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

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Abstract

India is moving towards a critical stage of demographic ageing, which is being driven by lower fertility and higher life expectancy. The country has a significant working age population, but the population aged 60 years and over is growing, imposing new demands on health care, income security, family support and public institutions. This paper reviews the extent and geographical distribution of ageing and its key socio-economic consequences. The analysis is based on Census 2011, official population projections, Sample Registration System (SRS) life tables for 2016-2020, Longitudinal Ageing Study in India (LASI), India Ageing Report 2023 and other research and policy documents. The older person population was 103.8 million (8.6%) in Census 2011, and is projected to be 10.1% (107.8 million) in 2021 and 13.1% (119.4 million) in 2031. By 2050, UNFPA estimates that the elderly population (aged 60 and older) may reach 347 million. The data shows significant disparities by state and gender, high rates of chronic disease and financial insecurity, and a persistent reliance on family care. Policy interventions such as the expansion of Ayushman Bharat to senior citizens (age 70 and above) in 2024 are steps forward, but significant gaps remain in preventive care and pensions and long-term support. The paper concludes that an approach that is life-course, gender-sensitive and regionally differentiated is needed to support healthy, financially secure and socially active later life, for successful adaptation.

Keywords: population ageing, demographic transition, older persons, social security, healthy ageing, LASI, India

Introduction

Population ageing is a gradual but far-reaching outcome of demographic transition. When fertility declines and the chances of surviving into older ages improve, older persons account for a growing share of the population. This transformation affects the organisation of work, the provision of health services, the distribution of household resources and the relationship between generations. Countries that experienced ageing alongside sustained economic development often had time to expand pensions and formal care arrangements. In India, demographic change is unfolding in a society where informal employment remains extensive, income inequality is substantial and family members continue to provide much of the care required in later life.

Indian policy usually defines a senior citizen as a person aged 60 years or above. This paper adopts that threshold throughout, unless a programme uses a different age criterion. The distinction matters because figures based on the population aged 65 and above cannot be compared directly with figures for those aged 60 and above. It is equally important to

distinguish observed population counts from demographic projections. Census 2011 remains the principal population enumeration underlying the discussion, while later national and state estimates draw on projection models rather than a new census count.

According to Census 2011, India had approximately 103.8 million people aged 60 and above, constituting 8.6% of its population. The Government of India's projections estimated that the elderly share would reach 10.1% in 2021 and approximately 13.1% in 2031. The India Ageing Report 2023 projects that older persons could account for roughly one-fifth of Indians by 2050 (MoSPI, 2021; UNFPA & IIPS, 2023). The absolute scale of change is especially important: a modest increase in India's elderly proportion represents many millions of additional people requiring appropriate services and opportunities.

The transition is not uniform. Kerala and Tamil Nadu experienced fertility decline earlier than several northern states and consequently face more advanced population ageing. Differences in survival, migration, employment and public services further complicate the national picture. Women often live longer than men, yet their longevity may be accompanied by widowhood, limited independent income and a lifetime of unpaid care work. Rural older persons are more likely to depend on agriculture and locally available public services, while urban residents may encounter high living costs and weaker everyday support networks.

Ageing must therefore be examined as more than a rise in the old-age dependency ratio. Chronological age does not establish whether an individual is healthy, working, financially secure or dependent on assistance. Some people continue to cultivate land, run businesses or support younger relatives after 60; others face illness, disability and economic hardship much earlier. The World Health Organization's concept of healthy ageing is useful because it emphasises functional ability, supportive environments and meaningful participation rather than age or diagnosis alone (WHO, 2020). Within this perspective, the central issue for India is how to improve the quality, security and dignity of additional years of life.

Review of Literature

Research on ageing in India has long questioned whether a growing elderly population should be treated principally as an economic burden. Rajan, Mishra and Sarma (1999) highlighted the institutional and social implications of changing age structures, while Alam (2004) showed that old-age income security is inseparable from labour-market experience and accumulated disadvantage. These contributions remain important because many people entering old age have spent their working lives outside formal pension systems.

The Longitudinal Ageing Study in India has substantially improved the evidence available for studying older adults. Its first wave, conducted mainly in 2017–2018, collected information on health, household circumstances, employment, pensions and social relationships. In an analysis of 31,464 respondents aged 60 and above, Chattopadhyay et al. (2022) found that about 36% were working. Around two-thirds of working older persons were engaged in agriculture and allied activities, while only a small minority had full-time employment or work-related pension protection. These findings demonstrate that continued work may reflect either valued participation or the necessity of earning an income in the absence of adequate retirement support.

Health studies reveal another dimension of vulnerability. Using LASI data, Patel, Muhammad and Sahoo (2023) estimated that 30.3% of older adults had one of the chronic conditions studied, while 32.1% had multimorbidity. The measured burden was higher among women and urban residents and increased with age. However, diagnosed morbidity can also depend on access to health services: a population with fewer diagnosed conditions is not necessarily healthier if disease detection is limited. Research consequently needs to consider functional limitations and care requirements alongside disease prevalence.

Household composition and emotional wellbeing have also attracted attention. LASI indicated that most older Indians still lived with children, either with or without a spouse, although smaller households and people living alone formed an important minority (IIPS et al., 2020). Kandapan, Pradhan and Pradhan (2023) linked living arrangements with life satisfaction. Srivastava and Srivastava (2023) found that 13.4% of older adults in their LASI analytical sample reported frequent loneliness, which was associated with health problems, marital circumstances and limited social participation. Together these studies suggest that living with relatives does not automatically guarantee psychological wellbeing, while living alone does not always mean abandonment.

Recent institutional research has called for a broader understanding of senior care. The India Ageing Report 2023 emphasised regional, gender and economic inequalities, particularly among older women and the oldest-old. NITI Aayog's *Senior Care Reforms in India* (2024) argued for closer integration of health, social, financial and digital inclusion. The literature therefore provides strong evidence on individual aspects of ageing, but a comprehensive policy response requires these dimensions to be considered together. This paper contributes an integrated synthesis using material available by the end of 2024, without treating survey findings from earlier years as current observations.

Research Objectives

The study seeks to examine the growth and regional variation of India's population aged 60 and above; assess major health, employment, income-security and family-support challenges; identify differences in later-life vulnerability associated with gender and place of residence; and evaluate the direction and remaining limitations of public policy up to December 2024. Its central question is whether India's health and welfare institutions are adapting sufficiently to the speed and unequal character of demographic ageing.

Research Methodology

This study follows a descriptive, analytical and comparative design based entirely on secondary data. It does not report an original household survey, independent field observations or statistical estimates computed from LASI microdata. Demographic patterns are examined using Census 2011 and the Technical Group on Population Projections for India and States, as reported by the Ministry of Statistics and Programme Implementation. The UNFPA–IIPS *India Ageing Report 2023* provides the longer-term outlook. Mortality and longevity are examined using the SRS Abridged Life Tables for 2016–2020.

Evidence on health, work, living arrangements, loneliness and social protection is drawn principally from published LASI Wave 1 results and peer-reviewed studies available by the cutoff date. Policy information is taken from government documents on the National Social Assistance Programme, geriatric health services, senior-citizen welfare and the 2024 expansion of Ayushman Bharat. The sources are assessed through trend comparison, state-level contrasts, gender analysis and thematic synthesis. The WHO healthy-ageing framework guides interpretation of the interaction between individual capacities and the surrounding social and institutional environment.

Several limitations are recognised. Census figures, sample-survey estimates and projections represent different forms of evidence and are not combined as though they were observations from one series. LASI Wave 1 largely reflects 2017–2018 rather than circumstances at the end of 2024. Disease prevalence may be affected by unequal diagnosis and reporting, while scheme enrolment does not establish its impact on health or poverty. The study therefore identifies associations and policy gaps without claiming causal effects unsupported by its design.

Analysis and Discussion

Demographic Change and the Scale of Ageing

India's elderly population has grown both in number and as a proportion of the total population. The 60+ share increased from around 5.6% in 1961 to 8.6% in Census 2011. Official projections subsequently estimated 10.1% for 2021 and 13.1% for 2031. UNFPA's 2023 assessment places the likely number of older persons at approximately 347 million by 2050, close to 21% of the population. These figures describe a country that can retain a substantial youth population while preparing for a much larger elderly population at the same time.

Indicator	Period	Figure	Nature of evidence
Population aged 60+	2011	103.8 million; 8.6%	Census count
Share aged 60+	2021	10.1%	Government projection
Share aged 60+	2031	13.1%	Government projection
Population aged 60+	2050	Approximately 347 million; nearly 21%	UNFPA projection
Life expectancy at birth	2016–2020	70.0 years	SRS life-table estimate
Remaining life expectancy at age 60	2016–2020	18.3 years	SRS life-table estimate

Sources: Census 2011; MoSPI (2021); ORGI (2022); UNFPA and IIPS (2023). Projection figures are not census observations.

The pace of ageing is shaped by both fertility and mortality. Smaller birth cohorts gradually reduce the proportion of children, while improved survival allows more people to reach advanced ages. The SRS life tables for 2016–2020 estimated life expectancy at birth at 70.0 years and remaining life expectancy at age 60 at 18.3 years. These figures imply that older age is increasingly a substantial stage of life requiring sustained access to care, social interaction and income, rather than a short period following retirement. The projected expansion of people aged 80 and above is particularly important because assistance with daily activities becomes more common at very advanced ages.

Regional Inequality and Gender

State-level contrasts show why one national elderly percentage is insufficient for planning. The projected share of people aged 60 and above in 2021 was 16.5% in Kerala and 13.6% in Tamil Nadu, compared with 7.7% in Bihar and 8.1% in Uttar Pradesh (MoSPI, 2021). Earlier fertility decline and longer survival explain much of this divergence. Older states may need immediate expansion of geriatric and long-term-care capacity, while states with younger age structures have an opportunity to develop services before demand rises sharply. Population size also matters: a state with a smaller elderly percentage can still contain a large absolute number of older residents.

Gender differences are equally significant. The 2016–2020 SRS life tables estimated female life expectancy at birth at 71.4 years, compared with 68.6 years for males. At age 60, women could expect 19.2 additional years and men 17.5 years. Women's longer survival contributes to a greater presence of widows and women living without spouses at advanced ages. Yet many older women have limited independent pension entitlements because of historically unequal access to paid employment, property and savings.

The experience of later life is therefore shaped by disadvantages accumulated long before the age of 60. Gender-responsive ageing policy should give particular attention to widows, women without regular income and those with limited mobility or legal control over assets. Regional policy, likewise, should consider healthcare access and local deprivation rather than assume that states reporting lower diagnosed morbidity have fewer unmet health needs.

Chronic Illness, Functional Ability and Long-Term Care

India's growing older population is accompanied by a changing pattern of disease. Chronic conditions such as hypertension, diabetes, arthritis, cardiovascular illness and sensory impairment frequently require repeated treatment rather than a single hospital episode. Patel et al. (2023) found multimorbidity in 32.1% of older adults covered by their LASI analysis, with especially high measured prevalence in Kerala. Multiple conditions may produce complicated treatment routines, medicine expenses, mobility problems and a greater need for help from relatives.

A health system focused mainly on acute illness cannot fully respond to these circumstances. Older people require regular screening, accessible primary care, medication review, rehabilitation, mental-health support, vision and hearing services, and assistance with the activities of daily living. The WHO's healthy-ageing framework is valuable because it does not

define good health simply as the absence of diagnosed illness. A person with controlled chronic disease may remain active and independent, while another without a formal diagnosis may face serious functional restrictions.

The demand for care is also likely to grow as households become smaller and younger relatives move for education or employment. Family caregiving will remain important, but it needs practical support through community services, home visits, respite care and trained care workers. NITI Aayog (2024) identified the need for better coordination of senior-care services, geriatric skills, assistive technologies and affordable home-based support. Expansion without quality standards could expose older persons to unsafe services and unaffordable charges. Long-term care should therefore be understood as a core component of public-health and social policy, not solely as a private family responsibility.

Employment, Pensions and Financial Security

Employment beyond 60 is common in India, particularly among people who have spent their working lives in agriculture or informal occupations. Chattopadhyay et al. (2022) found that 36% of older adults in their LASI sample continued working; about two-thirds of employed respondents worked mainly in agriculture and allied activities. Only about 5% of working older adults held full-time jobs, and roughly 6% had coverage through a work-related pension scheme. These patterns illustrate how retirement differs across social groups.

An older person who remains employed may be healthy, skilled and keen to participate. Equally, continued work can reflect inadequate savings or a lack of pension income. Treating all older workers as evidence of successful active ageing would conceal this distinction. India therefore needs both opportunities for voluntary employment and financial protection for those who cannot, or do not wish to, continue physically demanding work.

The Indira Gandhi National Old Age Pension Scheme provides central assistance to eligible older persons in below-poverty-line households. Under the programme's terms in 2024, central assistance was ₹200 per month for those aged 60–79 and ₹500 for those aged 80 and above, with state governments able to add their own contributions (Ministry of Rural Development, 2024). These payments offer some protection, but the central amounts are too small to provide an adequate independent livelihood. Differences in state top-ups create further unevenness.

LASI also found gaps between eligibility, awareness and access to welfare programmes. Limited knowledge of schemes, difficulties obtaining documents and complex procedures can prevent vulnerable households from receiving assistance. Better identification, simplified applications, reliable payments and accessible grievance channels are therefore as important as the existence of a scheme. Stronger old-age security would combine social pensions, expanded contributory arrangements for informal workers, affordable healthcare and support for people who have spent much of their lives in unpaid care work.

Family Arrangements and Psychological Wellbeing

The assumption that India's traditional family support system has disappeared is not supported by national survey findings. LASI Wave 1 reported that 40.6% of older adults lived with both spouse and children and another 27.6% lived with children but without a spouse. By

comparison, 20.3% lived with a spouse but no children and 5.7% lived alone. Multigenerational residence thus remained prominent, although other living arrangements were far from negligible.

Residence does not, however, measure the adequacy of care. Families may live together but struggle with financial stress, illness or limited time for caregiving. Spouse-only households may provide considerable independence until one partner becomes seriously ill. Older people who live alone may enjoy autonomy but may also face social isolation, especially after widowhood or the onset of disability. In their analysis of LASI, Srivastava and Srivastava (2023) found frequent loneliness among 13.4% of older respondents. Social contact, physical activity, health and participation in community life were all relevant to wellbeing.

Changes in migration, employment and family size are likely to increase the importance of support outside the household. Accessible public transport, safe walking environments, neighbourhood meeting places, telephone assistance and community volunteers can help older people remain connected. Preventing neglect and abuse, protecting property rights and making legal assistance available should also form part of ageing policy. The aim is to support family relationships without assuming that all households have equal capacity to meet increasing care needs.

Policy Response

India had developed several institutional measures for older persons before the end of 2024. The Maintenance and Welfare of Parents and Senior Citizens Act, 2007 established a legal framework for maintenance and welfare. The National Programme for Health Care of the Elderly sought to improve geriatric services, while the National Social Assistance Programme offered means-tested financial support. The Atal Vayo Abhyuday Yojana brought together interventions relating to senior-citizen welfare and care. Their effectiveness, however, depends on implementation capacity and coordination across agencies.

A significant development in 2024 was the expansion of Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana to all citizens aged 70 and above irrespective of socio-economic status. Approved in September and launched on 29 October 2024, the expansion provided hospital-treatment cover of up to ₹5 lakh annually, subject to the programme's family and top-up arrangements. A government release dated 9 December 2024 reported that enrolment for Ayushman Vay Vandana cards had reached 25 lakh and that more than 22,000 older persons had received treatment after the launch (Ministry of Health and Family Welfare, 2024). These are early administrative figures, not evidence that hospital access, health outcomes or financial hardship had already improved nationally.

The reform addresses an important risk because a major hospital admission can exhaust household savings. Nevertheless, insurance for hospitalisation does not fully cover the everyday requirements of ageing. Outpatient consultations, medicines, rehabilitation, dementia-related support and home-based personal assistance are often continuing needs. Moreover, the new entitlement applies to people aged 70 and above, while chronic illness and income insecurity may affect people in their sixties. Policy should therefore combine hospital

protection with primary healthcare, long-term care and income-security measures across the wider older population.

Three priorities follow from the available evidence. First, planning and funding should be sensitive to the age structures and institutional capacities of different states. Second, public programmes should be easier to access and should provide meaningful protection, especially for poor older people and women without independent income. Third, senior-care services should be integrated across healthcare, pensions, disability support and local administration. The 2024 NITI Aayog position paper reinforced the importance of such an approach, including digital inclusion and a skilled care workforce. Investment in age-friendly communities and suitable opportunities for work and volunteering would further help older adults retain autonomy and social participation.

Conclusion

Population ageing in India is a predictable result of lower fertility and improved survival, but its implications depend on how effectively institutions respond. Census 2011 identified 103.8 million older persons, and demographic projections available by December 2024 indicated a continued rise in their proportion and absolute number. The evidence shows that India is not experiencing one uniform transition. States differ in the pace of ageing, women experience longer survival alongside accumulated economic disadvantages, and older people vary considerably in health, income and family circumstances.

LASI-based research demonstrates that chronic disease, employment insecurity and loneliness are already important concerns. It also shows that many older people remain economically active and that family co-residence continues to be widespread. Neither employment after 60 nor living with relatives can be assumed to guarantee wellbeing. Healthy and secure ageing requires meaningful choices, adequate financial resources, accessible care and sustained social relationships.

Public policy had made important advances by the end of 2024, particularly through geriatric health initiatives, welfare programmes and the expansion of AB-PMJAY to citizens aged 70 and above. Yet gaps remained in pension adequacy, preventive care, support for unpaid caregivers and organised long-term services. A life-course approach that recognises gender and regional differences is therefore necessary. India's central challenge is not to prevent demographic ageing but to ensure that additional years of life are lived with health, independence, participation and dignity. Future research should draw on later longitudinal evidence and new population enumeration when available, while clearly distinguishing observed outcomes from projections and administrative counts.

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