Reviews & Letters in Social Sciences

Ageing in India as a Social, Economic, Medical, Psychological and Public-Policy Challenge: A Narrative Review

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ARTICLE INFO

Prepared 21st October 2026, www.esrapublications.com

Edited & Published 31st October 2026

ABSTRACT

Background. India is entering a period of rapid population ageing. The India Ageing Report 2023 estimates that about 149 million people (10.5% of the population) were aged 60 years and above in 2022, and that the number will approach 347 million (20.8%) by 2050. Experience of later life in India is shaped less by biology than by poverty, gender, place of residence, family structure, health-system design and social protection.

Objective. To synthesise evidence on ageing among adults aged 60 years and above in India across social, economic, medical, psychological and policy domains, with attention to rural–urban differences, gender and practical responses.

Methods. Narrative review prioritising the Longitudinal Ageing Study in India (LASI) Wave 1 (2017–18), the India Ageing Report 2023, peer-reviewed LASI-based studies and official government sources. Published estimates are reported as given; no data were re-analysed.

Findings. (i). More than 40% of older persons are in the poorest wealth quintile and 18.7% have no income. (ii). About 24% of those aged 60+ have multimorbidity on a common definition; estimates vary widely with definition, and higher recorded prevalence in urban, wealthier and more educated groups likely reflects diagnosis and access as well as risk. (iii). Out-of-pocket burdens are heavy: 46.5% of older adults incurred catastrophic health expenditure at a 10% threshold, hospitalisation in private facilities cost about six times more than in public facilities, and enrolment in publicly funded insurance was not associated with lower costs. (iv). Probable major depression affects about 8% of those aged 60+, while loneliness estimates range from 3.8% to 66.4% depending on measure and setting. (v). Disadvantage concentrates among women: 54.0% of women but 16.5% of men aged 60+ are widowed, and only 6.5% of women have 10 or more years of schooling. (vi). Elder abuse affected 5.2% of older adults in the past year, with state prevalence as high as 11.6%.

Conclusions. Pensions, health insurance, legal maintenance duties and health programmes exist but are fragmented, modestly funded and unevenly implemented. A life-course, gender-responsive, community-anchored approach is proposed, together with a research agenda for LASI Wave 2.

Key words: Population ageing; older adults; India; LASI; multimorbidity; loneliness; elder abuse; social protection; health financing.

1. Introduction

Population ageing in India is a consequence of success: falling fertility and rising life expectancy. It is also happening at a lower level of income than in the countries that aged earlier, and within a welfare state that was built around a young population. The 2011 Census counted 103 million people aged 60 years and above, 8.6% of the population [1]. The Longitudinal Ageing Study in India (LASI) was designed to fill the data gap, as a harmonised member of the Health and Retirement Study family of surveys [1].

This review treats ageing not as a purely biological process but as the product of interacting systems: household economics, family obligations, gender norms, the organisation of health care, and public policy (Figure 1). It asks four questions. What is the demographic and socioeconomic position of India's older adults? What are the principal health, psychological and social risks they face? How do these differ by place and gender? What do current programmes achieve, and what practical solutions are supported by the evidence?

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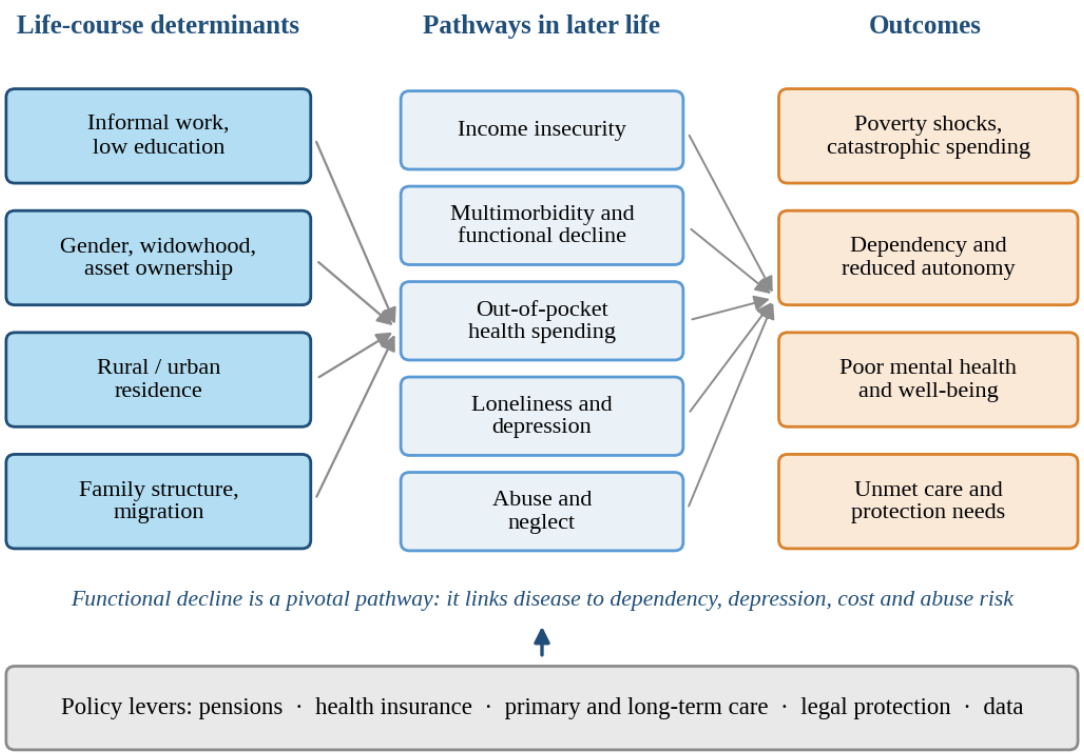


Figure 1. *Conceptual framework used in this review. Life-course determinants act through economic, medical, psychological and protective pathways to produce outcomes that policy levers can modify.*

2. Methods

Design. This is a narrative review. It is not a systematic review and did not follow a registered protocol; it is intended to integrate and interpret rather than exhaustively enumerate evidence.

Population. Adults aged 60 years and above, consistent with the definition of senior citizens in Indian policy and with the India Ageing Report 2023. Where LASI-based studies used samples aged 45+, this is stated.

Sources. (a). The LASI Wave 1 India Report and fact sheets [2,3]; (b). the India Ageing Report 2023 [4]; (c). peer-reviewed articles, mainly LASI-based analyses, identified through targeted searches of publisher and indexing sites; and (d). official government documents, programme pages and parliamentary replies.

Handling of data and references. Numerical values are reproduced from the cited source and are not recomputed or pooled; where studies differ in sample, threshold or year, values are shown side by side. Bibliographic details of journal articles (authors, journal, year, DOI) were checked against publisher or indexing records in October 2026. Official reports and policy documents without DOIs are cited with publisher and URL. References are numbered in order of first citation.

Data note. LASI Wave 1 interviewed 72,250 individuals aged 45+ and their spouses across 35 states and union territories between April 2017 and December 2018 [1]. IIPS fact sheets report a larger figure (73,396, including 31,902 persons aged 60+) that incorporates later-collected data for Sikkim [3]; most published analyses of persons aged 60+ use about 31,400 respondents. Percentages quoted from the fact sheets therefore differ slightly from some journal analyses.

3. Demographic Context

The India Ageing Report 2023 estimates 149 million people aged 60+ in 2022 (10.5% of the population) and projects 347 million (20.8%) by 2050 [4]. The 60+ share is projected to rise from 10.1% in 2021 to 15% in 2036, to exceed the population aged 0–14 around 2046, and to grow fastest among the 80+,

whose numbers are projected to rise by roughly 279% between 2022 and 2050 [4]. At age 60, women can expect about 19 more years of life and men about 17.5, a gap expected to widen [4]. Figure 2 and Table 1 summarise these trends. Demographic ageing is uneven: southern states and some northern states such as Himachal Pradesh and Punjab are ahead of the national average, whereas higher-fertility states such as Bihar and Uttar Pradesh are expected to see their elderly share rise between 2021 and 2036 [4].

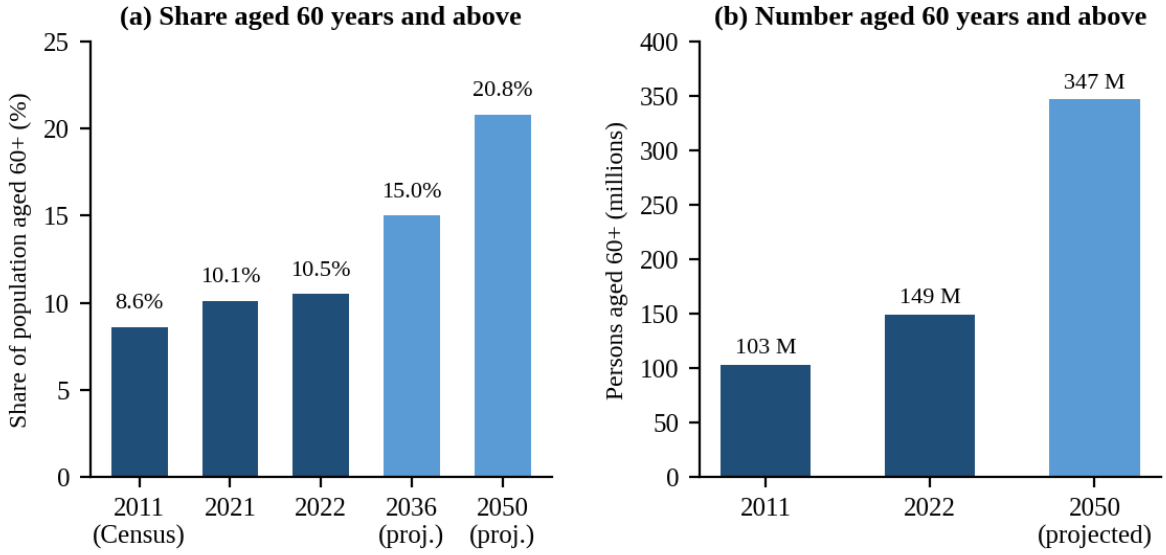


Figure 2. *Population ageing in India. (a) Share of the population aged 60+; 2011 from the Census, 2021–2050 from the India Ageing Report 2023 (2036 and 2050 are projections). (b) Number of persons aged 60+. Sources: [1,4].*

Table 1. *Key demographic and socioeconomic indicators for India's older population*

Indicator	Value	Source
Persons aged 60+, 2011 (Census)	103 million (8.6% of population)	[1]
Persons aged 60+, 2022	149 million (10.5%)	[4]
Persons aged 60+, 2050 (projected)	347 million (20.8%)	[4]
Share aged 60+, 2021 → 2036 (projected)	10.1% → 15%	[4]
Growth of the 80+ population, 2022–2050	About 279%	[4]
Remaining life expectancy at age 60	Women ≈ 19 years; men ≈ 17.5 years	[4]
Older persons living in rural areas, 2011	About 71%	[4]
Share aged 60+ in rural / urban population, 2011	8.8% / 8.1%	[4]
Older persons in the poorest wealth quintile	More than 40%	[4]
Older persons with no income	18.7%	[4]

Projections are those of the India Ageing Report 2023; the rural share is from the 2011 Census as reported there.

Two implications follow. First, the very old, who have the greatest need for care, will grow fastest. Second, because women outlive men, the oldest cohorts will be disproportionately female, widowed and poor.

4. Rural and Urban Differences

Most older Indians live in rural areas: about 71% in 2011, with persons aged 60+ forming 8.8% of the rural and 8.1% of the urban population [4]. Rural older adults are more dependent on agricultural or informal work, farther from hospitals and specialists, and less likely to have formal pensions or

insurance. Urban older adults have shorter distances to care but face housing costs, smaller dwellings, migration of children and, for some, isolation. LASI Wave 1 fact sheets show large gaps in schooling (10 or more years: 30.2% urban versus 7.5% rural), lifetime work (ever worked: 77.8% rural versus 63.6% urban) and living alone (6.6% rural versus 4.4% urban) (Table 2, Figure 3) [3]. Press summaries of the LASI report put current work participation among those aged 60+ at roughly half of men and 22% of women, and at 40% in rural versus 26% in urban areas [5].

Table 2. *Selected LASI Wave 1 indicators for adults aged 60+, by sex and place of residence (%)*

Indicator	Men	Women	Rural	Urban	All	Source
Currently married	81.1	44.1	62.8	58.8	61.6	[3]
Widowed	16.5	54.0	35.1	38.8	36.2	[3]
10+ years of schooling	22.8	6.5	7.5	30.2	14.2	[3]
Ever worked	96.2	53.2	77.8	63.6	73.6	[3]
Living alone	2.6	9.0	6.6	4.4	5.7	[3]

Weighted estimates from the LASI Wave 1 'Elderly in India' fact sheet (n = 31,902).

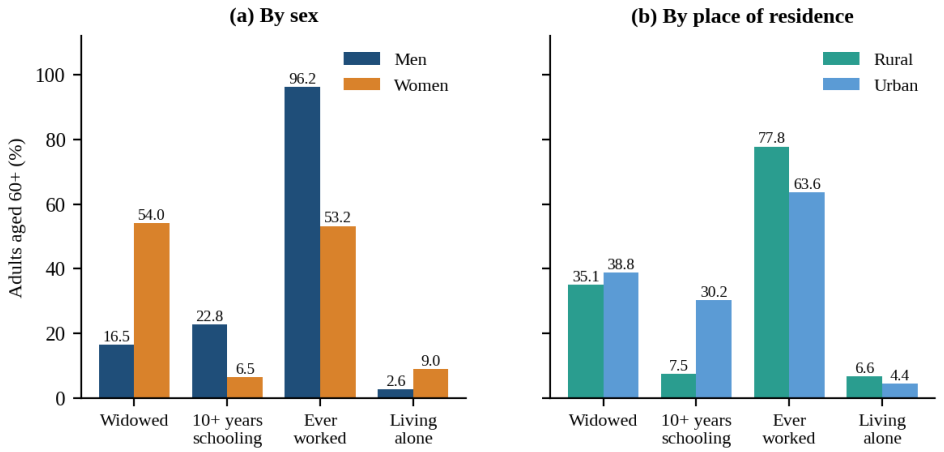


Figure 3. *Gender and rural–urban gradients among adults aged 60+ in LASI Wave 1: (a) by sex; (b) by place of residence. Data as in Table 2 [3].*

Evidence on health is mixed and must be read with caution. LASI-based analyses report higher *recorded* multimorbidity in urban, wealthier and more educated groups: urban older adults had a relative risk ratio of 2.35 (95% CI 2.02–2.74) compared with rural older adults, and higher-educated older adults 2.12 (1.49–3.04) compared with uneducated ones [6]; the LASI pilot also found higher prevalence with higher education and wealth [7]. This likely reflects greater diagnosis, longer survival and lifestyle risk in urban settings, and under-diagnosis in rural areas, rather than better rural health. Conversely, probable major depression is less likely among urban, higher-status and insured older adults [8], and higher education is protective against elder abuse [9]. Rural–urban comparisons should therefore always be adjusted for wealth, education and access, and interpreted alongside undiagnosed morbidity (Table 3).

Table 3. *Rural–urban differences in selected domains and how to read them*

Domain	Direction of difference in LASI-based work	Interpretive caution
Schooling	10+ years: urban 30.2% versus rural 7.5% [3]	Proxy for wealth and access to services
Lifetime work	Ever worked: rural 77.8% versus urban 63.6% [3]	Agricultural and informal work; necessity rather than choice
Multimorbidity	Higher recorded in urban areas (RRR 2.35) [6]	Diagnosis and access bias
Depression	Probable major depression less likely in urban, higher-status and insured adults [8]	Cross-sectional; mediated by wealth
Living alone	Rural 6.6% versus urban 4.4% [3]	Living alone is not the same as being unsupported

5. Poverty and Income Security

Most older Indians have worked in the informal economy and have no occupational pension. The India Ageing Report 2023, drawing on LASI, finds that more than 40% of older persons are in the poorest wealth quintile and that 18.7% have no income [4]. A NITI Aayog review cited by the Observer Research Foundation reports that only about one-fifth of those aged 60+ have health insurance and nearly 78% have no pension coverage [10]. Among older people who work or have worked, pension coverage reaches only about 12% of men and 3% of women [11]. Many continue to work out of necessity, and lifetime work histories differ sharply by sex (ever worked: 96.2% of men versus 53.2% of women) [3]; analyses of LASI indicate that participation falls earlier for women and that poor health is a main reason for stopping work [11].

Social pensions are the main public income source for the poor. The Indira Gandhi National Old Age Pension Scheme (IGNOAPS), part of the National Social Assistance Programme, targets older persons in households below the poverty line. Central assistance is Rs 200 per month for ages 60–79 and Rs 500 per month from age 80, with state top-ups that were reported to range from Rs 50 to Rs 3,000 per month [12,13]. The central sums are very small relative to subsistence costs. The India Ageing Report 2023 also documents limited awareness of, and access to, schemes among eligible older persons [4].

An analytic point matters for policy: old-age poverty is largely the accumulated result of lifetime disadvantage (informal work, caste, low education, gendered unpaid labour) and cannot be solved only by late-life transfers. It is also *dynamic*: health shocks can push near-poor households below the poverty line (Section 7).

6. Chronic Illness, Multimorbidity and Functional Limitation

Non-communicable diseases dominate morbidity in later life: hypertension, diabetes, heart disease, chronic respiratory disease, arthritis, vision and hearing impairment, and cognitive decline. In LASI Wave 1, about 24% of those aged 60+ had multimorbidity (two or more of nine chronic conditions in one analysis: 24.1%) [6,14]. Estimates vary by definition (two or more versus three or more conditions), by self-report versus measured data, by the list of conditions counted, and by age cut-off (Table 4). A narrative review of LASI-based studies found that definitions and prevalence differ and that, for example, prevalence among the urban poor was 34% at ages 45–59, 53% at 60–74 and 64% at 75+ in one study it summarises [15]. Complex multimorbidity (three or more conditions across more than two body systems) is associated with higher inpatient use, higher medical costs and poorer self-rated health [16], and multimorbidity clusters within families, compounding household care and cost burdens [17].

Table 4. *Selected LASI-based studies of multimorbidity*

Study	Sample	Definition / focus	Principal finding
Arokiasamy et al., 2015 [7]	LASI pilot (2010), n = 1,683, aged 45+	Count of self-reported chronic diseases	Multimorbidity strongly associated with ADL limitation and poor self-rated health
Srivastava et al., 2021 [14]	LASI Wave 1, aged 60+	Multimorbidity and obesity measures, physical activity	About 24% multimorbid; obesity and physical inactivity raised the odds
Chauhan et al., 2022 [6]	LASI Wave 1, aged 60+ (n = 31,373)	Two or more of nine chronic diseases	24.1% multimorbid; higher in urban and more educated groups
Sinha et al., 2022 [16]	LASI Wave 1, multimorbid adults aged 45+ (n = 30,489)	Complex multimorbidity (3+ conditions, >2 body systems)	Higher inpatient use, cost and poorer self-rated health
Pati et al., 2022 [17]	LASI Wave 1, 22,526 families	Family-level multimorbidity	Multimorbidity clusters within families (syndemic pattern)
Zanwar et al., 2024 [15]	15 LASI-based studies (narrative review)	Definition and sub-population prevalence	Definitions vary; prevalence rises with age and socioeconomic status

The LASI pilot showed that multimorbidity is strongly associated with limitations in activities of daily living (ADL) and poor self-rated health [7]. Functional decline is a pivotal pathway: it links disease to dependency, depression, abuse risk and cost.

A systems observation: India's health programmes remain organised around single diseases and episodic hospital care, whereas older adults need continuous, coordinated primary care, medicine adherence, rehabilitation, palliative care and long-term care. These services are thin or absent in most states.

7. Healthcare Affordability

Health spending in India is dominated by out-of-pocket payment, and older people are most exposed. A national analysis of consumer expenditure and utilisation surveys found that catastrophic health expenditure (out-of-pocket payments at or above 10% of household expenditure) rose from 12.4% of households in 1993–94 to 18.2% in 2011–12, and was most common in households composed only of people aged 60+ (adjusted OR 3.26 versus households without older people or young children) [18]. A study of the 75th National Sample Survey round reports that older adults spend about 17.4% of household consumption on health care, rising to 24.8% among the poorest, with catastrophic expenditure incidence of 46.5% and intensity of 16.1% at the 10% threshold; incidence falls as the threshold rises [19]. A LASI-based study of publicly funded health insurance found that enrolment was not associated with lower out-of-pocket expenditure or catastrophic spending on hospitalisation: mean expenditure per admission was INR 8,276 in public facilities and INR 49,700 in private facilities, and use of private facilities was the key determinant of cost [20] (Figure 4, Table 5).

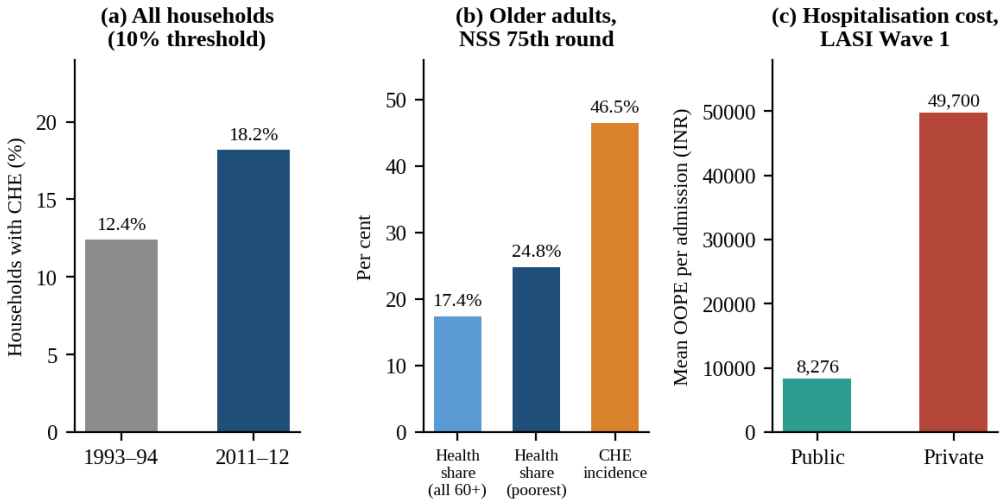


Figure 4. *Financial burden of health care. (a) Households with catastrophic health expenditure (CHE; out-of-pocket payments ≥10% of household expenditure), all households [18]. (b) Older adults' health spending as a share of household consumption and incidence of CHE at the 10% threshold [19]. (c) Mean out-of-pocket expenditure (OOPE) per hospital admission among older adults by facility type [20].*

Table 5. *Evidence on the financial burden of health care among older Indians*

Study	Data	Key finding
Pandey et al., 2018 [18]	NSS consumer expenditure and utilisation surveys, 1993–2014	CHE rose from 12.4% to 18.2% of households (1993–94 to 2011–12); aOR 3.26 in households with only people aged 60+
Ahmad and Mohanty, 2024 [19]	NSS 75th round (2018), older adults	Health = 17.4% of consumption (24.8% among the poorest); CHE incidence 46.5%, intensity 16.1% at 10% threshold
Garg et al., 2022 [20]	LASI Wave 1, hospitalisations of older adults	Mean OOPE INR 8,276 (public) versus INR 49,700 (private); insurance enrolment not associated with lower OOPE or CHE

Thresholds, datasets and age cut-offs differ, so absolute percentages are not directly comparable.

The consistent finding is that older households face disproportionate risk, that outpatient medicines and diagnostics (largely excluded from insurance) are major cost drivers, and that the poorest older adults bear the greatest relative burden.

Policy response has been significant. On 11 September 2024 the Union Cabinet approved extension of Ayushman Bharat PM-JAY to all citizens aged 70+, irrespective of income, through the separate Ayushman Vay Vandana card, with cover of up to Rs 5 lakh per year [10,21]. An independent analysis estimates that insurance coverage among those aged 70+ rose from about 15% in 2017–18 to over 55% by September 2025; the estimate rests on assumptions, and some states and union territories were initially outside PM-JAY [21]. Open questions include whether hospital cover reduces *outpatient* spending, whether empanelled facilities are accessible to rural elders, and whether benefit utilisation matches enrolment. The 60–69 age group remains outside the universal scheme.

8. Mental Health and Loneliness

Estimates of depression among older Indians depend heavily on the instrument. Using the Composite International Diagnostic Interview–Short Form (CIDI-SF), the prevalence of past-year major depressive disorder was 8.2% among persons aged 60+ in LASI Wave 1 [8]; among the oldest-old (80+), MDD was 10.3% and depressive symptoms 34.8% [22] (Figure 5a). A mediation analysis using LASI found that functional limitation (ADL/IADL difficulty) was associated with 1.85-fold higher odds of depression, that social disengagement explained 22.0% and loneliness only 3.08% of the association, and that living arrangements moderated it [23] (Figure 5b). Older adults who experienced abuse had about twice the odds of depressive symptoms [9]. These associations are cross-sectional, so causal direction cannot be asserted; depression also reduces social participation.

Loneliness is measured inconsistently. A systematic review of 20 Indian studies reported loneliness prevalence ranging from 3.8% to 66.4% across 11 studies, and social isolation from 3.6% to 86.4% across four [24]. In LASI Wave 1, 14.95% of elderly respondents reported feeling lonely, with higher prevalence among women [25] (Figure 5c). Cognitive impairment and dementia are not examined in depth here and are flagged as a priority gap (Section 14). Specialist geriatric mental-health capacity is limited and psychosocial screening is rarely built into primary care; systematic workforce data were not identified for this review.

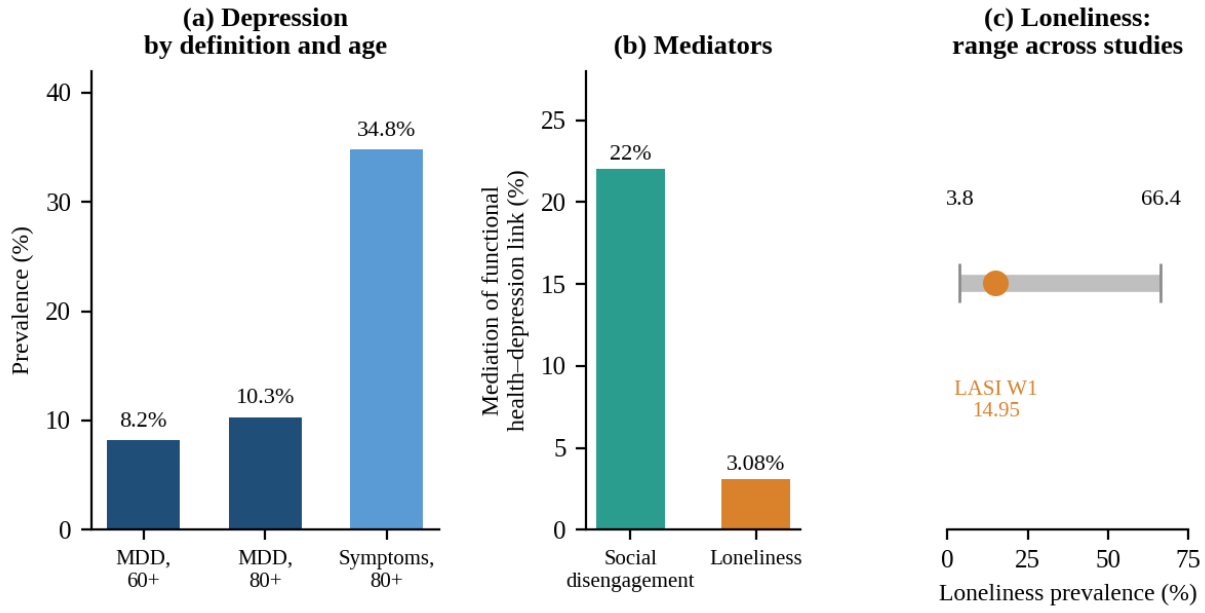


Figure 5. *Depression and loneliness among older Indians. (a) Major depressive disorder (MDD, CIDI-SF) and depressive symptoms by age group [8,22]. (b) Share of the association between functional health and depression*

mediated by social disengagement and loneliness [23]. (c) Range of loneliness prevalence across studies [24] and the LASI Wave 1 estimate [25].

9. Family Relationships and Living Arrangements

The Indian family remains the principal source of old-age care, and most older adults live with a spouse, children or both. But the picture is changing through migration, smaller families, rising female employment and the care burden on the 'sandwich' generation. In LASI Wave 1, 5.7% of those aged 60+ lived alone, with a marked gender gap (9.0% of women versus 2.6% of men) and a rural excess (6.6% versus 4.4% urban); 54.0% of older women were widowed [3].

Living arrangement matters for outcomes. Living alone is associated with lower life satisfaction [26] and with higher risk of elder abuse [9], while living with someone is negatively linked to depression [23]. Older persons living alone or only with a spouse are not a homogeneous group: some are well-resourced and independent, while others (especially widowed rural women) are poor and unsupported. Residence with children is not automatically protective either: about 3 of the 5.2 percentage points of past-year abuse occurred within the older person's own household, that is, over half [9].

Institutional options (old-age homes, day-care, assisted living) are limited in number and quality, concentrated in cities, and often stigmatised; central support for senior care homes exists under the Integrated Programme for Senior Citizens within the Atal Vayo Abhyuday Yojana [27]. Home-based and community-based long-term care remains largely informal and unpaid, carried predominantly by women.

10. Gender Inequalities

Gender runs through every domain. Women live longer after 60 but carry a heavier burden of widowhood, low schooling and economic dependency (Table 2, Figure 3). The India Ageing Report 2023 stresses that poverty in old age is gendered: older women are more likely to be widowed, to live alone, to have no income and fewer assets, and to depend on family [4]. In LASI Wave 1, 54.0% of older women were widowed (16.5% of men), 6.5% had 10 or more years of schooling (22.8% of men), and 53.2% had ever worked (96.2% of men) [3]. Pension coverage among those who have worked is about 3% for women against 12% for men [11]. Education is protective against abuse, particularly for women [9], and a decomposition analysis finds that working status and economic factors explain only about 10% of the gender gap in abuse prevalence, with sociodemographic and health-related factors accounting for more [28]. Men are not uniformly advantaged: older widowers living alone may face distinct isolation and self-care deficits, and gender patterns in health spending differ by dataset and definition.

Gender-responsive policy therefore needs to address property and inheritance rights, widow pensions, women's access to health services, and recognition of caregivers.

11. Elder Abuse and Neglect

Using LASI Wave 1 data on adults aged 60+, 5.2% reported abuse in the preceding year and 3% reported abuse within their own households; state prevalence varied widely, highest in Bihar (11.6%) and Karnataka (10.1%) [9] (Figure 6). Verbal abuse or disrespect was the most common form. Factors associated with abuse included living alone, functional limitations, multimorbidity and recent hospitalisation, while higher education was protective; abused older adults had about twice the odds of depressive symptoms [9]. A second LASI analysis emphasises state variation and gender differences and argues for protective policies and targeted interventions [28].

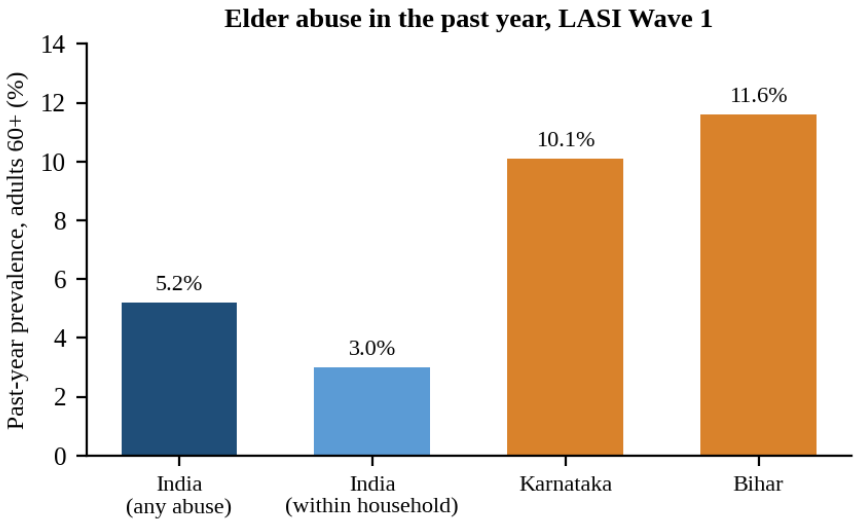
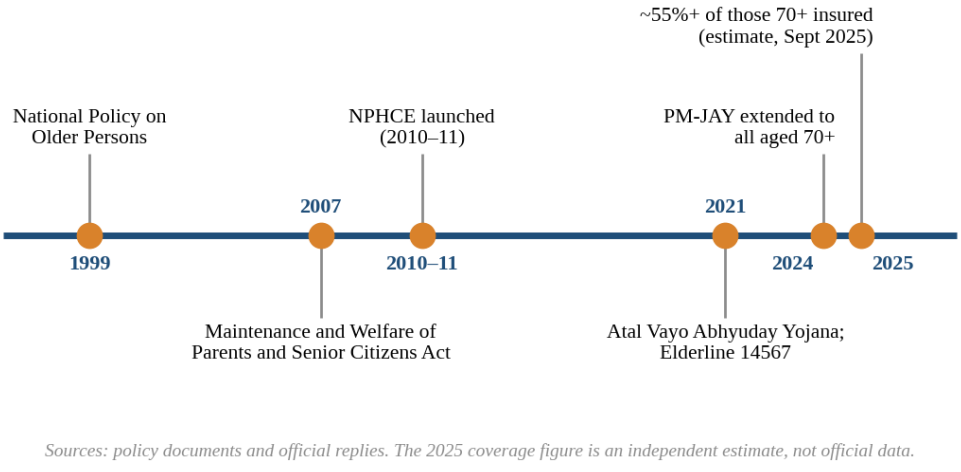


Figure 6. *Past-year elder abuse among adults aged 60+, LASI Wave 1: national estimates and the two highest-prevalence states [9].*

These figures should be interpreted as lower bounds. Older persons may under-report abuse by family members on whom they depend, and surveys ask few questions on financial abuse and neglect. The legal framework is the Maintenance and Welfare of Parents and Senior Citizens Act, 2007 [29], which provides for maintenance claims through tribunals and for protection of life and property, but implementation depends on state rules, tribunal capacity and awareness. Elderline, the national toll-free helpline for senior citizens (14567) run under the Ministry of Social Justice and Empowerment since 2021, provides information, guidance, emotional support and field intervention in abuse cases [27,30].

12. Government Programmes: A Critical Overview

Figure 7 places the main national instruments on a timeline and Table 6 summarises their purpose and principal limitations. Coverage of older persons has expanded fastest in hospital insurance, but income support remains the weakest link.



Sources: policy documents and official replies. The 2025 coverage figure is an independent estimate, not official data.

Figure 7. *Timeline of principal national policies and programmes for older persons [10,21,27,29,31,32].*

Table 6. *Principal national programmes and instruments for older persons*

Programme / instrument	Purpose	Main concern
National Policy on Older Persons (1999); National Policy for Senior Citizens (draft, 2011) [31]	Policy framework across income, health, housing and protection	Non-binding; limited resourcing
Maintenance and Welfare of Parents and Senior Citizens Act, 2007 [29]	Legal duty of maintenance; tribunals	Awareness; enforcement; state variation
IGNOAPS under the National Social Assistance Programme [12,13]	Pension for poor older persons	Low central amounts (Rs 200/500); BPL-only eligibility
National Programme for Health Care of the Elderly (NPHCE, launched 2010–11) [32]	Geriatric services in public facilities	Coverage; trained workforce
Ayushman Bharat PM-JAY and Ayushman Vay Vandana (70+) [10,21]	Hospital insurance	Outpatient costs; 60–69 excluded; empanelment
Atal Vayo Abhyuday Yojana (Integrated Programme for Senior Citizens; Rashtriya Vayoshri Yojana; Elderline 14567) [27,30]	Senior citizens' homes, assistive devices for eligible poor older persons, helpline	Reach; quality assurance

Scheme parameters change frequently and should be re-checked against ministry portals.

Three structural weaknesses recur: fragmentation across ministries (social justice, health, rural development, finance); reliance on schemes rather than rights-based entitlements; and weak monitoring. LASI provides, for the first time, a platform to evaluate programme reach, which the India Ageing Report 2023 begins to do, noting limited awareness and access among older persons [4].

13. Practical Solutions

The following are offered as evidence-informed directions, not as proven interventions. Each requires local testing and evaluation. Figure 8 summarises the proposed model and Table 7 links each direction to the evidence reviewed and to a monitoring indicator.

1. **Income security.** Raise and index social pension amounts; move toward a near-universal basic pension for older persons, with automatic enrolment; simplify identity and payment processes; provide a targeted top-up for women, those 80+ and persons living alone.
2. **Health financing.** Extend PM-JAY-type cover to ages 60–69 in a phased manner; add an outpatient and medicines benefit through primary care and Health and Wellness Centres; track utilisation and out-of-pocket spending by age.
3. **Primary care for chronic illness.** Establish integrated protocols for hypertension, diabetes, vision, hearing, falls and mental health in primary care, with community health workers trained in geriatric screening and home visits.
4. **Long-term and home-based care.** Build a trained caregiver workforce; offer caregiver allowances, respite and training; expand day-care centres, with state financing and quality standards.
5. **Mental health and loneliness.** Include depression, loneliness and cognition screening in routine care; support community groups, senior clubs, intergenerational programmes and peer visiting; use digital tools with offline alternatives.
6. **Gender-responsive measures.** Secure widows' property and residence rights; improve women's access to pensions and health care; recognise unpaid care work in social protection.
7. **Preventing abuse.** Train frontline workers, police and health staff to identify abuse; make tribunals accessible and time-bound; strengthen helplines; promote confidential reporting; target high-prevalence states.

8. **Housing and environment.** Age-friendly housing, safe mobility, accessible public transport; support ageing in place.
9. **Data and accountability.** Use LASI Wave 2 to evaluate programmes; create state ageing dashboards; mandate disaggregation of programme data by age and gender.

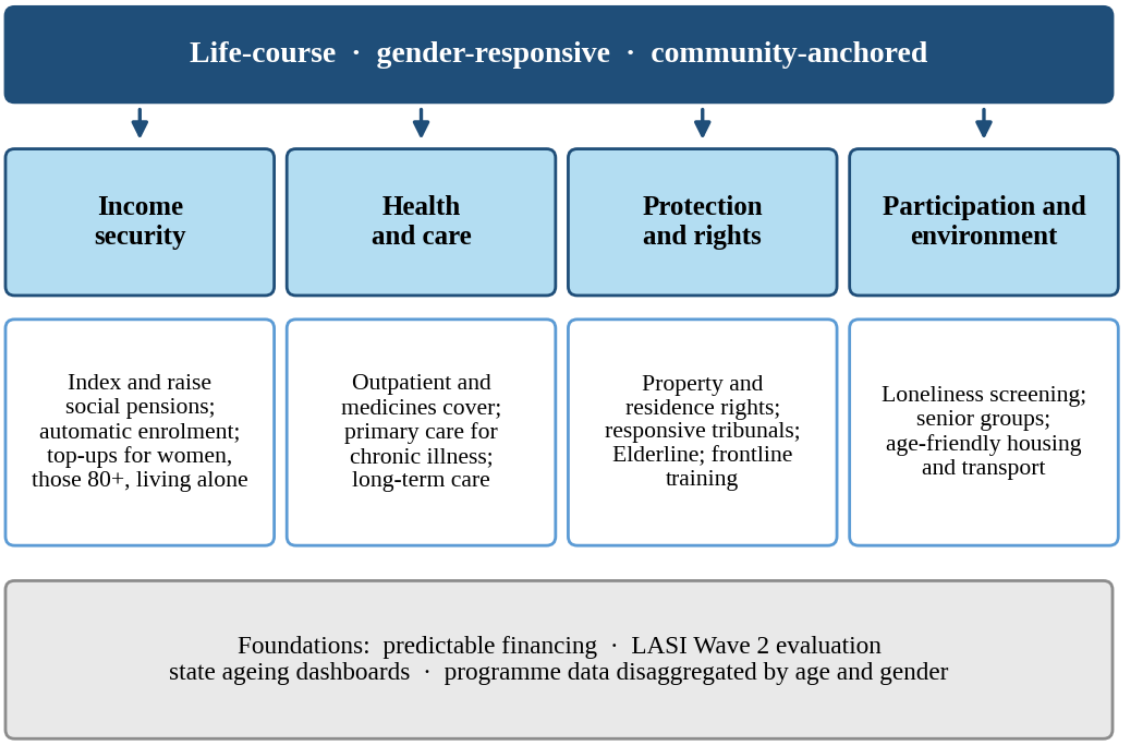


Figure 8. *Proposed integrated model: four service pillars carried by foundations of financing and data, under a life-course, gender-responsive, community-anchored approach. Author's synthesis.*

Table 7. *Proposed directions, supporting evidence and indicators to monitor*

Direction	Evidence anchor in this review	Indicator to monitor
Income security	18.7% have no income; central pension Rs 200/500; ~78% without pension [4,10,12]	Share of 60+ with a pension; real value of pension relative to a poverty line
Health financing	CHE incidence 46.5%; insurance not associated with lower hospitalisation cost; cover for 70+ rising [19–21]	CHE incidence and OOPE by age; outpatient spending; utilisation of insured care
Primary and long-term care	Multimorbidity ≈ 24% (60+); complex multimorbidity raises inpatient use and cost [6,16]	Screening and control rates; availability of home-based care
Mental health and loneliness	MDD 8.2% (60+); loneliness 3.8–66.4% by measure [8,24]	Screening coverage; validated loneliness measure in LASI Wave 2
Gender-responsive measures	54.0% of women widowed; 6.5% with 10+ years' schooling [3]	Women's pension coverage; property-rights cases resolved
Preventing abuse	5.2% past-year abuse; up to 11.6% in some states [9]	Tribunal time-to-decision; Elderline case outcomes by state

Indicators are the author's suggestions.

14. Limitations and Research Gaps

Several limits apply. Most LASI findings are cross-sectional (Wave 1), so causal claims are unsafe until Wave 2 longitudinal data are used. Much of the data is self-reported, including for chronic disease and abuse, which is vulnerable to under-reporting and recall error. Institutionalised and homeless older

persons are outside the household sampling frame [1]. Definitions of multimorbidity, depression, loneliness and catastrophic expenditure vary, so figures from different studies are not directly comparable. This review is narrative and non-systematic: sources were identified through targeted searches rather than a documented multi-database search strategy, no formal quality appraisal was undertaken, and some figures (for example, work participation and the 2025 insurance coverage estimate) come from press summaries or analytical commentary rather than primary data releases. A systematic review with a registered protocol would be the appropriate next step.

Priority gaps: loneliness measurement validated for India; long-term care needs and costs; dementia; end-of-life and palliative care; older persons with disability; tribal and migrant older adults; and robust evaluation of pension and insurance reforms.

15. Conclusions

Ageing in India is a question of whether lives lengthened by development can be lived securely and with dignity. The evidence reviewed shows that economic insecurity, multimorbidity, high out-of-pocket costs, depression, loneliness, gender disadvantage and elder abuse are interlinked, and that they are shaped by decisions about pensions, health financing, care services and law. The recent expansion of insurance to those aged 70+ and the availability of LASI and the India Ageing Report 2023 mark progress. Translating them into a rights-based, adequately funded, gender-responsive system of income, health and care support is the central policy task of the coming decades.

Declarations

1. Conflict of Interest

The author declares that there are no conflicts of interest, financial or otherwise, that could have influenced the preparation, interpretation, or presentation of this manuscript.

2. Funding Statement

This work received no specific financial support or external funding from any government, commercial, institutional or non-governmental funding agency.

3. Ethical Approval

Ethical approval was not required for this study because it is a narrative review based on previously published literature, publicly available reports, policy documents, and secondary sources. No human participants, animals or identifiable personal data were directly involved.

4. Informed Consent

Not applicable. This manuscript does not involve the recruitment of human participants or the collection of primary personal data.

5. Data Availability Statement

No new datasets were generated or analysed during this study. All information discussed in this review is derived from previously published literature, publicly available statistical reports, government publications and other relevant secondary sources.

6. Author Contributions

The author was responsible for conceptualisation, literature review, interpretation of available information, manuscript preparation, critical revision, editing and final approval of the manuscript.

7. Use of Artificial Intelligence (AI) Tools

Artificial intelligence (AI)-assisted tools were used to support the organisation of information, development of the manuscript structure, language refinement and presentation of the review. The author critically examined, reviewed, and verified the content and accepts full responsibility for the accuracy, originality, scientific integrity, interpretation and final presentation of the manuscript.

8. Acknowledgements

The author acknowledges the contributions of researchers, healthcare professionals, social scientists, economists, policymakers, and national and international organisations whose published research, reports and policy documents have contributed to the understanding of population ageing and its multidimensional implications for Indian society.

9. Disclaimer

The opinions and interpretations expressed in this manuscript are those of the author and do not necessarily represent the views of any affiliated institution or organisation. This review is intended for

academic, educational, and policy-discussion purposes and should not be interpreted as individual medical advice or a substitute for professional healthcare guidance.

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