

Ageing Population in India: Demographic Trends and Socio-Economic Challenges

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Abstract

India is undergoing a significant demographic transition in which declining fertility, improving survival and increasing longevity are progressively altering the age structure of the population. Although India remains relatively young, population ageing is accelerating and is likely to become a major social-policy concern over the coming decades. This paper examines the demographic trajectory of ageing in India and analyses its principal socio-economic implications, with particular attention to regional inequality, gender, health, employment, income security, family support and institutional responses. The study adopts a descriptive, analytical and comparative secondary-data design. It synthesises evidence from the Census of India, population projections of the Government of India, the Longitudinal Ageing Study in India (LASI), Sample Registration System life tables, the India Ageing Report 2023, United Nations population estimates, government programme documents and peer-reviewed research. Evidence indicates that the population aged 60 years and above increased from 8.6% of India's population in Census 2011 to a projected 10.1% in 2021 and is projected to reach 13.1% by 2031. Longer-term estimates indicate that older persons may constitute nearly one-fifth of the population by 2050. Ageing is, however, highly uneven across states, gender and socio-economic groups. Multimorbidity, informal employment, limited pension protection, widowhood, changing living arrangements and unequal access to care intensify vulnerability. The paper argues that population ageing should not be interpreted simply as a rising dependency burden. India's policy challenge is to convert greater longevity into healthy, secure and socially productive later life through integrated health care, stronger social protection, long-term care, gender-responsive policies and age-friendly communities.

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Introduction

Population ageing is one of the most consequential demographic transformations of the twenty-first century. Improvements in survival, declining fertility and changing family formation progressively increase the relative and absolute number of people at older ages. The process is already advanced in many high-income countries, but it is increasingly important in low- and middle-income countries where demographic ageing is often occurring before comprehensive pension, long-term-care and geriatric health systems have been established. India presents a particularly important case because its very large population means that even a moderate increase in the proportion of older persons translates into an exceptionally large absolute population requiring health, income, housing and care support.

The term *older person* is not completely uniform across demographic and policy systems. Indian government reports and the Longitudinal Ageing Study in India commonly define the elderly or senior population as persons aged 60 years and above. Some international demographic databases also report indicators for ages 65 and above. The present paper therefore adopts 60 years and above as its principal analytical threshold and explicitly identifies instances where another age definition is used. This is essential because comparisons between 60+ and 65+ populations without recognising the definitional difference can produce misleading conclusions.

India's demographic trajectory demonstrates the speed with which the ageing question is becoming important. Census 2011 recorded approximately 103.8 million persons aged 60 and above, representing 8.6% of the total population. Government projections subsequently estimated the 60+ share at 10.1% in 2021 and 13.1% by 2031. Longer-term UNFPA estimates place India's population aged 60 and above at about 153 million in 2022 and project approximately 346–347

million by 2050, equivalent to nearly 21% of the population. UNFPA further estimates that the number of older persons may exceed the number of children aged 0–15 around 2046. These figures should not be treated as measurements from a common statistical series: the 2011 figure is Census-observed, while post-2011 figures depend substantially on demographic projections. Nevertheless, all major sources point towards the same structural conclusion—ageing will become progressively more prominent in India's population profile.

This transition is driven by changes at both ends of the age distribution. Fertility decline reduces the proportion of children entering the population, while improvements in survival increase the probability of reaching and living through later ages. The latest Sample Registration System abridged life tables for 2020–24 estimate Indian life expectancy at birth at 70.6 years. More important for research on ageing, a person surviving to age 60 could expect, on average, another 18.6 years of life. Women had higher life expectancy than men both at birth and at age 60. Thus, old age is not a brief residual stage in the demographic life course; for many individuals it now represents almost two additional decades during which health, care, income security and social participation become central determinants of wellbeing.

The research problem consequently extends beyond the numerical increase in older people. India is ageing within a socio-economic structure characterised by extensive informal employment, substantial rural populations, uneven state development, unequal health infrastructure, limited contributory-pension coverage and continued dependence on family-based support. Longevity gains may therefore coexist with chronic disease, financial insecurity and care deficits. At the same time, depicting all older adults as economically dependent creates its own analytical problem. LASI-based research shows considerable employment beyond age 60, particularly in agriculture and informal activities. Chronological ageing, functional limitation and economic dependency are related but not interchangeable concepts.

An additional concern is spatial and social heterogeneity. States such as Kerala have progressed much further through the demographic transition than states such as Bihar. Women generally survive longer than men but frequently reach old age after experiencing lower lifetime labour-force participation, weaker ownership of assets and a higher probability of widowhood. Urban older populations can benefit from greater physical access to specialised health services while also

facing high treatment costs, reduced neighbourhood support or unsuitable built environments. Rural older populations may remain embedded in stronger family and community networks yet experience greater distances from specialised medical care and greater dependence on agriculture and informal income. The national average therefore conceals several distinct ageing trajectories.

Existing Indian scholarship has generated substantial evidence on particular components of the problem. Early studies examined demographic ageing and old-age income security, while more recent LASI-based research has analysed multimorbidity, labour-force participation, living arrangements, loneliness and social protection. Yet the evidence remains relatively fragmented. Health studies frequently analyse morbidity without fully integrating labour or pension conditions; economic-security studies may understate functional health and care requirements; and analyses using LASI Wave 1 necessarily describe conditions largely during 2017–18, whereas several policy arrangements have subsequently changed. There is therefore value in an integrated synthesis combining demographic trends with updated evidence on longevity, health, work, family arrangements and institutional policy responses.

Against this background, the present study has four objectives: first, to examine the scale, pace and regional pattern of population ageing in India; second, to analyse the principal health, economic and social challenges associated with the transition; third, to assess how gender, state-level development, employment structures and family arrangements differentiate later-life vulnerability; and fourth, to evaluate the adequacy and direction of India's evolving policy response. Correspondingly, the paper asks four questions: How rapidly is India's population ageing and what demographic processes are driving the transition? What health and economic vulnerabilities accompany longer lives? How do regional, gender and family differences shape the experience of ageing? And to what extent is the current policy architecture equipped to support healthy and economically secure ageing?

Conceptually, the paper combines demographic-transition reasoning with the World Health Organization's healthy-ageing framework. Demographic transition explains the changing age structure generated by lower fertility and improved survival. The healthy-ageing perspective shifts attention from chronological age alone to *functional ability*: the interaction between an individual's physical and mental capacities and the social, physical and policy environment in which that

individual lives. This approach is particularly appropriate for India because an older agricultural worker who remains economically active, an urban pensioner living independently and a care-dependent oldest-old widow may share the same chronological age category while experiencing fundamentally different forms of ageing. WHO therefore emphasises that healthy ageing does not require complete absence of disease; rather, it involves maintaining the abilities that allow older people to meet needs, remain mobile, sustain relationships, make decisions and contribute to society.

The central argument developed in the paper is that India's emerging challenge is not population ageing in itself, but the mismatch between rapid demographic ageing and the incomplete adaptation of health, income-security, care and community systems to longer lives. The implications are therefore not adequately captured by a simple "burden" narrative. Appropriate policy can reduce avoidable dependency, extend healthy and productive life, and transform longevity from a source of household vulnerability into a social achievement.

Literature Review

Population ageing in India began receiving sustained academic attention well before the elderly population reached its present size. Rajan, Mishra and Sarma's *India's Elderly: Burden or Challenge?* (1999) was important in framing the central conceptual dilemma: whether a rising older population should primarily be understood through dependency and fiscal cost or through changing institutional responsibilities and opportunities for social participation. The significance of this distinction has increased over time. A purely dependency-oriented interpretation risks equating age with incapacity, whereas a purely celebratory view of longevity may obscure the financial and care disadvantages accumulated by vulnerable populations across the life course.

Research on economic security has consistently identified India's employment structure as a critical problem. Alam (2004) argued that population ageing was taking place among cohorts marked by substantial socio-economic disadvantage and emphasised the need for stronger and more diversified old-age income-security arrangements. The continuing relevance of this argument is evident in later evidence from LASI. Chattopadhyay et al. (2022), analysing 31,464 adults aged 60 and above, found that 36% continued to work; among those working, around two-thirds were

engaged mainly in agriculture and allied activities, only about 5% had full-time jobs, and approximately 6% were covered by a work-related pension or provident-fund arrangement. The study demonstrates why work in old age is analytically ambiguous. Continued employment can signify active and productive ageing, but in a context of limited retirement benefits it can also represent an economic necessity rather than free occupational choice.

This finding challenges conventional interpretations of the old-age dependency ratio. Demographic dependency measures classify individuals above a particular age as dependants on the working-age population, but they do not measure actual work, income, wealth, health or care dependence. The classification is useful for population structure but insufficient as an economic measure. India's extensive informal economy makes this limitation particularly consequential because retirement does not occur at a single institutionally defined age for much of the population. Formal-sector employees may retire with pensions or accumulated savings, while cultivators, self-employed workers and casual labourers may continue earning for as long as physical capacity permits.

Health research has meanwhile shifted from mortality to chronic disease, functional limitation and multimorbidity. Patel, Muhammad and Sahoo (2023), using LASI data for 31,464 persons aged 60 and above, estimated single morbidity at 30.3% and multimorbidity at 32.1%. Multimorbidity increased with age and was higher among women and urban residents, while Kerala recorded particularly high measured prevalence. Such results are important but require careful interpretation. Greater reported diagnosed morbidity in relatively developed or urban settings can reflect a genuinely higher non-communicable disease burden, but it may also partly reflect greater contact with medical services and therefore higher probability of diagnosis. Conversely, lower self-reported diagnosed morbidity in underserved populations cannot automatically be interpreted as better health. The authors themselves recognise regional variation in diagnosis, utilisation and reporting as important issues.

The WHO healthy-ageing framework helps resolve this limitation by distinguishing disease from functional ability. Older people may live with one or more controlled chronic conditions yet retain mobility, decision-making ability, social relationships and economic participation. Conversely, a person without a formally diagnosed condition may experience untreated sensory, cognitive or

mobility limitations that restrict everyday functioning. This makes intrinsic capacity, environment and access to support at least as important as disease counts for evaluating the consequences of demographic ageing. WHO's Decade of Healthy Ageing consequently organises action around age-friendly environments, combating ageism, person-centred integrated care and access to long-term care.

A second major strand of literature concerns family and living arrangements. The Indian family continues to provide much of the everyday support available to older adults, yet falling family size, migration, urbanisation and changing employment patterns can alter the availability of co-resident caregivers. LASI Wave 1 nevertheless cautions against exaggerated claims of a wholesale collapse of intergenerational living. Among people aged 60 and above, 40.6% lived with a spouse and children and 27.6% lived with children without a spouse; 20.3% lived with a spouse but without children, while 5.7% lived alone. Nearly three-fourths were satisfied with their existing living arrangements. Thus, multigenerational family residence remained the predominant pattern, although the presence of a sizeable spouse-only and alone-living population indicates growing diversity.

Research also indicates that household composition alone does not fully describe social wellbeing. Kandapan, Pradhan and Pradhan (2023) found living arrangements to be closely associated with life satisfaction among older Indians, while Srivastava and Srivastava (2023) reported that 13.4% of older LASI respondents in their analytical sample experienced frequent loneliness. Loneliness was associated with marital status, chronic conditions, functional difficulties, physical inactivity, limited social networks and lower participation in social and leisure activities. The literature therefore supports a multidimensional interpretation of social support: co-residence matters, but relationship quality, social interaction, health and community participation also influence later-life wellbeing.

The literature on social protection reveals another important gap between nominal policy availability and effective access. LASI found that only 55% of older people were aware of the Indira Gandhi National Old Age Pension Scheme (IGNOAPS), while awareness of several other programmes was lower. Among rural older persons belonging to below-poverty-line households, only around one-third were receiving old-age pension benefits during the LASI survey period.

Administrative obstacles were also evident: cumbersome enrolment and lack of documents were reported as reasons for non-utilisation, and awareness of the Maintenance and Welfare of Parents and Senior Citizens Act, 2007 was only 12%. These findings demonstrate that programme existence cannot be equated with effective social protection.

Recent policy expansion has, however, changed parts of the institutional landscape since LASI Wave 1. Most notably, the Government of India expanded Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) in October 2024 to provide ₹5 lakh of annual hospitalisation cover to all citizens aged 70 years and above irrespective of socio-economic status. By 5 December 2025, more than 93 lakh Ayushman Vay Vandana cards had been issued, while 7.89 lakh hospital admissions worth ₹1,741 crore had been authorised by 31 October 2025. This expansion represents a substantial change in financial protection for hospital treatment, although it does not by itself resolve outpatient, preventive, home-based or long-term-care requirements.

Three unresolved issues emerge from the literature. First, much research remains sectoral even though health, employment, pensions and family support interact strongly in old age. Second, nationally representative individual-level evidence still depends heavily on LASI Wave 1, whose principal fieldwork was carried out in 2017–18; policy and economic conditions have changed since then. The survey nonetheless remains an unusually rich national resource, covering 73,396 persons aged 45 and above and their spouses and incorporating health, economic, family, social-security and biomarker domains. Third, the national average conceals substantially different demographic transitions across states. The present study addresses these gaps through an integrated secondary-data synthesis that explicitly distinguishes demographic projection from observed survey evidence and connects ageing trends to health, economic security, gender, family support and current policy.

Research Methodology

The study adopts a secondary-data-based, descriptive, analytical and comparative research design. No primary survey, interview, questionnaire or field observation was undertaken. Consequently, no independently generated sample size, respondent profile or primary statistical result is reported.

The objective is instead to triangulate authoritative demographic, health, socio-economic and policy evidence to construct an integrated assessment of population ageing in India.

The primary demographic sources include Census 2011; *Elderly in India 2021* published by the Ministry of Statistics and Programme Implementation (MoSPI), drawing on the Technical Group on Population Projections for India and States, 2011–2036; the Office of the Registrar General and Census Commissioner's Sample Registration System; the United Nations Population Division; and the UNFPA–IIPS *India Ageing Report 2023*. For mortality and longevity, particular attention is given to the SRS Abridged Life Tables 2020–24, published in May 2026.

Individual- and household-level evidence is drawn principally from the Longitudinal Ageing Study in India Wave 1. LASI is nationally representative and includes 73,396 interviewed individuals aged 45 years and above and their spouses, including approximately 31,902 people aged 60 and above. Main Wave 1 fieldwork was conducted between April 2017 and December 2018, with Sikkim subsequently covered in 2020–21. LASI provides information on health, biomarkers, healthcare utilisation, income, wealth, employment, pensions, family networks, social participation and welfare programmes. The present paper uses published national estimates and peer-reviewed LASI-based studies rather than re-estimating the microdata.

The main analytical indicators are the number and percentage of persons aged 60 and above; projected growth of the elderly population; life expectancy at birth and at age 60; state and gender variations; chronic morbidity and multimorbidity; employment and pension coverage; living arrangements and loneliness; awareness and use of social-security programmes; and recent institutional expansion in health and senior-citizen welfare. Where periods differ, survey years and projection years are stated explicitly rather than merged into a single time series.

Analysis proceeds through demographic trend comparison, regional comparison, gender analysis, synthesis of published LASI findings and assessment of programme design and implementation. The interpretive framework combines demographic transition with WHO's healthy-ageing perspective. It also applies a life-course interpretation: old-age outcomes reflect not only conditions after age 60 but also accumulated differences in education, labour-market participation, earnings, health exposure and asset ownership.

The methodology has four important limitations. First, the latest completed population Census observation used here is from 2011; subsequent age structures depend heavily on projections. Second, much detailed national evidence on older adults' circumstances derives from LASI Wave 1 and therefore should not be presented as a measurement of conditions in 2026. Third, diagnosed disease estimates may be affected by differential healthcare access and awareness. Fourth, administrative counts for government programmes measure enrolment or service utilisation rather than the programmes' causal effects on health or poverty. The study therefore avoids causal claims unsupported by longitudinal or experimental evidence.

Analysis and Discussion

Demographic Scale and Pace of Ageing

India's population ageing is best understood as a transition occurring in stages rather than as an abrupt demographic reversal. The share of persons aged 60 and above was only about 5.6% in 1961. Census 2011 recorded 8.6%, representing approximately 103.8 million people. Official projections placed the share at 10.1% in 2021 and 13.1% by 2031. UNFPA's longer-term estimates suggest approximately 346–347 million people aged 60 and above by 2050, close to 21% of the population.

Indicator	Reference period	Estimate	Statistical status/source
Population aged 60+	2011	103.8 million; 8.6%	Census-observed
Population aged 60+	2021	10.1%	Government projection
Population aged 60+	2031	13.1%	Government projection
Population aged 60+	2050	About 346–347 million; nearly 21%	UNFPA/UN projection

Life expectancy at birth	2020–24	70.6 years	SRS estimate
Remaining life expectancy at age 60	2020–24	18.6 years	SRS estimate

Sources: Census of India/Government of India; MoSPI (2021); ORGI (2026); UNFPA & IIPS (2023).

Two interpretations follow. First, India can remain a country with a large young and working-age population while simultaneously ageing rapidly. These demographic characteristics are not contradictory. A very large base population means that the absolute number of older adults can rise substantially before the elderly become the majority of the population. Second, the ageing process has temporal momentum. People currently in middle adulthood constitute the future elderly population, while sustained lower fertility reduces the relative size of younger cohorts. Planning only after the elderly share becomes very high would therefore be institutionally late.

The 2020–24 life tables reinforce the significance of longevity. Average life expectancy at age 60 was 18.6 additional years, meaning that the social and economic organisation of life after 60 must increasingly account for periods extending into the late seventies and beyond. Moreover, the oldest-old population is expected to expand especially rapidly: the India Ageing Report projects very strong growth among those aged 80 and above between 2022 and 2050. This group is particularly relevant for long-term care because advanced age raises the probability of multiple chronic conditions, mobility restrictions, widowhood and dependence on assistance.

Ageing thus changes the policy horizon from a relatively narrow pension question to a multi-decade issue involving housing, transport, preventive medicine, chronic-disease management, mental health, assistive technology, caregiving and end-of-life support. The appropriate unit of planning is therefore not merely the number of pensioners but the functional and social needs of different older-age groups.

Regional and Gender Differentiation

India is not experiencing a single uniform ageing transition. MoSPI's projections demonstrate pronounced interstate variation, reflecting differences in past fertility decline, mortality, migration and socio-economic development. Kerala, which experienced an early fertility transition and has high longevity, had a projected elderly share of approximately 16.5% in 2021, compared with around 7.7% in Bihar. The implication is that ageing-related institutional pressure will emerge at different speeds across states. A uniform national programme may establish rights or minimum entitlements, but service capacity must respond to state-specific age structures.

The latest life tables reveal similarly large geographic inequalities in survival. For 2020–24, life expectancy at birth varied from 64.7 years in Chhattisgarh to 75.6 years in Kerala. Such variation affects not only the number of older persons but the length of later life and potential duration of chronic-disease management. States further along the longevity transition need stronger geriatric and long-term-care capacity now; states at earlier stages have an opportunity to build such systems before ageing accelerates.

Gender is equally important. For 2020–24, female life expectancy at birth was 72.8 years compared with 68.7 years for males. At age 60, women could expect a further 19.8 years compared with 17.5 years for men. Greater female longevity is a major demographic achievement, but it produces what is often described as the feminisation of later life. Women's longer survival combines with age differences between spouses and widowhood to produce a comparatively large group of older women who must manage late life without a surviving spouse.

Longevity advantage should therefore not be equated with socio-economic advantage. Many women now entering old age spent their working years in unpaid household work, informal employment or occupations without contributory pension rights. Lower lifetime earnings and asset ownership can translate into financial vulnerability after widowhood. The gendered distribution of unpaid caregiving compounds the issue: women often provide care for spouses and relatives before later becoming care recipients themselves. An ageing policy that treats older persons as a gender-neutral population risks overlooking this cumulative disadvantage.

Regional and gender analyses also caution against crude interpretation of health statistics. Higher diagnosed multimorbidity in Kerala and urban populations can reflect an older age structure and genuine epidemiological change, but stronger diagnosis and healthcare utilisation may also increase measured prevalence. Areas with limited medical access may appear healthier if undiagnosed disease remains invisible in self-reported data. The correct policy response is therefore not to rank states mechanically by diagnosed morbidity but to combine epidemiological measurement with service access, functional status and population age structure.

Chronic Disease, Functional Health and the Emerging Care Economy

Increasing survival inevitably changes India's disease and care profile. LASI-based research shows that multimorbidity is already common among older Indians. Patel et al. (2023) estimated that 32.1% of people aged 60 and above had multimorbidity, in addition to 30.3% reporting a single morbidity. Multimorbidity increased with advancing age and was particularly prominent among women and urban populations. Kerala recorded 59.2% in that study, illustrating how states further through the epidemiological and demographic transitions can experience a particularly substantial chronic-disease burden.

These findings have implications beyond the number of illnesses. Health systems organised around individual acute conditions are poorly suited to an ageing population in which hypertension, diabetes, arthritis, cardiovascular disease, sensory impairment and mental-health conditions may coexist. Multimorbidity can create complex medication regimens, repeated appointments, high out-of-pocket expenditure and dependence on relatives for transport and care coordination. The relevant model must therefore become more continuous, integrated and patient-centred.

WHO's functional approach is especially useful here. The policy objective should not be simply to prolong survival or eliminate every chronic diagnosis, but to enable people to retain mobility, cognition, social participation and independence for as long as possible. This requires preventive and rehabilitative services, physiotherapy, vision and hearing support, assistive devices, nutritional support and home- or community-based care alongside conventional hospital treatment.

India's health-financing response has recently expanded. Since October 2024, AB-PMJAY has included all people aged 70 and above irrespective of socio-economic status, with up to ₹5 lakh

annual cover for eligible secondary and tertiary hospitalisation. By December 2025, more than 93 lakh Ayushman Vay Vandana cards had been created, and substantial hospital utilisation had already been recorded. The reform is significant because catastrophic hospital expenditure can severely erode household savings in old age.

Yet insurance for hospitalisation and a comprehensive ageing-health system are not equivalent. Many later-life needs arise before admission to hospital: routine management of hypertension and diabetes, medication adherence, physiotherapy, screening, dementia support, rehabilitation following injury, palliative care and assistance with daily living. Hence the extension of hospital insurance should be understood as one layer of protection rather than a substitute for strong primary health care and long-term care.

This distinction points to an emerging care economy. As the number of very old people grows and family size declines, demand will increase for trained home-care workers, geriatric nurses, physiotherapists, social workers, counsellors and community health personnel. Building the care economy can simultaneously address a welfare need and create employment. However, professionalisation is necessary to establish standards of training, safety, remuneration and accountability. Reliance on poorly paid informal care labour would reproduce existing inequalities rather than resolve them.

Employment, Retirement and Economic Security

The economic implications of ageing are frequently presented in terms of a rising dependency ratio, but Indian evidence shows why a more nuanced interpretation is necessary. Chattopadhyay et al. (2022) found that 36% of adults aged 60 and above were still working in LASI Wave 1. Approximately two-thirds of those working were concentrated in agriculture and allied activities, and only a small minority had full-time formal jobs or work-related pensions.

These findings overturn two simplistic assumptions. The first is that reaching 60 automatically means economic withdrawal. For many Indians, the boundary between working age and retirement is much less distinct than in formal salaried employment. The second is that older-age work necessarily signals successful “active ageing”. Continued employment may reflect capability, preference and social participation, but it can also be driven by inadequate pension protection.

Indeed, the same evidence shows a predominance of agriculture and informal work, sectors in which physical capacity is important and retirement benefits are limited.

Old-age income security consequently remains one of the central challenges of demographic ageing. Contributory pensions are more accessible to workers with sustained formal employment histories than to those whose lives were spent in casual labour, farming, household enterprises or unpaid family work. This creates a substantial lifetime linkage between labour-market informality and old-age vulnerability.

Tax-financed social assistance provides an important second layer, but adequacy is a persistent concern. As of April 2026, the central contribution under IGNOAPS remained ₹200 per month for eligible below-poverty-line beneficiaries aged 60–79 and ₹500 for those aged 80 and above, although states and union territories may provide additional top-ups. More than ₹32,000 crore had been released under the programme over the five financial years to 2024–25. The continued existence and scale of the programme are important, but the central transfer amounts themselves highlight the difference between programme coverage and adequate income replacement.

LASI evidence additionally indicates administrative barriers. Only slightly more than half of older persons surveyed were aware of the national old-age pension scheme, and among the eligible poor, receipt was far from universal. Respondents reported cumbersome enrolment and documentation requirements as obstacles. These findings pre-date some recent digital-government expansion, but the underlying lesson remains relevant: effective social protection depends on identification, enrolment, portability and timely payment as much as on statutory eligibility.

Policy should therefore avoid framing income security as a choice between family responsibility and state support. Family transfers can be substantial and socially valuable, but they are unequally distributed and vulnerable to unemployment, migration, household conflict and the care obligations of younger generations. A more resilient system requires several layers: personal savings where feasible, contributory pensions for organised and increasingly for informal workers, adequate non-contributory pensions for people with limited lifetime earnings, health-risk protection and accessible public services that reduce the amount of cash households must spend on essential care.

Population ageing also creates an economic opportunity. Older people who retain functional ability can remain in paid work, self-employment, mentoring, caregiving, volunteering and community activity. Flexible work arrangements, age-friendly workplaces, reskilling and protection against age discrimination could therefore extend productive participation without forcing people to work because retirement is unaffordable. This distinction between choice-based productive ageing and necessity-driven late-life labour is crucial.

Family Support, Living Arrangements and Social Wellbeing

Much discussion of Indian ageing assumes the rapid disappearance of the joint family. National evidence supports a more measured conclusion. In LASI Wave 1, 40.6% of older adults lived with a spouse and children and 27.6% lived with children without a spouse. Together, these categories demonstrate that intergenerational co-residence remained the dominant arrangement. Around 20.3% lived only with a spouse and 5.7% lived alone. Moreover, 74.9% reported satisfaction with their current living arrangement.

The appropriate interpretation is therefore not that family care has collapsed, but that family arrangements are becoming more diverse while remaining central. Smaller families, internal and international migration, women's increased participation in paid employment and greater urban residential mobility can reduce the number of relatives available for continuous hands-on care. Spouse-only households may function independently while both partners remain healthy but become vulnerable when one develops major disability. Living alone may similarly reflect autonomy for some people and isolation for others.

The psychosocial dimension deserves equal attention. Srivastava and Srivastava (2023) found frequent loneliness among 13.4% of older people in their LASI-based study. Loneliness was associated not merely with household composition but also with marital status, chronic illness, functional difficulty, limited social networks and low participation in physical or leisure activities. Kandapan et al. (2023) likewise demonstrated a significant relationship between living arrangements and life satisfaction.

Consequently, simply ensuring physical co-residence does not guarantee wellbeing. Elderly care policy must address social participation, community relationships, protection from abuse, mental

health and opportunities for meaningful activity. Parks, public transport, walkable neighbourhoods, accessible community centres and digital-assistance facilities can therefore be understood as components of ageing policy rather than unrelated urban amenities.

This has particular importance for women and the oldest-old. Greater female longevity increases the probability of living after spousal loss, while advanced age increases functional limitations. Intergenerational households will continue to be indispensable, but expecting families alone to absorb rapidly increasing long-term-care needs is unlikely to be sustainable. The better policy objective is supported ageing in place: strengthen families where care relationships are desired while supplementing them with home-health services, day-care facilities, respite care, assistive technology and high-quality residential options for those who require them.

Institutional Response and Priorities for Healthy Ageing

India does not lack an institutional architecture for senior citizens. Programmes now span pensions, hospital insurance, geriatric health services, assistive devices, helplines and institutional care. The Atal Vayo Abhyuday Yojana (AVYAY), for example, functions as an umbrella framework for several senior-citizen welfare interventions. In July 2026, the Ministry of Social Justice and Empowerment reported that Elderline 14567 was operational across 32 states and union territories and that 734 Senior Citizen Homes were receiving support. Rashtriya Vayoshri Yojana had also distributed millions of assistive devices to older beneficiaries.

The policy question is therefore increasingly about integration, adequacy and scalability rather than the complete absence of schemes. Health programmes, social pensions, disability support and senior-citizen welfare frequently operate through different ministries, eligibility rules and administrative channels. An older person with hypertension, impaired mobility and no pension does not experience these as separate policy domains; his or her vulnerability is cumulative. Greater coordination between primary healthcare, social welfare, pensions, disability assistance and local government could reduce administrative burden and improve continuity of care.

State differentiation is equally essential. Kerala and other advanced-ageing states require rapid expansion of geriatric and long-term-care infrastructure, whereas younger states have a strategic window to incorporate ageing into health and urban planning before the demographic pressure

becomes acute. Central funding and rights can provide a common floor, but planning ratios based simply on total population may fail to reflect dramatically different proportions of elderly residents.

Income security also requires reconsideration. The persistence of very low central social-pension amounts and evidence of limited formal pension coverage indicate that longer lives are not automatically financially secure lives. Periodic review of pension adequacy, simplified enrolment and stronger portability could reduce later-life poverty. Women's lifetime disadvantages warrant particular attention, including widows and older women without independent income or pension entitlements.

Health policy needs a similarly layered model. Universal hospital coverage for those aged 70 and above is an important development, but healthy ageing requires preventive and primary care across the full 60+ age range, not only hospital finance after severe illness. Screening, chronic-disease management, rehabilitation, mental-health services, dementia care, physiotherapy and palliative services should increasingly be available near where older people live.

Long-term care represents perhaps the largest emerging institutional gap. WHO identifies access to good-quality long-term care as one of the four core action areas of the UN Decade of Healthy Ageing. India will require a continuum extending from family caregiving and home assistance to community day care, respite care, assisted living and medically supported residential facilities. Regulation and quality assurance are particularly important because the growth of private care markets without enforceable standards could create financial exploitation and unequal quality.

Finally, ageing policy should explicitly recognise older adults as social and economic participants. Age-friendly transport, lifelong learning, assisted digital access, flexible employment, volunteering and community institutions can preserve autonomy and reduce loneliness. A focus exclusively on dependency would miss the contribution that healthier older adults can make through work, family care, knowledge transmission and civic activity. India's policy objective should therefore be neither indefinite employment nor passive retirement, but the expansion of meaningful choices in later life.

Conclusion

India's demographic future will be characterised by the coexistence of a large working-age population and a rapidly expanding elderly population. Census 2011 recorded 103.8 million people aged 60 and above, while subsequent official and international projections indicate a substantial increase in both their number and population share during the coming decades. The central demographic finding of this study is therefore not that India has already become an "old" society, but that the transition is sufficiently rapid and numerically large to require institutional preparation well before 2050.

The first research question concerned the pace and drivers of ageing. Evidence demonstrates that lower fertility, improved survival and longer life expectancy are changing India's age structure. Remaining life expectancy of 18.6 years at age 60 during 2020–24 illustrates why later life must be treated as a substantial stage of the life course rather than a short period of dependency. Ageing will simultaneously become more internally differentiated as the number of people in their seventies and eighties rises.

The second question examined health and economic vulnerabilities. Longer life is occurring alongside a substantial burden of chronic disease and multimorbidity, while India's predominantly informal employment history leaves many older adults without comprehensive retirement protection. At the same time, the fact that more than one-third of older adults in LASI were working demonstrates that chronological age does not measure economic dependency. Employment in later life can represent both continued capability and insufficient income security. Policy analysis must distinguish the two.

The third question concerned inequality. India is experiencing several ageing transitions rather than one. States differ markedly in age structure and longevity; women live longer but can face cumulative economic disadvantages; and family circumstances range from multigenerational co-residence to spouse-only and single-person households. Family support remains strong and should not be portrayed as disappearing, but demographic and labour-market change makes exclusive dependence on unpaid household caregiving increasingly fragile.

The fourth question addressed institutional preparedness. India's response has expanded substantially through geriatric programmes, AAY, social pensions and the extension of AB-PMJAY to all citizens aged 70 and above. These measures constitute an increasingly important foundation. Nevertheless, institutional fragmentation, limited social-pension adequacy, unequal service availability and underdeveloped long-term care remain major concerns. Hospital insurance alone cannot substitute for integrated primary care, rehabilitation, community support and sustained assistance with daily living.

The broader academic implication is that the consequences of ageing cannot be inferred directly from demographic ratios. A population can become older without becoming proportionately dependent if morbidity is delayed, functional capacity is preserved, savings and pensions are adequate, and institutions allow continued participation. Conversely, relatively modest demographic ageing can generate severe vulnerability where chronic illness, poverty and care shortages coincide. The relevant policy target is therefore not the reduction of ageing—which is largely the result of successful improvements in survival—but the reduction of avoidable dependency and inequality within ageing.

India should pursue a life-course and healthy-ageing strategy based on stronger preventive health care, universal and adequate old-age income protection, gender-sensitive planning, an organised long-term-care system, support for family caregivers, age-friendly communities and opportunities for productive participation. States should receive flexibility to adapt programmes to their different stages of demographic transition while maintaining national minimum standards of protection.

This study is limited by its secondary-data design. The latest completed Census observation used for detailed national age structure is from 2011; later figures rely significantly on demographic projections. Much individual-level evidence derives from LASI Wave 1 and therefore reflects conditions primarily in 2017–18, while administrative programme statistics cannot by themselves demonstrate policy effectiveness. Future research should use subsequent longitudinal LASI waves and newer Census data when available to examine transitions in health, work, income, caregiving and living arrangements at the individual level. Greater attention is also required to dementia, long-term-care financing, the economics of unpaid caregiving, digital exclusion and district-level variation.

Population ageing ultimately represents both the outcome of developmental progress and a test of institutional adaptability. The relevant question for India is not whether its population will age—it clearly will—but whether the additional years of life gained by millions of citizens will be lived with health, financial security, autonomy and dignity. Meeting that objective will determine whether demographic ageing becomes primarily a source of inequality and household strain or an extension of India's social and developmental achievements.

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