibilities lie with daughters or daughter-in-law. These patterns are also visible for economically advanced nations, where three out of five informal elderly caregivers were women. Elderly care in India is mostly informal and family-dependent. Despite the cultural centrality of family caregiving, many elderly people reported unmet needs in long-term care. In fact, among the elderly having at least three limitations in activities of daily living (ADLs) but not receiving care, 60.5% were women **(Figure 4.4, Panel A).** This proportion was as high as 80% to 90% in Tripura, Lakshadweep, and Uttarakhand, respectively. Contrary to this, Punjab, Jammu and Kashmir, and Assam showed as high as 58.9% of men with unmet care. This gender imbalance is concerning in the context of India's ageing experience from a gender perspective. The distribution of income is another dimension to understand the vulnerability. Almost half of the elderly with unmet care needs (47.1%) belong to the poorest 40% of the population. Only 16.9% lie within the richest income bracket **(Figure 4.4, Panel B).** Therefore, both affordability and accessibility play a critical role in care outcomes. While wealthier households are able to supplement care through institutional services, poorer households have to rely exclusively on the household, regardless of its adequacy. Although India's demand for elderly residential care homes has been rising gradually, supply-side limitations have been observed by studies. Free home and day-care facilities, often run by non-governmental organizations (NGOs) and mainly subsidized by state or central governments, provide only basic support like food and shelter. Except for a few, most exclude the elderly with severe restrictions in basic ADLs or those requiring continuous medical care. The pay-and-stay options have comparatively better provisions, yet are not very affordable[14]. Depending on family support, elderly care often causes stress to care providers who are mainly adults juggling economic pressures and other lifestyle struggles simultaneously. Robust external support is required, mainly for the poorest and vulnerable elderly.

4.3. Social Life

About half of the elderly in India engage in a social activity at least once a month, and only one-fifth participate at least once a week. Engaging in social activities, including informal interactions as well as volunteering and participation in community clubs, has consistently been associated with healthy and active aging. Socially active elderly have been shown to be less likely to develop depression and cognitive decline, and displayed reduced risk of mortality compared to those who are socially isolated[15]. However, only 19% of the elderly in the country reported that they were socially engaged (visiting friends, going to parks, playing games, or attending cultural events) regularly (daily or weekly) **(Figure 4.5, Panel A).** The rates were notably higher in Chandigarh (49.3%) and Maharashtra (34.6%), and lower in Tripura and Telangana (<10%). The interstate disparities of social engagement reflect the uneven availability of community infrastructure and activities for the elderly. Programmes that foster environments that enable active ageing (parks, senior clubs, and cultural participation opportunities) could generate returns in terms of delaying disability, reducing healthcare costs, and enhancing life satisfaction.

There is a huge scope for increasing religious and spiritual gatherings among the elderly. In the Indian context, religious engagement holds salience, as religious customs and traditions are deeply woven into daily life. Research has displayed psychological and longevity benefits of religious involvement[16,17] reinforcing the idea of the socially embedded nature of ageing. It plays a central role in developing psychological resilience in the face of loneliness, bereavement, and declining cognitive capacity. In India's context, particularly for elderly women, participation in religious gatherings, engaging in rituals, or belonging to faith-based groups serves as one of the very few accessible avenues for social participation outside the household. Surprisingly, regular religious participation (attending religious functions/events such as bhajan/satsangs/prayer, daily or weekly) was reported to be only 8.6% at the national level **(Figure 4.5, Panel B).** Almost half (47.6%) of the sample elderly population reported non-participation in religious activities. Disability and mobility limitations in religious spaces could be plausible explanations for this gap. From a policy lens, this points to the need for developing elder-friendly environments that enable their continued participation in religion and spirituality. At the same time, recognizing the rise of home and technology-based religiosity is also important. Policy support in making this arena more inclusive and accessible could be highly beneficial in harnessing a spirit of resilient ageing.

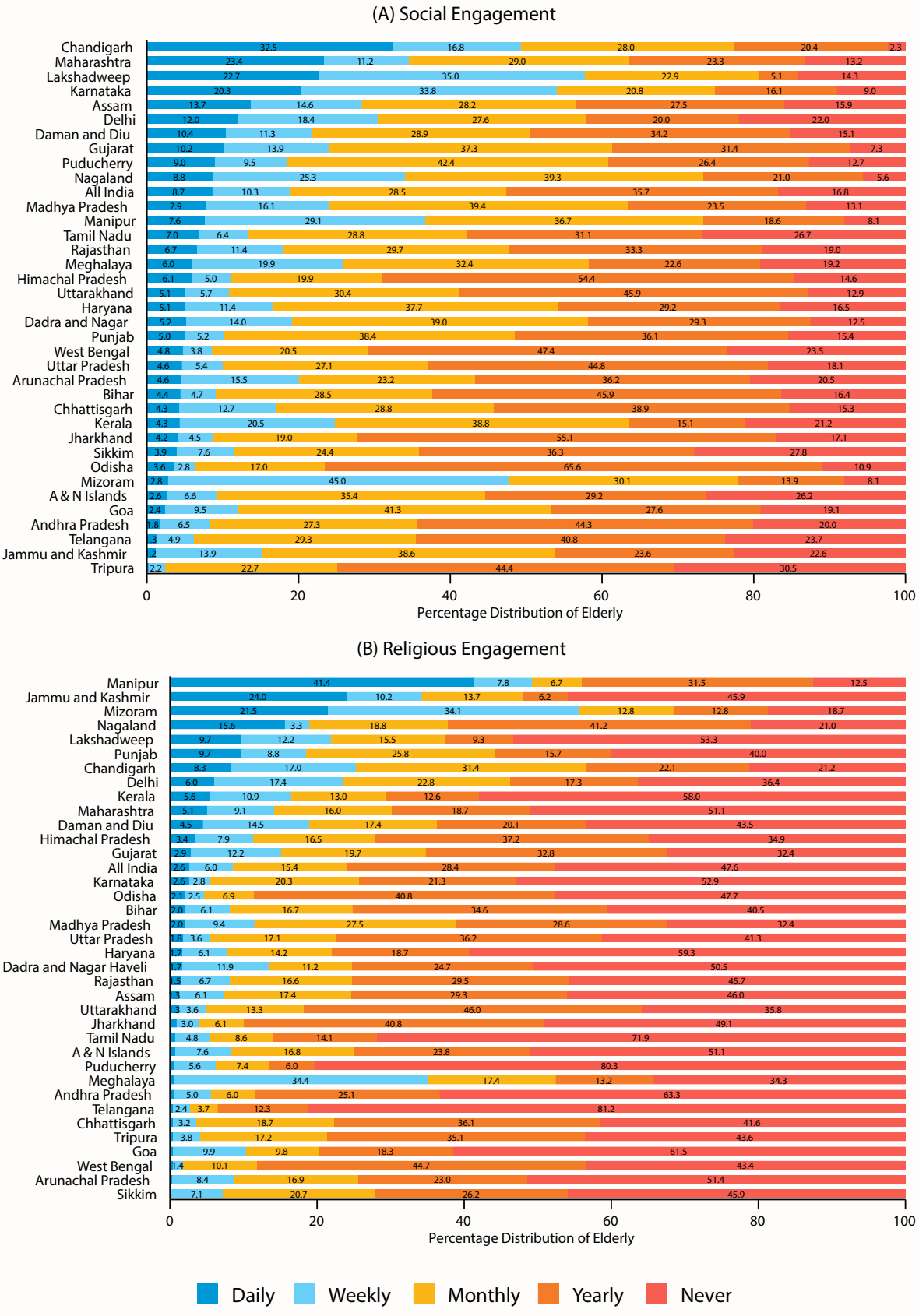
Figure 4.4: Distribution (%) of elderly (with three ADL limitations) reporting unmet long-term care needs by sex and MPCE quintile across states, India, LASI, 2017-18



Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

Note: Graphs consider people aged 60 years or above who received no help despite impairment affecting at least three ADLs. Elderly - aged 60 years or above

Figure 4.5: Reported frequency (%) of social and religious activity among the elderly across major states, India, LASI, 2017-18



Source: Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

Note: 'Social engagement' is based on participation in five activities: visiting friends or relatives, going to parks, playing games, exercising, or attending cultural events. 'Religious engagement' is defined as the percentage of older people who attend religious functions /events such as bhajan/satsang/prayer. Elderly - individuals aged 60 years or above

4.4. Conclusion and Way forward

Timely policy intervention is warranted to address the increasing LTC of elderly persons. Policy efforts to provide regular care in basic activities of living to the elderly can enhance their nutrition levels, prevent accidents and injuries, and support health management at the population level. On the other hand, informal care by family members aids mental and emotional wellbeing and reduces the risk of depression among the elderly. However, in most cases, the opportunity cost of informal caregiving by adults can take the form of career and financial sacrifice, especially by women.

Community-led interventions can immensely support informal caregivers through counselling, training, and elderly day-care centres. Interventions tailored to regional and local needs can go a long way in providing information, counselling, and training to deal with the informal caregiving of the elderly. Further, it is important to grant due respite care to the informal caregivers. More specifically, intermittent breaks for family caregivers from their usual duties and responsibilities can be effective in supporting caregivers.

An integrated service delivery approach can be an effective pathway to provide elderly care from a policy standpoint. It is imperative to integrate the fragmented systems and actors from healthcare, social support, and development agencies to help informal caregivers. For example, Japan's LTC insurance schemes serve as the primary body to bridge coordination between medical care and long-term care for the elderly. This strategy ensures that older people who are in need of both medical and support care can live in their homes while getting all types of care until the end of their lives.

A range of community-based initiatives is warranted to engage older persons in socialization. A variety of multifaceted initiatives and programs to engage older persons in some social activity can essentially reduce the risk of isolation and depression. Volunteering in nongovernment organizations, community health workers, and religious and spiritual groups are effective pathways to increase socialization among the elderly.

Some of the other effective ways are:-

1. To develop dedicated physical space for clubs and socializing activities;
2. Promoting volunteer activities through subsidization and incentives;
3. Developing intergenerational connectedness through cultural learning programs and events;
4. Addressing the digital divide among the elderly to maintain social connections.

Dedicated public and private funds to such interventions are required for the sustained ability to pursue volunteering activities that enrich people's lives by connectedness, social purpose, and wellbeing. Existing schemes like the National Social Assistance Programme (NSAP), "Pradhan Mantri Vaya Vandana Yojana (PMVVY)", and the "Senior Citizens' Welfare Fund (SCWF)" form the backbone of India's financial safety net for the elderly. With regards to accessibility, safety, and social participation, the Accessible India Campaign ("Sugamya Bharat Abhiyan"), and the Ministry of Home Affairs' Safety and Security Initiatives are aimed at making public infrastructure elder-friendly with ramps, accessible transport, and barrier-free toilets. The "Rashtriya Vayoshri Yojana (RVY)" has improved access to mobility aids and assistive devices. The Integrated "Programme for Senior Citizens (IPSrC)" has increased the number of old-age homes and mobile healthcare units. While these initiatives represent significant progress, their fragmented scope and uneven implementation limit their full potential. Outreach in most programmes is observed to be inconsistent across states, and therefore, they need to penetrate the most vulnerable elderly.

Increasing awareness in terms of cultural attitudes toward ageing merits attention. Many elderly remain largely unaware of the schemes available to them, and institutional care is often stigmatized as abandonment rather than viewed as a legitimate complement to family support. Information campaigns led through local governments, panchayats, and community health workers could improve uptake. Effective implementation of solutions to promote happy ageing requires the participation of older people themselves.

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05 Chapter
Subjective Dimensions of Wellbeing

Background

Subjective wellbeing contributes immensely to health in old age and longevity.[1-2] While the human interest in wellbeing has been around for centuries, offering complex interpretations of living well, it is now in the sphere of important concerns of modern social science, shaping how we study human life, societies, and policies. Self-rated assessments of the subjective dimensions of wellbeing are known to be important markers of quality of life and health status. The study of wellbeing has evolved considerably in recent decades, incorporating insights from psychology, sociology, economics, and public health.

Subjective wellbeing primarily entails self-assessments (an individual's own perception) of overall life satisfaction in totality.[3] Literature on the subject elicits both contrasting and complementary frameworks to understand the determinants of wellbeing and their interpretations. Some have drawn from evolutionary psychology and neuroscience, proposing a model that differentiates between objective, experiential, reflective, and narrative layers of wellbeing, including the human motives, emotions, and adaptive motivation systems, which suggests that wellbeing arises from fundamental psychological processes and can be understood across multiple levels.[4-5] The literature is further extended by examining overlooked aspects such as mental balance, a sense of tranquillity achieved through inner peace and harmony with the environment, and by demonstrating, through cross-group analyses, that measures of life satisfaction can be meaningfully compared across diverse populations by gender, age, ethnicity, or nationality.[6-7] These theoretical contributions affirm that wellbeing is both a multidimensional and a universally comparable construct, allowing cross-cultural and cross-national studies to generate robust insights.

Subjective wellbeing dimensions are yet to receive due research and policy attention in India. In developed countries, subjective wellbeing has gained much research and policy attention through frameworks such as the World Happiness Report and the OECD's guidelines on measuring subjective wellbeing[8]. The initiatives have influenced policies that emphasize economic growth, mental health promotion, social participation, and opportunities for active ageing. Despite being home to one of the world's fastest-growing elderly populations, India has limited systematic evidence on the levels and patterns of subjective wellbeing among the elderly population. Research has often focused on economic deprivation, morbidity, and mortality while overlooking psychosocial dimensions of ageing[9,10]. Given India's socioeconomic diversity, high levels of informal work participation, low pension coverage, and intra-household inequalities, particularly affecting older women, the issues warrants timely investments.

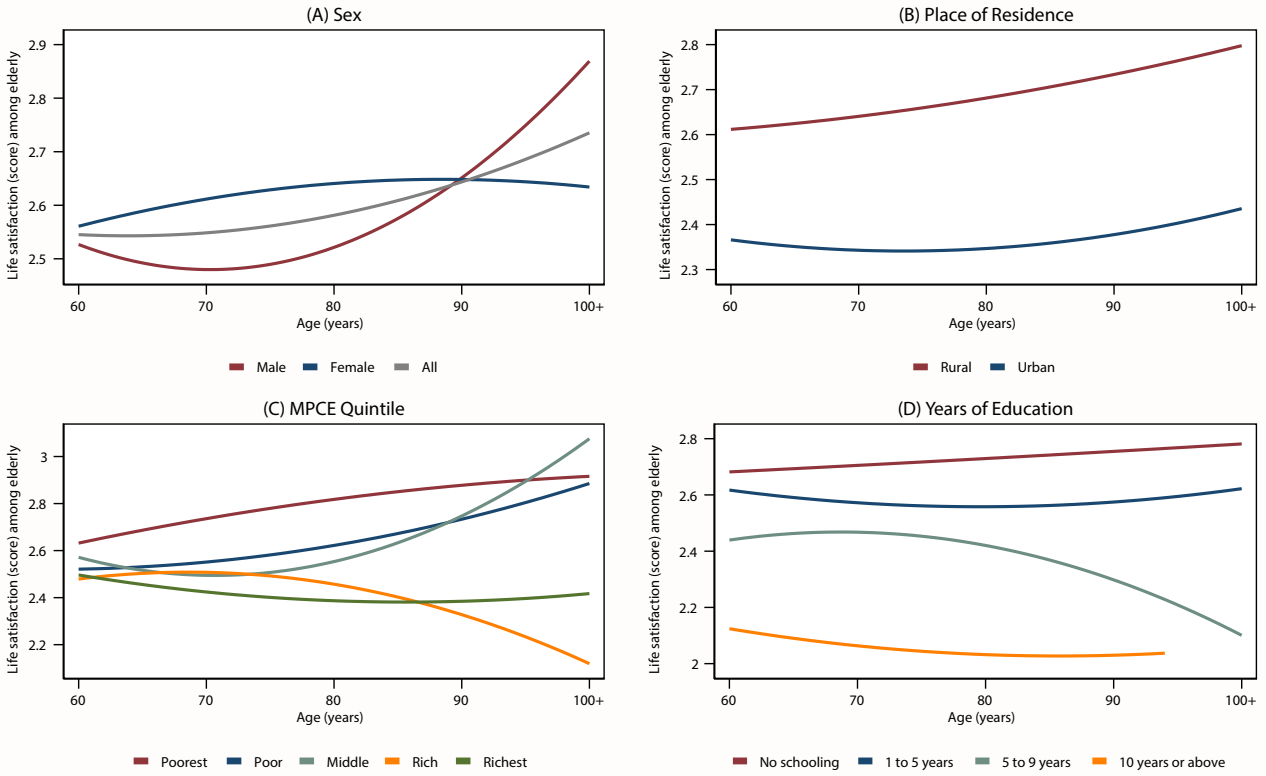
Using data from the Longitudinal Ageing Study in India (LASI), this chapter explores several aspects of evaluative wellbeing measures among the elderly in India.[11] More specifically, the chapter presents levels and patterns of overall life satisfaction level scores, self-rated health, and self-rated mortality among the elderly in India. The distribution across sex, place of residence, education, economic status, social participation, marital status, and living arrangements is presented. The chapter emphasizes the need for strategies that move beyond income or health-centric approaches to include mental health and social connectedness. Such a multidimensional perspective is crucial for India to align with regional and global priorities, ensuring that its ageing population lives longer and enjoys greater wellbeing in later life.[9]

5.1 Life Satisfaction Scores

Life satisfaction scores across age groups exhibit a U-shaped curve, with decreasing satisfaction up to the age of 62-65 years and decreasing scores thereafter (Figure 5.1). Life satisfaction declines scores initially declines with age among the elderly, which shows the challenges associated with chronic health conditions, declining mobility, and the reduction of social connectedness[12]. Overall, life satisfaction was slightly higher among men than among women, but the pattern reverses in later years (after 80 years of age). Life satisfaction is lower in later ages, mainly due to the higher prevalence of widowhood among women, who often experience reduced social and

financial support after the loss of a spouse. Losing a spouse reduces family closeness and social networks, and increases dependence on others, which may further exacerbate this decline, highlighting the multidimensional vulnerabilities with ageing that reduce life satisfaction with age[12] This sense of purpose diminishes with age, which also contributes to women's life satisfaction. Therefore, marital status shows a strong association with life satisfaction, with currently married individuals reporting significantly higher levels of satisfaction than the elderly who are widowed or separated[13]. Marriage often provides emotional companionship, social support, and economic security, all of which contribute positively to subjective wellbeing in later life in both males and females. However, widowhood or separation reduces emotional support and may increase loneliness and financial difficulties, decreasing life satisfaction[13]. This shows the importance of spousal support and family structures, which are critical in life satisfaction.

Figure 5.1: Life Satisfaction (score) among elderly population, by demographic and socioeconomic characteristics, India, LASI, 2017-18



Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

Note: Life satisfaction scale: 1 "Completely satisfied", 2 "Very satisfied" 3, "Somewhat satisfied" 4, "Not very satisfied" and 5 "Not at all satisfied"

Urban elderly reported higher satisfaction levels than Rural elderly in India. Previous studies have discussed possible reasons, such as low multimorbidity levels, stronger family and social networks, more meaningful roles in the family in later life, and lower material expectations. Further, relatively lower day-to-day stress and pressure compared to an urban lifestyle is reflected in higher life satisfaction scores. Additionally, a close connection to culture and traditions gives a sense of purpose in older age, thereby enhancing wellbeing evaluations. Living arrangements in rural areas are such that there is little to no exposure to the idea of loneliness and social isolation. However, a lot of literature also asserts a higher satisfaction in urban areas, as a consequence of better healthcare facilities, economic position, and opportunities.

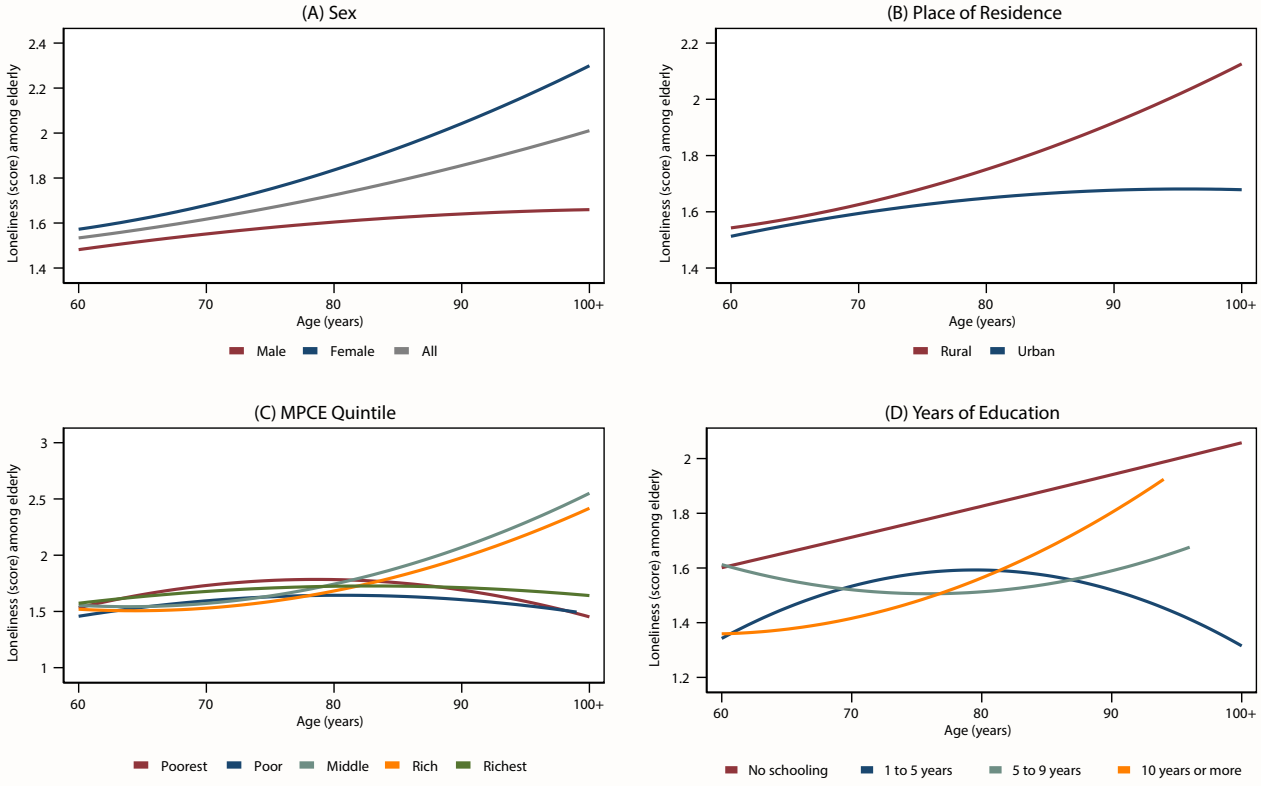
Elderly people living alone reported lower satisfaction levels. This dynamic is further reflected in living arrangements, where the elderly population living alone reported lower life satisfaction compared to the elderly residing in extended households. The family members in joint or extended households provide emotional support, support in physical work, and, with this, the elderly feel a sense of belonging, which collectively affects life satisfaction and healthy ageing. These factors are missing in widows, which is a disadvantage for them as they live alone, often face both economic dependency and limited social support, making them particularly vulnerable to reduced wellbeing. These patterns highlight the interdependence of marital status and living arrangements as critical determinants of subjective wellbeing in later life.

Economic status, measured by MPCE quintiles, reveals only a modest association with life satisfaction. Such a finding suggests that factors beyond material resources, such as health, autonomy, and social ties, play also important role[8]. However, previous literature depicts that elderly populations with higher income but poor health or weak social connections may still experience low life satisfaction, whereas those with modest resources but strong family support and community participation often report higher levels of wellbeing [8,12]. This highlights the multidimensional nature of wellbeing, where economic security is important but insufficient. Such a holistic approach acknowledges that wellbeing in old age cannot be reduced solely to financial status but is deeply embedded in social and relational contexts. Furthermore, the elderly who are active in social activities reported higher life satisfaction levels. Among socially active individuals, life satisfaction increases with age. Participation provides meaning, combats isolation, and fosters a sense of belonging, all directly enhancing wellbeing. [9]

5.2 Loneliness in Later Life

Loneliness scores increase with age and are particularly pronounced among women, with the gender gap widening in later years (Figure 5.2). This depicts the demographic reality that women outlive men, experiencing widowhood and the associated loss of companionship and support[13]. The rural elderly report higher levels of loneliness than urban elderly, a trend linked to the migration of children to urban centers for

Figure 5.2: Loneliness (score) among elderly population, by demographic and socioeconomic characteristics, India, LASI, 2017-18



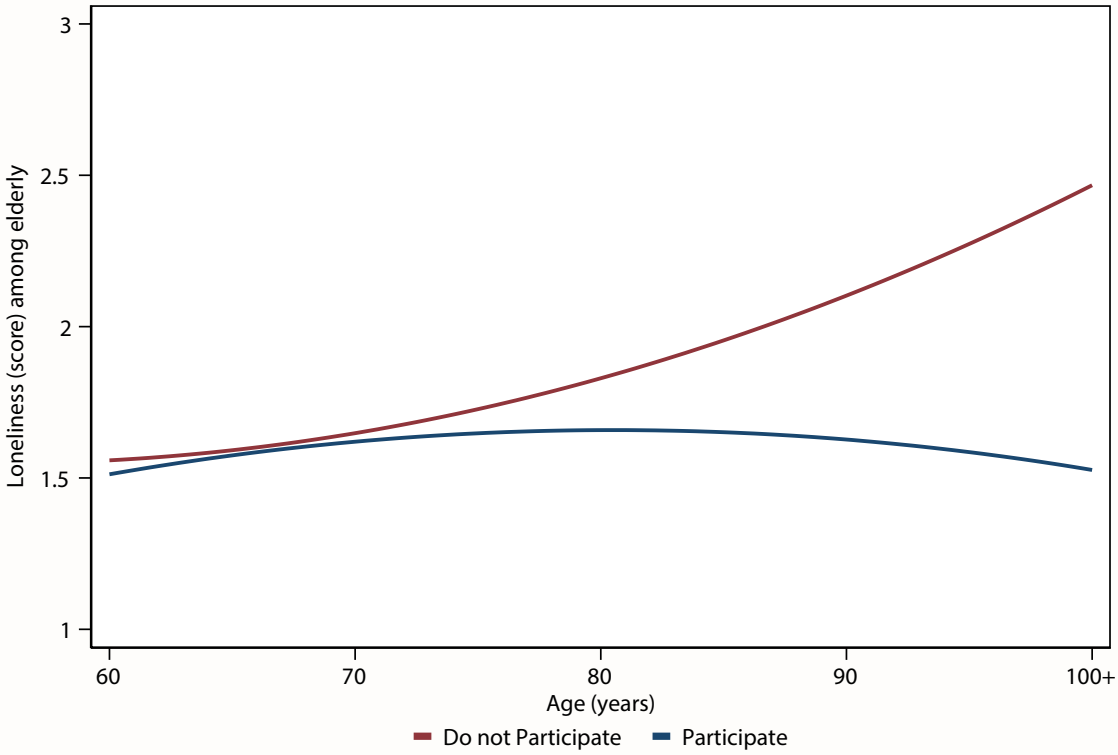
Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

Note: "loneliness scale: 1 "Not at all", 2 "A little", 3 "Somewhat", 4 "Quite a bit" and 5 "Very"

education and employment, causing increased levels of isolation and loneliness among the elderly. Unlike in urban areas, where elderly individuals may have greater access to community organizations, senior citizen groups, and better healthcare infrastructure, rural settings frequently lack such institutional and social support systems. As a result, the absence of close family members, coupled with weaker community engagement opportunities, exacerbates feelings of social isolation among rural elderly. Moreover, traditional expectations of intergenerational co-residence and care are increasingly being undermined by economic pressures and changing family structures, further intensifying the loneliness experienced in rural areas. Further, the higher educated elderly tend to experience less loneliness, may have stronger social capital and greater access to support networks[7]. The relationship between loneliness and economic status is weak, with wealth offering only partial protection.

Social participation remains the most consistent protective factor for loneliness. The elderly who participate more frequently in social activities are reported to feel less lonely than those who do not. Conversely, loneliness rises sharply among non-socially active individuals as they age. Participation reduces feelings of isolation and strengthens life satisfaction and happiness, demonstrating its central role in overall well-being.[5] A socially active life in older age enhances a sense of belonging and increases emotional support, which mitigates feelings of loneliness. In addition, engaging in any social activity requires some level of physical activity and routine that further enhances wellbeing. Bridging intergenerational gaps and collective coping are important pathways through which increasing social participation is linked to low levels of loneliness. Creating community infrastructure and spaces, encouraging intergenerational programs, promoting volunteerism, and leveraging cultural and religious institutions are potential pathways for intervention to increase the frequency and levels of social participation among the elderly in India.

Figure 5.3: Loneliness (score) among elderly population, by regular social participation, India, LASI, 2017-18



Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

Note: loneliness scale: 1 "Not at all", 2 "A little", 3 "Somewhat", 4 "Quite a bit" and 5 "Very"; Social Participation refers to participation in social activities (restaurant, beach/park, indoor games, outdoor games, visit friends/relatives, cultural cinema, religious functions, community meetings, reading, television, computer/internet) at least once a month.

5.3 Self-rated Health

Male elderly rated their health status relatively higher than females. This pattern was consistent across states. At the national level, approximately 50% of male elderly and 60% of female elderly reported their health to be in excellent, very good, or good condition. A higher proportion of elderly from states of Gujarat (80%), Delhi (70%), Chhattisgarh (69%), Madhya Pradesh (61%), Karnataka (60%), and Rajasthan (58%) rated their health status to be in good.

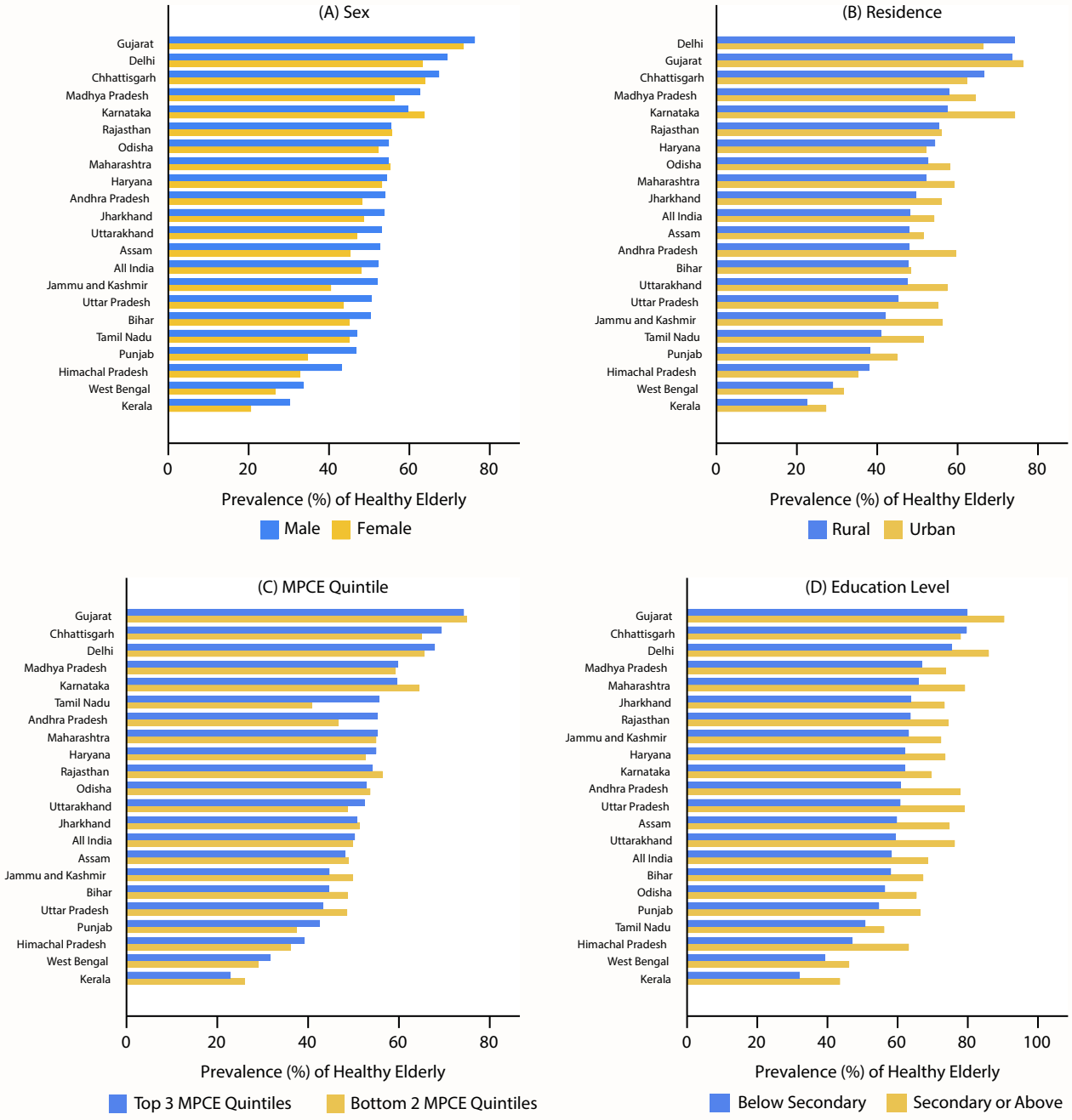
Urban and educated elderly are more confident about their health than rural elderly with less education. Across all states, a higher proportion of urban elderly reported their health to be in good condition **(Figure 5.4).** Possible explanations for such patterns could be access to better quality healthcare, easy and early diagnosis, higher awareness, and literacy about health conditions. In addition, socioeconomic advantage and better living standards and lifestyle resources further

this gap. Additionally, rural elderly continue to work in sectors that require physical strain and hard work which can cause lower self-assessment levels of health.

5.4 Subjective Longevity

Perceived mortality score increases with age, reflecting low survival confidence at later life in India (Figure 5.5). These points towards the fact that older persons adjust themselves towards their survival expectations as they encounter health problems, diminishing physical and functional abilities, along with the death of a spouse and peers. Such a pattern also indicates the psychological wellbeing as the elderly become more aware of vulnerabilities associated with later life. Decreasing subjective longevity with age can have important implications for health behaviours, financial planning, and mental wellbeing, as they influence motivation to invest in long-term goals versus short-term satisfaction. From a policy standpoint, it is imperative to promote healthy ageing narratives at the population level along with health screening and assurance schemes.

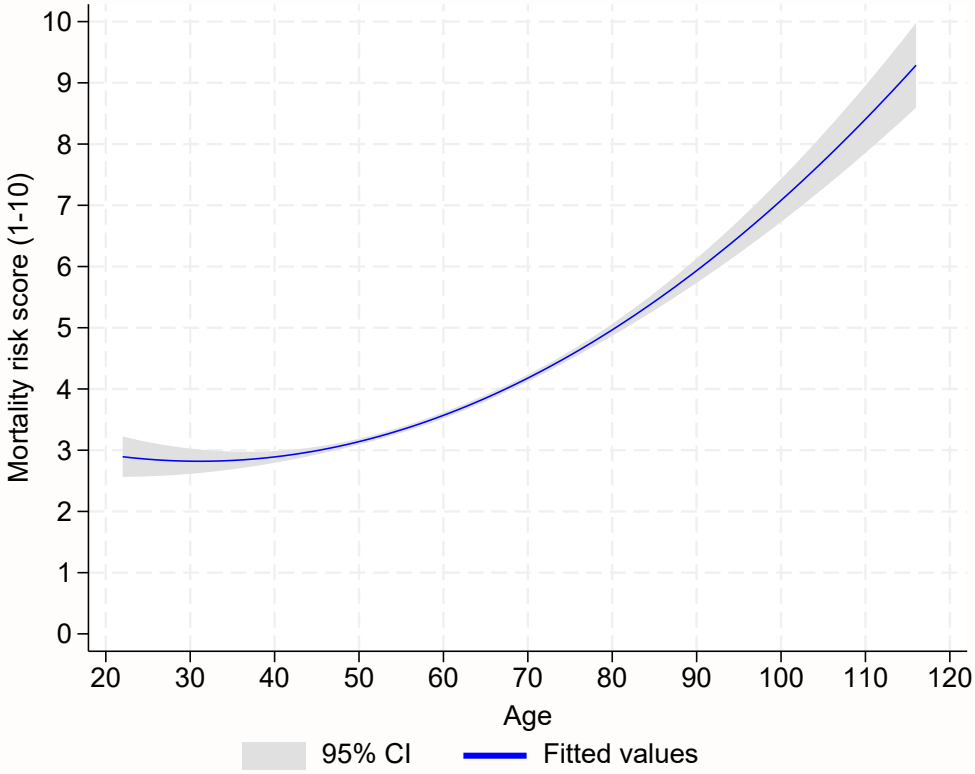
Figure 5.4: Prevalence (%) good self-rated health among the elderly by demographic and socioeconomic characteristics, India, LASI, 2017-18



Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

Note: "loneliness scale: 1 "Not at all", 2 "A little", 3 "Somewhat", 4 "Quite a bit" and 5 "Very"

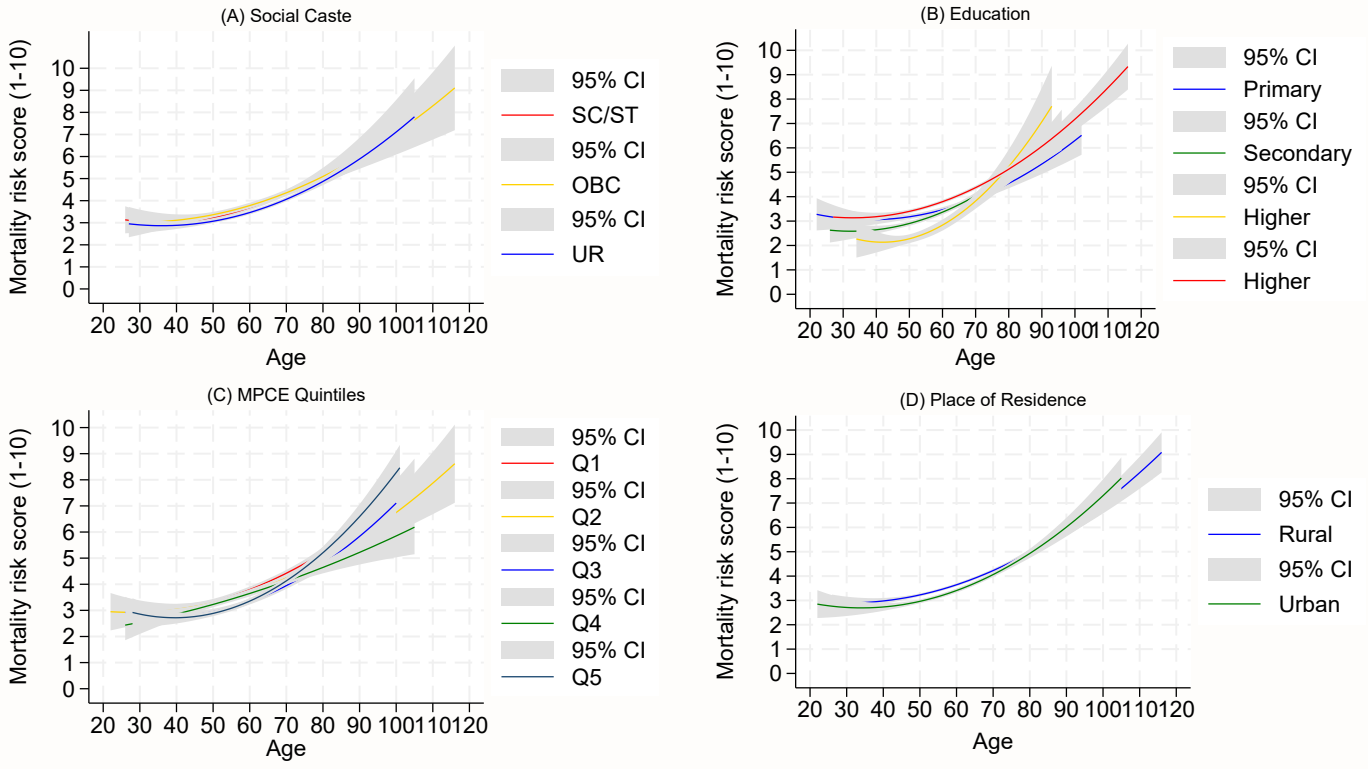
Figure 5.5: Perceived mortality risk (Score) among the elderly, India, LASI, 2017-18



Source: Longitudinal Study of Ageing in India, 2017-18, International Institute for Population Sciences (IIPS), Mumbai. https://www.iipsindia.ac.in/content/lasi-wave-i

Note: Perceived mortality risk refers to the self-rated likelihood that an individual would be alive as time goes by.

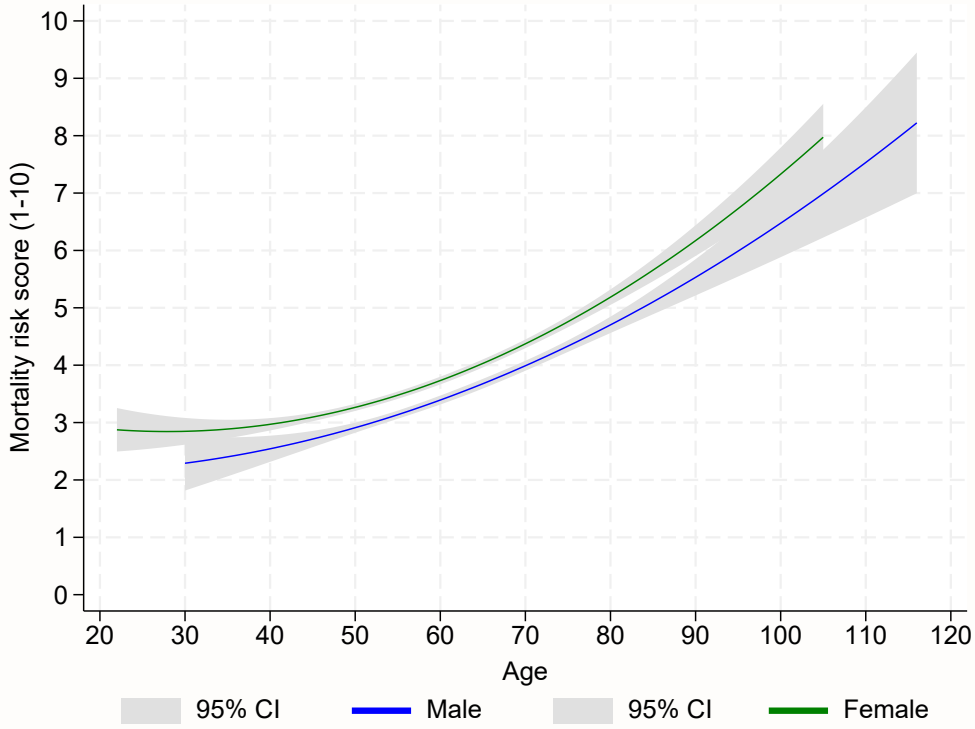
Figure 5.6: Perceived mortality risk (score) among the elderly across demographic and socioeconomic characteristics, India, LASI, 2017-18



Subjective longevity at older age shows no pattern across social groups, education, and MPCE Quintiles in India (Figure 5.6). These results are in contrast with objective health and longevity measures that show socioeconomic patterning towards the better off and affluent groups. It seems like cultural norms and personal experiences shape the perceived longevity relatively stronger than formal education and economic advantage. Clearly, self-assessments on longevity in India are not driven by income, caste, or education, but rather shared ageing experiences and psychological factors.

Perceived mortality risk is higher among female than male elderly. In later life, female elderly are more likely to have depressive symptoms that create psychological vulnerability, thereby resulting in lower survival confidence. Further, females generally have a burden of the caregiver role in the family, which can potentially cause deterioration in health and increase their sense of frailty. Further, female elderly awareness regarding health status versus longevity might be limited in India.

Figure 5.7: Perceived mortality risk (score) among male and female elderly, India, LASI, 2017-18



5.5 Conclusion

The chapter points toward the assertion that economic security is important, but it is not sufficient. In the Indian scenario, where large sections of the elderly rely on informal work and lack comprehensive pension coverage, there is a need to complement financial support with initiatives that promote social engagement and accessible healthcare. Current initiatives such as the Indira Gandhi National Old Age Pension Scheme (IGNOAPS), National Programme for Health Care of the Elderly (NPHCE), and Maintenance and Welfare of Parents and Senior Citizens Act (2007) provide some degree of income and legal protection. However, these schemes are often limited in coverage and implementation. These schemes do not adequately address the multidimensional aspects of wellbeing. To go beyond wealth, community-based initiatives that actively encourage social interaction and intergenerational connection must be incorporated. Senior Citizen Clubs and daycare facilities for the elderly, for instance, have been tested in a few Indian states and show promise in reducing social isolation; nevertheless, they still need to be expanded. There is a need to integrate community-based programs that actively promote social engagement and intergenerational bonding to move beyond income. Rural disadvantage, in particular, must be addressed through investments in rural social infrastructure, accessible healthcare delivery, and community-level elder-care services that can reach those left behind in "empty-nest" households.

International experiences also provide valuable lessons. In Japan, Ikigai programs and community-based care initiatives encourage purposeful ageing by integrating social, cultural, and physical activities into local communities, thereby reducing loneliness and improving mental health. In Nordic countries, universal pension systems are complemented by strong local government support for home-based and community-centred care, ensuring economic and social security. Similarly, Singapore's Active Ageing Hubs combine health services, recreational facilities, and opportunities for intergenerational interaction in one accessible space, serving as an integrated model that India could adapt to its local context.

The policy in the Indian scenario should be based on community-based programs encouraging social participation, fostering intergenerational engagement, and supporting widowed or single elderly women. This chapter also suggests the importance of distinguishing between different dimensions (objective and subjective) of wellbeing when analysing ageing outcomes. The findings suggest integrating subjective wellbeing indicators into ageing policy so that India can move toward a holistic approach that ensures its elderly population lives longer and experiences dignity, purpose, and connectedness in later life.

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06 Chapter
Ageing Well in India

Given the pace of economic development, healthcare improvements, rapid urbanization of infrastructure, family transitions, and longevity increments; India needs to invest in, develop, and prepare for enhancing the ageing experience across all regions. Notable economic and social progress witnessed over the last few decades has brought poverty and deprivation levels to an all-time low, thereby improving both the quantity and quality of life in India. However, ensuring the wellbeing of the elderly has yet to receive due research and policy attention. Policy efforts to improve the quality of life, thereby adding extra years to life, should also be envisioned in qualitative terms. Our analysis exhibits stark inequalities across age and regions, with elderly persons struggling in the important wellbeing domains of economic security, health (care), and social engagement. India's first attempt to recognize ageing as a policy priority came with the National Policy on Older Persons (1999), later updated as the National Policy for Senior Citizens (2011). However, both have remained largely declaratory, with uneven adoption and limited financing. A population-wide comprehensive framework with long-term vision and perspective is warranted to ensure ageing well in India. Adapting a life-long approach ensures continual investments in human capital throughout lives. Approaching wellbeing through a life-cycle lens requires age-based tailored interventions in all the important domains.

Wellbeing in later life depends on four interconnected domains, i.e., economic security, health status, family connections and support, and social engagements. A balanced approach is required because working in silos might not yield desirable results. For example, generous pension amounts will enhance economic security, but at the same time, they might disincentivize work and promote a more sedentary lifestyle, along with financial discords in the family. However, from a policy angle, the health and healthcare domain seems to be the most important, as it drives the other three domains. Good health enables longer participation in the workforce, thereby strengthening economic security. It also reduces the caregiving burden within households, easing family stress and ensuring better intergenerational relationships. Similarly, healthier elderly are more likely to remain active in community networks, contributing to stronger social engagement and reduced isolation. Investment in preventive healthcare and early detection of chronic conditions, therefore, multiplies returns across the wellbeing spectrum. Policies that integrate nutrition, mental health, and access to affordable healthcare can reinforce resilience in later life.

Economic security and independence are vital for ageing well, and policy frameworks should be tailored considering the magnitude of informal employment in India. India, with the mix of formal and informal employment, has notable heterogeneities in terms of retirement plans and economic security in later life. This requires urgent policy attention as the quantum of informal and gig workers in the economy is on the rise, and overlooking their financial needs in the future (after one to two decades) will result in a substantial economic burden on the government. Concerted efforts, tailored to the type of employment, are required from a policy standpoint to strengthen financial independence during older age. This includes a focus on increasing pension coverage to informal workers, periodically revising the mandatory and statutory retirement age, increasing financial literacy and awareness, and dedicated platforms for the elderly job market.

Tackling the burden of NCDs among older adults and the elderly should be the top policy priority. Along with curative measures, early prevention is the key to a sustainable pathway to curb the burden of NCDs. Delaying the onset of chronic ailments through improved diets, physical activity, tobacco control, and alcohol reduction significantly reduces the years lived with disability. In this regard, the "National Programme for Health Care of the Elderly" (NPHCE, 2010) was designed as India's first dedicated programme for geriatric care, establishing Regional Geriatric Centres, geriatric OPDs, and ward facilities, while training specialists. In parallel, the "National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke" (NPCDCS) has strengthened screening and management of chronic conditions that disproportionately affect older persons. Despite these initiatives, coverage remains limited, particularly in rural districts where NPHCE units are

non-functional and NPCDCS screening is irregular. "Ayushman Bharat PM-JAY" further supplements elderly health coverage by financing hospitalisation, but outpatient and preventive care remain inadequately addressed. Screening for hypertension, diabetes, and cancers at primary healthcare levels can detect risks early, when interventions are more effective and affordable. Awareness campaigns must be designed to normalize routine health checkups among middle-aged and older adults. Equally critical is building capacity in community health systems for continuous monitoring, rather than one-time detection. Digital health records, mobile-based reminders, and teleconsultations can play a role in strengthening follow-up systems. Preventive and promotive health efforts should be mainstreamed into India's health missions, ensuring equitable access across rural and urban populations. With rising longevity, the measure of success will not only be years lived but years lived in good health.

Family relations and social engagement are critical drivers of wellbeing in the Indian context. Despite low reported levels of social and religious engagement among the elderly, it must be recognized that the family continues to be the first line of support for healthcare, financial assistance, and daily living in the Indian context. Intergenerational bonds with children, siblings, and extended kin play a decisive role in ageing with dignity. Not only do they provide practical care, but they also sustain identity, belonging, and psychological resilience. While shifting demographics, urban migration, and nucleation of households are undermining this traditional set-up, supply-side limitations of institutional care have not been able to compensate for the shortfall. In the policy context, the "Maintenance and Welfare of Parents and Senior Citizens Act (2007)" provides a legal obligation for children to maintain their parents and provides for state-run old-age homes. However, awareness remains low and implementation is subpar. To ease caregiving pressures, the "Integrated Programme for Senior Citizens (IPSrC)" funds NGOs to run day-care centres, old-age homes, and mobile medical units, thereby supplementing family care. Yet, coverage is uneven and urban-skewed, leaving rural caregivers without structured respite or support. Therefore, the challenges lie in not supplanting but supplementing family care with formal care. Policy should focus on easing the strain on caregivers, expanding training services, and building elder-friendly infrastructure.

A mixed model of informal and formal care could be a potential pathway for support and care during later life in India. The experience of ageing cannot be interpreted uniformly across states. In southern states, where demographic transition is more advanced, stronger social security nets and higher financial independence mean that elderly living alone often signals autonomy rather than neglect. In contrast, in northern states, solitary living reflects vulnerability, limited inclusion, and weak institutional arrangements. A mixed model of strengthening family systems while building complementary formal care, with a tailored approach adapting to local contexts at the region, state, district, and village levels, can ensure promising returns while preserving the country's cultural ethos of intergenerational responsibility.

It is high time for India to take cognizance of the gender dimension to ageing and wellbeing. Women face layered disadvantages across all domains. Lower lifetime earnings, limited pension coverage, and heavy reliance on informal work leave many without a secure income in old age. Widowhood further compounds vulnerability, stripping women of financial protection, companionship, and household security. Health neglect, unequal access to care, and entrenched gender norms add to their burden, while social isolation is heightened by longer life expectancy and weaker family support in later years. These realities make elderly women especially at risk of poverty, ill-health, and exclusion. With regards to pension, the Indian government introduced the "National Social Assistance Programme (NSAP, 1995)", which anchors income security for the elderly through the "Indira Gandhi National Old Age Pension Scheme (IGNOAPS)". For the financially better-off, the "Pradhan Mantri Vaya Vandana Yojana (PMVVY)", implemented by LIC, has provided assured returns for retirees able to invest savings. These schemes reflect India's dual economy of one heavily reliant on small, inadequate pensions for informal workers, and another with investment-based pensions for formal retirees. Access to these remains limited to elderly women who often remain outside of formal work and community engagement. While some state-run widow pensions, such as Tamil Nadu's "Destitute Widow Pension Scheme (REV-DWPS)", support women beneficiaries, they provide basic income security, often excluding women outside formal widowhood categories, such as deserted or unmarried elderly women. Expanding dedicated pension schemes for all women, enhancing

healthcare access, and strengthening community-based support can provide an immediate and high-yield policy response. Prioritizing women's wellbeing in later life is not only a matter of equity but also an efficient intervention, as gains will extend to household stability, intergenerational support, and community resilience. Targeting elderly women thus represents a clear and urgent opportunity, a low-hanging fruit for India's ageing policy agenda.

Government can resort to a range of policy interventions to promote health and active ageing that are not only cost-effective but can also reap silver dividend. Timely investments in health, employment, pensions, and social engagement for individuals across the life course are essential for the elderly to remain healthy, productive, and engaged, contributing to both the economy and society. Besides preventive and curative healthcare efforts, involving the elderly in lifelong learning and skilling initiatives, strengthening platforms for volunteering, mentorship, and intergenerational exchange can help channel their experience and knowledge for wider social good. Along with this, it is necessary to invest in establishing an age-friendly environment in terms of transport, housing, and digital inclusion to keep them integrated in community life. The Ministry of Housing and Urban Affairs prescribes standards for the creation of elder-friendly environments, including low-floor buses, ramps, lifts, and seat reservations for metro rail. However, there is a need for wider implementation of these guidelines, especially in rural areas. Such cost-effective measures can transform the growing elderly population in India into an asset and help secure a tangible silver dividend.

Addressing the knowledge gap about ageing by strengthening the research ecosystem and increasing awareness at the population level is critical to enhance wellbeing. While India has shown significant progress in collecting and monitoring information on child and maternal health, it is still evolving in terms of longevity research. The launch of the Longitudinal Ageing Study in India (LASI, 2017-18) marks a major step in filling ageing data gaps, with rich information on health, economics, and social participation. LASI aligns India with the global Health and Retirement Study (HRS family), enabling cross-country comparisons. Complementing this, WHO's Study on Global Ageing and Adult Health (SAGE) has also provided insights, though with smaller samples. Despite these advances, systematic long-term ageing data remain scarce, with limited integration into national surveys and policy planning. Lack of reliable information on elderly cohorts hinders the development of adequately informed policies. Given that India is at the forefront in the context of ageing, strengthening the research ecosystem through greater academic and policy collaboration, and embedding ageing questions in national data systems, would build a stronger base for evidence-driven reforms. Equally important to note is the low level of awareness among households about ageing itself. Financial literacy remains patchy, particularly for women, and preventive health practices such as regular check-ups, balanced nutrition, and exercise are not widely adopted. Social attitudes also reinforce ageing as a phase of decline rather than continued contribution, limiting both preparation and policy innovation. Parallel efforts to reshape the narrative of ageing into a story of success rather than decline are crucial. Awareness campaigns and community-based activities can help families better prepare and ensure a better ageing trajectory.

Early policy attention and response will be the key to ensuring ageing well in India. The country faces the distinct risk of "ageing before getting rich," with large numbers entering old age while income security, health systems, and care arrangements are still in transition. A forward-looking approach must recognize that wellbeing in later life is not a distant issue but a present development challenge. Interventions across nutrition, education, preventive health, and savings behavior need to begin well before old age, creating resilience across the life course. With timely reforms, India can move from the risk of being inadequately prepared to harnessing a genuine silver dividend, where longevity contributes to national growth and wellbeing.

Note

Centre for Research in Wellbeing and Happiness

The Centre for Research in Wellbeing and Happiness (CRWBH) at FLAME University, Pune, is envisaged to foster interdisciplinary thoughts and ideas encompassing subjective aspects of wellbeing through a social-science lens. It is a pioneering research initiative established at FLAME University, dedicated to addressing challenges related to individual and societal wellbeing by integrating objective and subjective dimensions within the Indian context. We aim to conduct academic and policy research in the areas allied to wellbeing, focusing on the interaction between objective and subjective measurements. The centre aims to explore and advance the understanding of wellbeing beyond conventional social and economic metrics, by focusing on subjective aspects through a comprehensive social science perspective. It seeks to incorporate diverse factors of wellbeing into academic, research, and policy discussions to foster holistic societal development.

For more details visit: http://www.crwbh.flame.edu.in

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