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From Dependence to Dignity: A Multidimensional Analysis of Perceived Health among Elderly in India

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ABSTRACT

Population ageing in India is accelerating rapidly, raising important concerns about the health and well-being of older adults. This study examines the determinants of perceived health status among the elderly using a sample of 42,762 individuals aged 60 years and above from the 75th round of the National Sample Survey (2017–18). An ordered logistic regression model is employed for the analysis. The findings indicate that while most elderly report moderate health, a significant proportion experiences poor health. Economic dependence emerges as a key determinant, with fully dependent individuals more likely to report poor health. Advancing age, low education, informal employment, lack of social support, and poor living conditions are also associated with adverse health outcomes. In contrast, health insurance and improved living conditions contribute positively to better health. The study highlights the multidimensional nature of elderly health and underscores the need for integrated policy interventions to enhance economic security, healthcare access, and overall well-being.

Key Words: Population ageing, Perceived health status, Elderly health, Economic dependence, Living arrangements, Dignity

Introduction

Population ageing is increasingly recognised as one of the most significant demographic transitions of the twenty-first century, with far-reaching implications for health systems, social security framework, and economic sustainability (Sahoo et al., 2023; Alam, 2006). This transition becomes even more important for India given that it has one of the largest ageing populations globally, and is witnessing a steady rise in the proportion of elderly individuals

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(Brinda et al., 2016; Agarwal et al., 2020; Subaiya & Bansod, 2014). Projections by the United Nations suggest that this trend will accelerate significantly in the coming decades, with the elderly population in India expected to reach nearly 300 million by 2050, indicating a more than twofold increase from current levels (Giridhar et al., 2014; Mishra, 2020). Whereas, this transformation reflects improvements in survival and longevity on one hand, but on the other, it presents new challenges as well. As the population ages, pressure on healthcare systems, social security arrangements, and traditional family-based support structures is likely to intensify, particularly in a context where formal institutional care remains limited (Sahoo et al., 2023; Malik et al., 2021; Mohapatra et al., 2024). Consequently, concerns regarding the health and well-being of older adults have become increasingly prominent, particularly in the context of persistent socio-economic inequalities and limited institutional support frameworks (Alam, 2006; Dwivedi & Raj, 2026).

A growing body of research suggests that health in later life is shaped by a combination of demographic and socio-economic factors. As individuals grow older, they are more likely to experience chronic illnesses and functional limitations, making age itself a key determinant of health (Singh et al., 2013; Pandey & Ladusingh, 2015). At the same time, gender differences remain deeply embedded in the ageing experience in India. Elderly women, in particular, often face poorer health outcomes, reflecting a lifetime of social and economic disadvantages that accumulate over time (Singh et al., 2013; Brinda et al., 2016). Education also plays an important role by shaping health awareness, access to information, and the ability to seek and utilize healthcare services effectively (Banerjee, 2021; Roy et al., 2020). Economic independence further strengthens this relationship. Older adults who have their own sources of income or financial autonomy are generally better positioned to meet their healthcare needs and tend to report better health compared to those who depend on others (Ghosh & Husain, 2010; Prasad et al., 2023). In addition, broader social structures such as religion and caste continue to shape access to resources and opportunities in India. These social stratifications influence living conditions, healthcare utilization, and overall quality of life, thereby playing a significant role in determining health outcomes among the elderly (Goli et al., 2014; Subramanian et al., 2006).

The literature also suggests that a range of living conditions, including house ownership status, cooking fuel used and the source of drinking water too play an important role in determining the health status of the elderly. The elderly people staying in their own houses are expected to have better health status as owning the house goes beyond physical shelter and reflects issues of autonomy, control, and dignity. Older individuals who live in their own homes often experience a greater sense of independence, psychological comfort, and security. In contrast, those residing in someone else's house may find themselves in more dependent positions, with limited decision-making power, which can negatively affect their overall well-being (Samanta et al., 2015;

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Muhammad et al., 2021; Seo & Kim, 2022). In addition, for many elderly, especially those belonging to impoverished settings, continued exposure to smoke from unclean cooking fuels and unsafe water sources can have serious health consequences. Studies have consistently shown that such exposures are linked to respiratory problems, infections, and a general decline in health, making the elderly particularly vulnerable (Jana & Chattopadhyay, 2022; Mohapatra et al., 2024).

The living arrangements of the elderly i.e. who they live with can make a significant difference to their overall well-being. Household structure and living arrangements often determine the kind and extent of social support available to them. For instance, elderly individuals living alone or in nuclear households may be more vulnerable to loneliness, neglect, and declining health, as they have limited day-to-day support compared to those living in extended family settings (Srivastava et al., 2021; Agrawal, 2012; Paul & Verma, 2016). In contrast, co-residence with family members can provide emotional comfort, caregiving support, and a sense of belonging, all of which contribute positively to health.

Although research on ageing and health in India has grown considerably in recent years, much of it tends to examine individual factors in isolation. As a result, our understanding of elderly health often remains fragmented. There is still a clear need for more integrated approaches that bring together demographic, socio-economic, and household-level factors to better capture the complexity of perceived health in later life. Looking at these dimensions collectively can provide a more holistic and realistic picture of the challenges faced by the elderly population. Against this backdrop, the present study seeks to understand what shapes perceived health among the elderly in India by examining it through a more comprehensive and integrated lens. Rather than looking at isolated factors, it attempts to capture the combined influence of multiple dimensions that together define the ageing experience. By doing so, the study aims to offer a more subtle understanding of how different aspects of life interact to influence health in later years. In turn, this approach seeks to contribute to the existing literature and generate insights that can inform policies aimed at reducing dependence and enhancing dignity among older adults.

Elderly Health in India: A Review of Literature

The existing body of research on ageing in India has increasingly focused on understanding variations in health outcomes among older adults, with particular emphasis on self-rated or perceived health as a comprehensive measure of well-being. Empirical studies consistently demonstrate that perceived health status is closely aligned with objective health conditions, including morbidity, functional limitations, and survival outcomes, making it a widely accepted indicator in ageing research (Kumar & Pradhan, 2019; Singh et al., 2013; Idler & Benyamini, 1997). In the Indian context, this measure has been particularly useful in capturing inequalities

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that may not be fully reflected through clinical indicators alone (Subramanian et al., 2009; Brinda et al., 2016).

A substantial strand of literature has examined how health outcomes vary systematically across population groups. Evidence suggests that disparities in perceived health are not randomly distributed but follow identifiable socioeconomic and demographic patterns. Empirical findings indicate that individuals with higher levels of education and stronger economic standing tend to report better health, suggesting that access to resources, information, and healthcare plays a mediating role (Banerjee, 2021; Singh et al., 2019). Studies further emphasize that financial autonomy is strongly associated with improved well-being, not only through enhanced healthcare access but also through its influence on individual agency and decision-making capacity (Ghosh & Husain, 2010; Prasad et al., 2023). These findings point to the importance of economic security as a critical dimension of ageing. Further, studies also report poor health conditions with advancing age and pronounced gender differences (Singh et al., 2013; Pandey & Ladusingh, 2015).

Parallel to this, a growing body of literature has drawn attention to persistent inequalities rooted in social stratification. Empirical evidence shows that individuals belonging to historically disadvantaged social groups experience systematically poorer health outcomes, reflecting unequal access to resources and services (Goli et al., 2014; Subramanian et al., 2006). These disparities are further shaped by cultural and institutional factors that influence healthcare utilization and social support mechanisms (Brinda et al., 2016). Recent studies have also expanded the scope of analysis by incorporating living conditions into the understanding of elderly health. Findings suggest that inadequate access to clean energy and safe water continues to pose significant health risks, particularly for vulnerable populations, reinforcing existing socio-economic disparities (Jana & Chattopadhyay, 2022; Saha et al., 2024). Such evidence highlights the need to view health outcomes within a broader context.

At the household level, studies have consistently emphasized the importance of family dynamics in shaping elderly well-being. Empirical findings suggest that living arrangements are closely associated with both physical and mental health outcomes, with co-residence generally linked to better support systems (Srivastava et al., 2021; Agrawal, 2012). At the same time, emerging research points to the significance of intra-household dynamics, indicating that the quality of support depends not only on living arrangements but also on factors such as autonomy and control within the household (Muhammad et al., 2021). Despite these contributions, the literature remains fragmented in its approach. Most studies tend to examine specific dimensions of elderly health in isolation, focusing either on socio-economic status, healthcare access, or living conditions. As a result, there is limited understanding of how these factors interact with one another in shaping perceived health outcomes. Recent research has begun to acknowledge the

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importance of adopting a multidimensional perspective; however, comprehensive empirical analyses that integrate these diverse determinants remain scarce (Ladusingh & Ngangbam, 2016; Mohsin et al., 2024). This highlights the need for a more holistic framework that captures the interconnected nature of ageing and health in the Indian context.

Data Sources and Methodology

The present study is based on unit-level data obtained from the 75th round of the National Sample Survey (NSS), conducted by the National Sample Survey Office (NSSO) between July 2017 and June 2018. The NSS, established in 1950, is one of India's most reliable and comprehensive sources of nationally representative data, regularly collecting information on various socio-economic aspects through large-scale cross-sectional surveys. The 75th round, which focused primarily on health, covered the entire Indian Union and collected detailed information from 113,823 households, encompassing a total of 555,115 individuals. A key feature of this round is the inclusion of detailed information on the health and economic conditions of older adults. In particular, Block 10A of Schedule 25.0 provides specific data on individuals aged 60 years and above, including their health status and level of economic independence. For the purpose of this study, the analysis is restricted to individuals aged 60 years and above, resulting in a sample of 42,762 elderly persons. The dependent variable in this study is perceived health status, which reflects the individual's self-assessment of their overall health. In the NSS dataset, this variable is categorized into three groups: excellent/very good, good/fair, and poor. This classification captures varying levels of health perception and is widely used in empirical studies to assess subjective well-being among the elderly.

To examine the determinants of perceived health status among the elderly, this study employs an ordered logistic regression model, which is appropriate when the dependent variable is ordinal in nature. An ordinal variable represents categories that follow a natural order but do not have equal intervals between them. In the present study, perceived health status is measured as an ordered outcome with three categories: excellent/very good, good/fair, and poor, reflecting a progression from better to worse health. The ordered logit model is based on the idea that there exists an underlying (latent) continuous variable representing an individual's true health status, which cannot be observed directly. Instead, what is observed is the categorical response, determined by where this latent health variable falls relative to certain threshold values (cut points). These thresholds divide the latent variable into the three observed categories of perceived health.

Finally, the model estimates the probability that an individual falls into a particular health category as a function of a set of explanatory variables, including demographic, socio-economic, and household characteristics. The relationship between the dependent variable and the

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independent variables is expressed through a linear predictor, while the cumulative probabilities are modelled using the logistic distribution.

Results and Discussion

Table 1 presents the socioeconomic and demographic profile of the elderly population. A majority of the sample (around 65%) falls within the age group of 60–69 years, indicating that a large proportion of the elderly population is relatively young. The gender distribution is fairly balanced, with a slight predominance of males. Educational attainment is notably low, with more than half of the respondents having education below the primary level, reflecting historical limitations in access to education (Banerjee, 2021). Most elderly individuals are currently married, suggesting the continued importance of family support, although a significant proportion remains unmarried and potentially vulnerable (Kumar & Pradhan, 2019).

In terms of occupation, nearly half are self-employed, highlighting the dominance of informal employment and limited social security in India (Singh et al., 2019). The distribution across religion and social groups broadly reflects the national population structure, but also points to existing social inequalities that may influence health outcomes (Goli et al., 2014). Overall, the table indicates that the elderly population is characterized by low education, dependence on informal work, and social stratification, all of which are important determinants of their health status.

Table 1: Socioeconomic and Demographic Profile of the Elderly Population

		No.	%
Age	60 to 64	15124	35.4
	65 to 69	12645	29.6
	70 to 74	7506	17.6
	75 and above	7487	17.5
Gender	Male	21902	51.2
	Female	20858	48.8
	Other	2	0
Highest completed education	Below Primary	24898	58.2
	Primary	4671	10.9
	Up to secondary	7752	18.1
	Higher secondary	2062	4.8
	Graduate or above	3379	7.9
Marital Status	currently unmarried	13438	31.4
	currently married	29324	68.6
Occupation	Self Employed	20986	49.1
	Salaried	8536	20

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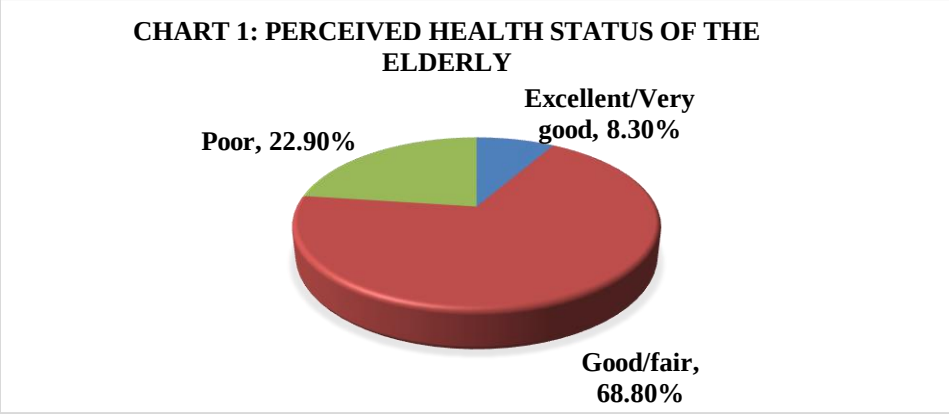
	Casual labour	6709	15.7
	Other	6531	15.3
Religion	Hindu	33243	77.7
	Muslim	4934	11.5
	Others	4585	10.7
Social group	ST	3913	9.2
	SC	6133	14.3
	OBC	16519	38.6
	Others	16197	37.9
	Total	**42762**	**100**

Source: Author's calculation from NSS 75th Round Survey Data

Chart 1 (pie chart) shows the distribution of perceived health status among the elderly. A clear majority of respondents (**68.8%**) report their health as **good/fair**, indicating that most elderly individuals perceive their health to be moderate rather than excellent. In contrast, only a small proportion (**8.3%**) rate their health as **excellent or very good**, suggesting relatively low levels of optimal health in later life.

At the same time, a notable share (**22.9%**) of the elderly report **poor health**, highlighting a significant segment of the population experiencing adverse health conditions. This distribution reflects the typical pattern observed in ageing populations, where the burden of chronic illness and functional limitations increases with age, leading to a concentration in the middle and lower categories of self-rated health.



Source: Author's calculation from NSS 75th Round Survey Data

Table 2 highlights the economic, and living conditions of the elderly population. A large proportion of the elderly (47.3%) are fully dependent, while only 29% are economically independent, indicating a high level of financial dependence in later life. This reflects limited

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pension coverage and continued reliance on family support systems in India. In terms of housing, the vast majority (90.6%) reside in their own houses, suggesting a degree of residential stability, which may contribute positively to their sense of security and well-being. Regarding household amenities, about two-thirds (66.3%) of the elderly use clean cooking fuel, while a significant one-third still relies on unclean fuels, exposing them to health risks. Access to safe drinking water is nearly universal (98.2%), which is a positive indicator of basic living conditions. However, health insurance coverage remains low, with only 37% of the elderly being insured, pointing towards continued vulnerability to healthcare expenses. Finally, living arrangements show that most elderly individuals live with spouse and/or family members (around 57.5%), highlighting the continued importance of family-based support. However, a small yet important proportion lives alone (2%), indicating potential risks of isolation and lack of care. Overall, the table suggests that while basic living conditions such as housing and water access are relatively satisfactory, economic dependence, limited insurance coverage, and reliance on informal support systems remain key challenges for the elderly population.

Table 2: Status of Elderly Economic Independence, Living Arrangement and Household Amenities

		No.	%
State of economic independence	Not dependent	12404	29.0
	Partially dependent	10129	23.7
	Fully dependent	20221	47.3
Place of stay	Owned house	38751	90.6
	Other's house	4003	9.4
Cooking fuel	Clean	28334	66.3
	Unclean	14428	33.7
Drinking water	Protected source	41980	98.2
	Unprotected source	782	1.8
Insurance	No	26949	63.0
	Yes	15813	37.0
Living arrangement	with spouse and other members	24578	57.5
	with spouse only	4549	10.6
	without spouse but with other members/relations	12792	29.9
	living alone	842	2.0
	Total	**42761**	**100.0**

Source: Author's calculation from NSS 75th Round Survey Data

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Table 3 presents the distribution of perceived health status across key demographic, social, and household characteristics of the elderly. A clear age gradient is observed, with the proportion of elderly reporting excellent/very good health declining sharply with age, from 12.1% in the 60–64 age group to only 3.5% among those aged 75 and above. At the same time, the share reporting poor health increases significantly with age, reaching over 42% in the oldest age group, reflecting the growing burden of illness and functional limitations in later life. Gender differences are also evident, with women reporting poorer health outcomes compared to men. Marital status appears to play an important role, as currently married elderly report better health outcomes compared to those who are unmarried. A substantially higher proportion of unmarried individuals fall into the poor health category, indicating the importance of spousal support in maintaining well-being. Household conditions also show noticeable associations. Elderly individuals using clean cooking fuel report relatively better health compared to those using unclean fuel, among whom the prevalence of poor health is higher. Similarly, those with access to protected drinking water sources tend to have slightly better health outcomes compared to those relying on unprotected sources. Overall, the table suggests that ageing, gender, marital status, and living conditions are closely associated with variations in perceived health, providing preliminary evidence of disparities that warrant further multivariate analysis.

Table 3: Distribution of Perceived Health Status across Key Characteristics of the Elderly Population

		Elderly Perceived Health Status						
		Excellent/Very good		Good/fair		Poor		Total
		No.	%	No.	%	No.	%	No.
Age	60 to 64	1826	12.1	11246	74.4	2050	13.6	15122
	65 to 69	1071	8.5	9136	72.3	2436	19.3	12643
	70 to 74	373	5.0	4970	66.2	2159	28.8	7502
	75 and above	259	3.5	4070	54.4	3158	42.2	7487
Gender	Male	2164	9.9	15180	69.3	4555	20.8	21899
	Female	1365	6.5	14241	68.3	5247	25.2	20853
	Other	0	0.0	1	50.0	1	50.0	2
	Total	3529	8.3	29422	68.8	9803	22.9	42754
Marital Status	currently unmarried	714	5.3	8615	64.1	4107	30.6	13436
	currently married	2815	9.6	20807	71.0	5696	19.4	29318
Cooking Fuel used	Clean	2600	9.2	19755	69.7	5974	21.1	28329
	Unclean	929	6.4	9667	67.0	3829	26.5	14425

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Source of Drinking Water	Protected source	3469	8.3	28909	68.9	9594	22.9	41972
	Unprotected source	60	7.7	513	65.6	209	26.7	782
	Total	**3529**	**8.3**	**29422**	**68.8**	**9803**	**22.9**	**42754**

Source: Author's calculation from NSS 75th Round Survey Data

Table 4 shows clear socio-economic differentials in perceived health status among the elderly. A strong positive association is observed between education and health, with the proportion reporting excellent/very good health increasing steadily from 6.5% among those below primary educations to 13.6% among graduates, while the share reporting poor health declines correspondingly. This highlights the role of education in improving health awareness and access to resources. Occupational differences also emerge, with casual labourers reporting the highest levels of poor health (26.2%), reflecting the long-term effects of physically demanding work and economic insecurity. In contrast, those in salaried and self-employed categories show relatively better health outcomes. Variations across religion and social groups indicate persistent inequalities. Muslims and Scheduled Castes report a relatively higher proportion of poor health compared to other groups, suggesting the influence of socio-economic disadvantage and differential access to resources. Overall, the table indicates that education, occupation, and social background are important factors associated with disparities in perceived health status among the elderly.

Table 4: Distribution of Perceived Health Status by Socioeconomic Characteristics of the Elderly

		Elderly Perceived Health Status						
		Excellent/Very good		Good/fair		Poor		Total
		No.	%	No.	%	No.	%	No.
Highest completed education	Below Primary	1630	6.5	16685	67.0	6577	26.4	24892
	Primary	363	7.8	3312	70.9	996	21.3	4671
	Upto secondary	843	10.9	5557	71.7	1351	17.4	7751
	HIgher secondary	233	11.3	1484	72.0	345	16.7	2062
	Graduate or above	460	13.6	2384	70.6	534	15.8	3378
occupation of member	Self Employed	1827	8.7	14547	69.3	4606	22.0	20980
	Salaried	769	9.0	5937	69.6	1829	21.4	8535
	Casual labour	437	6.5	4515	67.3	1757	26.2	6709
	Other	496	7.6	4423	67.7	1611	24.7	6530
Religion	Hindu	2793	8.4	23005	69.2	7439	22.4	33237
	Muslim	316	6.4	3199	64.9	1417	28.7	4932

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	Others	420	9.2	3218	70.2	947	20.7	4585
Social group	ST	362	9.3	2759	70.5	792	20.2	3913
	SC	432	7.0	4158	67.8	1543	25.2	6133
	OBC	1391	8.4	11501	69.6	3624	21.9	16516
	Others	1344	8.3	11004	68.0	3844	23.7	16192
	Total	3529	8.3	29422	68.8	9803	22.9	42754

Source: Author's calculation from NSS 75th Round Survey Data

Table 5 highlights significant differences in perceived health status based on economic independence and living conditions. A strong gradient is observed with respect to economic independence, as elderly individuals who are not dependent report much better health outcomes (14% excellent health and only 12% poor health), whereas those who are fully dependent show the highest prevalence of poor health (31.3%). This underscores the importance of financial autonomy in later life. Housing conditions also matter, with those living in their own houses reporting relatively better health compared to those residing in others' houses, where the proportion of poor health is notably higher. Similarly, living arrangements reveal that elderly individuals living with spouse and family members experience better health outcomes, while those living without spousal support or alone are more likely to report poor health, reflecting the role of social and emotional support. Insurance coverage shows a modest but positive association, as insured individuals report slightly better health outcomes compared to those without insurance, indicating the role of financial protection in accessing healthcare. Overall, the table suggests that economic independence, secure housing, family support, and insurance coverage are key factors associated with better perceived health among the elderly.

Table 5: Distribution of Perceived Health Status by Economic and Living Conditions of the Elderly

		Elderly Perceived Health Status						
		Excellent/Very good		Good/fair		Poor		Total
		No.	%	No.	%	No.	%	No.
State of economic independence	Not dependent	1740	14.0	9177	74.0	1487	12.0	12404
	Partially dependent	791	7.8	7360	72.7	1978	19.5	10129
	Fully dependent	998	4.9	12885	63.7	6338	31.3	20221
Place of stay	Owned house	3313	8.5	26903	69.4	8535	22.0	38751
	Other's house	216	5.4	2519	62.9	1268	31.7	4003
Living arrangement	with spouse and other members	2457	10.0	17471	71.1	4650	18.9	24578
	with spouse only	335	7.4	3182	70.0	1030	22.7	4547
	with other members/relations	682	5.3	8219	64.3	3888	30.4	12789

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	living alone	55	6.5	550	65.5	235	28.0	840
Insurance	No	2022	7.5	18473	68.6	6447	23.9	26942
	Yes	1507	9.5	10949	69.2	3356	21.2	15812
	Total	**3529**	**8.3**	**29422**	**68.8**	**9803**	**22.9**	**42754**

Source: Author's calculation from NSS 75th Round Survey Data

Table 6 presents the results of the ordered logistic regression analysis, identifying key determinants of perceived health status among the elderly. The findings reveal that economic dependence is one of the strongest predictors of poor health, as both partially and fully dependent elderly have significantly higher odds of reporting worse health compared to those who are economically independent. Living arrangements also play an important role. Elderly individuals living alone or without spousal support are more likely to report poorer health compared to those living with spouse and family, highlighting the importance of social and emotional support. Age shows a clear and strong effect, with the likelihood of poor health increasing sharply with advancing age, particularly among those aged 75 and above. Gender differences indicate that female elderly are less likely to report poor health compared to males, after controlling for other factors. Socio-economic factors such as education and occupation are also significant. Higher levels of education are associated with lower odds of poor health, while individuals engaged in casual labour or other informal work are more likely to experience poor health outcomes. Among other factors, living in someone else's house, using unclean cooking fuel, and belonging to disadvantaged social and religious groups (such as SCs and Muslims) are associated with higher likelihood of poor health. In contrast, having health insurance and residing in urban areas reduces the likelihood of poor health, reflecting better access to healthcare and living conditions. Overall, the results confirm that perceived health among the elderly is shaped by a combination of economic independence, social support, demographic characteristics, and living conditions, reinforcing the importance of a multidimensional approach to understanding ageing and health.

Table 6: Determinants of Perceived Health Status among the Elderly Population: Results from the Ordered Logistic Regression

	Elderly Perceived Health Status	Coef.	St. Err.	t-value	p-value	[95% Conf Interval]		Sig.
State of Economic Independence	# Not dependent	1	.	.	.	.	.	
	Partially dependent	1.76	0.057	17.54	0	1.652	1.874	***
	Fully dependent	2.916	0.091	34.24	0	2.742	3.1	***
Living Arrangement	# with spouse and other members	1	.	.	.	.	.	
	with spouse only	1.289	0.051	6.39	0	1.193	1.394	***

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	without spouse but with other members	1.121	0.058	2.21	0.03	1.013	1.24	**
	living alone	1.428	0.134	3.81	0	1.189	1.715	***
	# Male	1	.	.	.	.	.	
Gender	Female	0.809	0.021	-8.2	0	0.769	0.851	***
	Other	1.682	2.432	0.36	0.72	0.099	28.619	
	# 60 to 64	1	.	.	.	.	.	
Age	65 to 69	1.397	0.038	12.22	0	1.324	1.474	***
	70 to 74	2.21	0.07	24.9	0	2.077	2.353	***
	75 and above	3.572	0.116	39.06	0	3.351	3.807	***
Marital Status	# currently unmarried	1	.	.	.	.	.	
	currently married	0.889	0.046	-2.26	0.02	0.803	0.984	**
	# Below Primary	1	.	.	.	.	.	
	Primary	0.922	0.033	-2.27	0.02	0.86	0.989	**
Highest Education completed	Upto secondary	0.799	0.026	-7	0	0.751	0.851	***
	HIgher secondary	0.835	0.046	-3.29	0	0.75	0.93	***
	Graduate or above	0.749	0.036	-6.05	0	0.682	0.822	***
	# Self employed	1	.	.	.	.	.	
Occupation	Salaried	0.966	0.028	-1.19	0.24	0.911	1.023	
	Casual labour	1.21	0.038	6.08	0	1.138	1.287	***
	Other	1.29	0.047	6.95	0	1.201	1.386	***
Place of Stay	# Owned house	1	.	.	.	.	.	
	Other's house	1.143	0.042	3.62	0	1.063	1.229	***
Insurance	# No	1	.	.	.	.	.	
	Yes	0.845	0.019	-7.53	0	0.809	0.883	***
Sector	# Rural	1	.	.	.	.	.	
	Urban	0.901	0.022	-4.32	0	0.86	0.945	***
	# ST	1	.	.	.	.	.	
Social Group	SC	1.207	0.056	4.02	0	1.101	1.322	***
	OBC	0.975	0.041	-0.61	0.54	0.898	1.058	
	Others	1.172	0.049	3.78	0	1.08	1.273	***
	# Hindu	1	.	.	.	.	.	
Religion	Muslim	1.39	0.047	9.73	0	1.301	1.485	***
	Others	0.978	0.036	-0.62	0.54	0.909	1.051	
Source of Drinking water	# Protected	1	.	.	.	.	.	
	Unprotected	1.162	0.092	1.9	0.06	0.995	1.357	*
Cooking Fuel used	# Clean	1	.	.	.	.	.	
	Unclean	1.314	0.032	11.11	0	1.252	1.379	***
	cut1	-1.12	0.139	.b	.b	-1.4	-0.85	
	cut2	2.887	0.14	.b	.b	2.612	3.163	
	Mean dependent var		2.147	SD dependent var			0.539	
	Pseudo r-squared		0.075	Number of obs			42754	
	Chi-square		5153.574	Prob > chi2			0	
	Akaike crit. (AIC)		63378.64	Bayesian crit. (BIC)			63638.53	

*# base category, *** p<.01, ** p<.05, * p<.1*

Source: Author's calculation from NSS 75th round survey data

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Conclusion

This study examined the determinants of perceived health status among the elderly in India using a multidimensional framework and found that health in later life is shaped by a complex interplay of economic, social, demographic, and household factors. Among these, economic independence emerges as a critical determinant, with financially dependent elderly, especially those fully dependent are significantly more likely to report poor health. This underscores the close link between financial security, access to healthcare, and overall well-being. The findings further highlight the importance of living arrangements and social support, as elderly individuals lacking spousal or family support, or residing in others' households, are more vulnerable to adverse health outcomes. At the same time, advancing age, low levels of education, informal employment, and social disadvantage continue to reinforce inequalities in health. The use of unclean cooking fuel, further aggravate health risks, while access to health insurance and improved living conditions contributes positively to better health outcomes. Overall, the study reveals that elderly health in India is deeply embedded within broader structures of dependence, inequality, and access to resources. Addressing these challenges requires an integrated policy approach that simultaneously strengthens economic security, expands healthcare access, improves living conditions, and supports family and community-based care systems. Expanding pension coverage, enhancing insurance penetration, promoting clean energy use, and targeting vulnerable social groups can play a crucial role in reducing health disparities. At the same time, policies that encourage active and independent ageing can help improve not only physical health but also the dignity and quality of life of the elderly population.

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