RESEARCH PAPER

Exploring Financial Insecurity among the Elderly in Chennai, Tamil Nadu: A Community-Based Qualitative Study

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ABSTRACT

Background: India's elderly population is projected to more than double from 10.16 crore in 2011 to 22.74 crore by 2036 — close to one in every seven citizens. Across urban centres like Chennai, the informal family-based safety nets that once cushioned economic hardship are eroding, while formal welfare mechanisms have not filled that gap. A significant share of older adults consequently face economic strain that spills directly into nutrition, healthcare access, and day-to-day quality of life.

Methods: An interpretive phenomenological design was employed to examine the financial lives of community-dwelling persons aged 60 years and above in urban and peri-urban Chennai. Eleven face-to-face in-depth interviews (IDIs) were carried out using a semi-structured guide; recruitment continued until successive transcripts produced no new themes. Purposive sampling ensured variation across age, sex, and income background. Transcripts were analysed through Braun and Clarke's six-phase thematic framework, with the COREQ 32-item checklist applied throughout.

Results: Three overarching themes emerged: (1) Financial Challenges — characterised by erratic or meagre income and heavy personal health costs; (2) Coping Mechanisms — encompassing family reliance, asset pawning, and deliberate deferral of medical care; and (3) Support Systems and Perceptions — marked by limited awareness of government entitlements and inconsistent experiences with pension provision. Across all narratives, financial hardship was actively shaping health behaviour and deepening social dependency.

Conclusion: Elderly residents of urban Chennai bear a substantial and layered financial burden rooted in pension inadequacy, high personal health expenditure, and welfare schemes with limited reach. Meaningful redress will require pension revisions calibrated to urban living costs, proactive welfare outreach at the community level, and financial literacy integrated into routine primary care contacts.

Keywords: *Financial insecurity, elderly, ageing, qualitative study, thematic analysis, Chennai, out-of-pocket expenditure, social support, pension, coping mechanisms*
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INTRODUCTION

The world has never aged as rapidly as it does right now. WHO projections put the global population aged 60 and above at approximately 1 billion in 2020, rising to 2.1 billion by 2050; by 2030 alone, one in every six persons worldwide around 1.4 billion individuals will be over sixty.[1] Social protection systems built for elderly populations are well established in developed nations . The burden falls hardest on low- and middle-income countries (LMICs), where pension coverage is thin and the state's capacity to rapidly expand benefits is constrained. When older adults cannot meet the cost of food, medicines, or utilities without cutting into their basic standard of living, the outcome is financial insecurity one of the most concrete public health consequences of demographic shift.

Asia holds the world's largest share of elderly persons, yet institutional support remains fragmentary across much of the region. In South and Southeast Asian LMICs, contributory pension schemes have not filled the resulting gap: fewer than one in five elderly workers in South Asia has access to any such scheme, leaving most dependent on

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informal or family-based transfers.[2] Urbanisation, nuclear family trends and labour migration have dismantled the extended family networks that historically provided informal economic protection

The MoSPI Elderly in India 2021 report, drawing on National Commission on Population projections, documents that persons aged 60 and above are set to rise from 10.16 crore in 2011 to 22.74 crore 14.9% of the national population by 2036 with goes in hand with the global trajectory of demographic shift in aging population.[3] National Survey data indicate that only a minority of older Indians are economically independent, with elderly women particularly dependent: roughly 10–11% of older women are financially independent compared with around half of older men.[3] National Health Accounts data for 2021–22 place out-of-pocket (OOP) expenditure at 39.4% of total health expenditure in India a burden disproportionately carried by older adults managing chronic conditions.[4] The downstream effects are well documented: skipped meals, unfilled prescriptions, mounting anxiety. What begins as an economic problem converts, predictably, into a direct threat to physical and mental health.[5]

Southern Indian states Tamil Nadu, Kerala, Karnataka, and Andhra Pradesh are ageing faster than the national average, driven by decades of lower fertility and rising longevity. On National Commission on Population projections, Tamil Nadu's elderly share was around 20.5% for 2021 well above the national average.[6] Several welfare instruments exist on paper: the Indira Gandhi National Old Age Pension Scheme (IGNOAPS), the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS), and the state old-age pension programme all target this group.

Rapid peri-urban growth has drawn ageing migrants from rural Tamil Nadu, while many older residents have been left behind as younger family members relocate for employment, weakening the co-residence arrangements on which elderly economic security has traditionally rested.[7] Despite growing policy attention to non-communicable diseases, the financial circumstances of Chennai's elderly as they actually experience and articulate them remain poorly understood. Quantitative surveys can map income levels and expenditure patterns; they cannot capture the meaning, negotiation, and emotional weight that older adults attach to economic hardship.

Previous research has examined pension coverage, food insecurity, and OOP expenditure among older Indians at the national level, consistently linking financial strain to poorer health and well-being.[8] What remains underexplored is the qualitative, lived dimension how community-dwelling elderly in urban South India experience and respond to financial hardship. Understanding these experiences is essential for designing contextually relevant interventions that go beyond income-support measures and address root causes such as welfare inaccessibility, financial illiteracy, and structural barriers to care.

This study was therefore undertaken with two objectives: (1) to explore the financial challenges faced by elderly individuals aged 60 years and above residing in urban and peri-urban Chennai, Tamil Nadu, in maintaining economic security post-retirement; and (2) to understand the financial strain and to describe the coping mechanisms and support systems that influence financial security in old age among this population.

MATERIALS AND METHODS

Study Design

This study adopted an interpretive phenomenological design to examine how elderly residents of urban Chennai understand and navigate their financial circumstances. The approach was chosen because financial insecurity in old age is not simply a measurable deficit it is a lived experience shaped by meaning, memory, family obligation, and cultural expectation. Phenomenological inquiry creates space for precisely these dimensions, which remain opaque to surveys and administrative datasets.

Study Setting

Study took place across localities of Chennai, Tamil Nadu. These sites were selected to ensure the findings would reflect the older adults circumstances rather than a single residential profile.

Study Population

Eligible participants were community-dwelling men and women aged 60 years and above, capable of providing voluntary written informed consent, and able to communicate in Tamil or English. Persons residing in institutional settings old-age homes or inpatient wards and those whose cognitive status or acute illness would have prevented meaningful engagement with the interview were excluded.

Sample Size and Sampling Technique

Eleven in-depth interviews (n = 11) were conducted and participants were recruited through purposive sampling, with the variation across age, sex, income source, and residential locality to maximise the range of experience within the sample. Enrolment stopped when successive interviews produced no new codes and no meaningful shifts in emerging patterns the point at which thematic saturation was judged to have been reached. This sample size falls within the 9–17 interview range that Malterud et al. (2016) identified as typically sufficient for saturation in community-based qualitative studies with relatively homogeneous populations.[9]

Data Collection

All interviews were conducted face-to-face between August to October 2025, guided by a semi-structured interview guide developed through literature review and faculty consultation in community medicine and geriatric health. Five domains were covered: (i) current income and financial situation since retirement; (ii) out-of-pocket health spending and its effect on daily life; (iii) strategies used to manage financial shortfalls; (iv) knowledge and

use of government welfare programmes; and (v) personal perceptions of economic security and social support. Interviews were conducted in Tamil and typically lasted 30–45 minutes.

With written consent, all sessions were audio-recorded and later transcribed verbatim; Tamil transcripts were translated into English where needed. Field notes were maintained throughout to capture non-verbal cues and contextual observations.

Data Analysis

Printed verbatim transcripts were analysed manually following Braun and Clarke's six phases[10]: (1) repeated reading to build familiarity with the data; (2) generating initial codes line by line; (3) grouping codes into candidate themes; (4) reviewing those themes against the full dataset; (5) naming and precisely defining each theme; and (6) producing the interpretive account. Codes were first developed within individual transcripts, then mapped across all eleven to identify recurring patterns. The process was iterative — themes and codes were consistently cross-checked against source material to protect interpretive accuracy. The COREQ 32-item checklist was applied throughout to ensure transparency in reporting.[11]

Ethical Considerations

Institutional Ethics Committee approval was obtained from Saveetha Medical College and Hospital (SIMATS) Chennai, (1039/06/2025/PG/SRB/SMCH) before any participant was approached. Each individual signed a written informed consent form and was explicitly informed that withdrawal at any point carried no penalty. To protect anonymity, all names were replaced with sequential codes (IDI 1 through IDI 11). Audio recordings and transcripts were stored in password-protected files accessible only to the research team. The study was conducted in full conformity with the Declaration of Helsinki (2013 revision) and the ICMR National Ethical Guidelines for Biomedical and Health Research Involving Human Participants (2017).

RESULTS

Eleven participants took part, aged between 65 and 80 years (mean 72.3 years, SD ± 5.1). Six were women and five men. By prior occupation: , three in the unorganised sector (domestic work or petty trade),five had worked as daily wage labourers, two as salaried government employees, and one was a homemaker . Seven lived with family; four lived alone. Five were receiving a pension or some government transfer, yet every one of them described the monthly amount as inadequate for their actual needs.

Thematic analysis of the eleven IDIs produced three major themes: (1) Financial Challenges; (2) Coping Mechanisms; and (3) Support Systems and Perceptions. Each theme contained two subthemes, described below.

THEME 1: FINANCIAL CHALLENGES

Subtheme 1.1: Irregular or Insufficient Income

Every participant in this subtheme spoke of a persistent shortfall that set in once paid work ended and never lifted and participants who had spent their working life in the informal sector had never contributed to any provident fund or contributory scheme. Their sole income sources were family remittances and the state old-age pension, which ranged from ₹1,000 to ₹5,000 per month sums that fell conspicuously short against Chennai's cost of living. The observed pattern across these accounts was not anger or protest but settled resignation: financial scarcity had become so constant that participants no longer experienced it as exceptional.

"My allowance is just ₹3,000. It doesn't even cover my medicines." – IDI 2, female, 74

"There are days I drink only tea for dinner. Buying vegetables is a luxury now." – IDI 9, male, 75

Together, these accounts illustrate how pension inadequacy translates directly into food insecurity — a linkage falling most heavily on women who had no formal employment history and therefore no independent financial base.

Subtheme 1.2: High Out-of-Pocket Healthcare Expenditure

Most participants in this subtheme were managing at least one chronic condition such as hypertension, type 2 diabetes, or a musculoskeletal disorder requiring regular medication. Buying those medicines on a fixed or near-zero income created relentless financial pressure, which many had quietly resolved through rationing: stretching a fortnight's prescription across a month, or postponing clinic visits until symptoms became impossible to ignore. Cost-driven non-adherence had been accepted as an ordinary feature of old age rather than a clinically dangerous practice a finding with serious implications for disease management at the community level.

"I have to buy tablets for sugar and BP. I skip some days." – IDI 5, male, 68

"I avoid the doctor unless it is really serious. The consultation fee, the tests, the medicines — it adds up to what I do not have." – IDI 1, male, 75

What emerges from these accounts is a self-reinforcing cycle: financial constraint drives non-adherence and care avoidance, which in turn raises the risk of complications generating even higher future expenditure a spiral for those on fixed incomes.

THEME 2: COPING MECHANISMS

Subtheme 2.1: Family Dependency and Intergenerational Financial Transfers

Turning to adult children for financial help was the most commonly described coping strategy yet it was rarely spoken of with uncomplicated relief. Threaded through almost every account was sharp awareness of the parallel pressures those children faced: school fees, home loans, the general cost of running a household in urban India.

Receiving money felt less like support and more like an imposition. Several participants described holding back from asking even when genuinely in need, because asking had come to feel wrong. The psychological costs of this dependency guilt, self-suppression, persistent fear of being seen as a burden represent a dimension of financial insecurity that no income survey can register. Some even register that their own pensions were utilised by their children for daily expenses.

"My son gives money, but he has his own burdens. I feel guilty asking him each time." – IDI 3, male, 65

"I do not want to ask my daughter every month. It feels wrong. But what choice do I have?" – IDI 6, female, 71

Subtheme 2.2: Asset Liquidation and Distress Borrowing

When neither family support nor savings were available, participants described turning to whatever tangible assets remained. For women in this sample, that most often meant gold jewellery such as ornaments of personal and ceremonial significance accumulated across a lifetime. Pawning such items was not a casual financial manoeuvre; it was a last resort, undertaken with visible reluctance and the hope of eventual redemption. Alongside asset pawning, informal borrowing from neighbours served as a bridge during acute crises, particularly around hospital bills. Conspicuously absent from every account was any awareness of a formal credit facility designed for elderly persons without formal income documentation or a credit history. Many were not aware of the Government Schemes available to them.

"I pawned my wedding chain for hospital bills. I hope to get it back, but I don't know when." – IDI 7, female, 70

"I borrowed from a neighbor last time. I am still paying it back slowly." – IDI 10, female, 80

THEME 3: SUPPORT SYSTEMS AND PERCEPTIONS

Subtheme 3.1: Lack of Awareness of Government Welfare Schemes

Perhaps the most arresting pattern across this theme was how little participants knew about the welfare entitlements nominally available to them. Nearly all had a vague sense that old-age pensions existed, but very few could describe eligibility criteria, the application process, or the broader benefits package including health insurance under CMCHIS, subsidised food through the Public Distribution System, or disability-linked allowances. The absence of structured, proactive outreach was cited repeatedly as the most fundamental barrier to uptake.

"I heard something about old-age pension but I don't know how to apply. No one came and explained it." – IDI 8, female, 66

"They give free medicines for BP, but most of my acquaintances did not know about it. There should be more awareness about government schemes." – IDI 4, female, 69

Subtheme 3.2: Mixed Experiences with Existing Pension and Social Protection Schemes

The five participants enrolled in a pension or welfare scheme did not report uniformly positive experiences. Monthly transfers arrived but amounts bore no practical relation to what life in Chennai actually costs. Not one had knowledge about supplementary schemes or how to stack benefits. Several expressed a wish for a single access point: somewhere they could enquire about, apply for, and manage all elderly entitlements at once, rather than navigating multiple offices with no guidance.

"The government pension comes, but it is not enough." – IDI 10, female, 80

DISCUSSION

Elderly men and women in urban and peri-urban Chennai face economic hardship that is simultaneously deep and multi-layered. Drawing on eleven in-depth interviews, this study examined how that hardship is experienced, managed, and understood. Three major themes — financial challenges, coping mechanisms, and perceptions of support — each with distinct subthemes, together reveal the complexity of financial insecurity in old age. From a public health perspective, financial insecurity in old age is not an isolated economic problem: it is a preventable social and health issue shaped by structural inequalities, welfare gaps, and cultural barriers to access. The findings are discussed in conjunction with supporting literature in Table 1.

Table 1. Themes, key findings, and supporting literature from the study on financial security among elderly in urban Chennai

Theme	Findings from Study	Supporting Literature	Reference
1. Insufficient Income and Pension Inadequacy	Pension of ₹1,000–3,000/month was wholly inadequate for food and medicines in Chennai. Former informal-sector workers had no pension access whatsoever. Food insecurity was a direct downstream consequence.	Financial stress and insecurity among older Indians are strongly associated with undernourishment and food insecurity; older adults in the poorest wealth quintiles are the most likely to be food insecure (LASI Wave 1).	Banerjee, Sahoo & Govil (2023)[12]
2. High Out-of-	Medication rationing	OOP expenditure remains a major	Garg, Bebarta &

Pocket Healthcare Expenditure	(intentional dose-skipping) and avoidance of clinic consultations were widespread strategies to manage pharmaceutical costs. Cost-driven non-adherence was normalised.	source of catastrophic health spending and financial hardship for elderly Indian households, even under publicly funded insurance schemes. NHA 2021–22 reports OOPE at 39.4% of total health expenditure.	Tripathi (2022)[13]; NHA 2021–22[4]
3. Family Dependency and Intergenerational Transfers	Intergenerational financial transfers were the dominant coping strategy, accompanied by significant emotional guilt, self-suppression, and fear of burdening children.	Children-to-parent financial transfers in India are roughly triple parent-to-child transfers, and older adults living alone receive the most support from children — underscoring reliance on family in the absence of adequate formal protection (LASI Wave 1).	Nagargoje, Dilip & James (2023)[14]
4. Asset Liquidation and Distress Borrowing	Pawning of gold jewellery and informal borrowing from neighbours were the primary distress-financing strategies during medical emergencies. No participant was aware of any formal elderly-accessible microcredit facility.	In the absence of adequate financial protection, Indian elderly households frequently resort to distress financing — borrowing and asset depletion — to meet catastrophic health costs.	Garg, Bebarta & Tripathi (2022)[13]
5. Lack of Awareness of Government Welfare Schemes	Most participants were unaware of eligibility criteria or application processes for IGNOAPS, CMCHIS, or disability allowances. Contradictory guidance from government offices was a key barrier. Absence of proactive outreach was the most cited structural gap.	In Tamil Nadu, old-age pension provision (IGNOAPS and state social security pensions) is fixed at roughly ₹1,000–₹1,200/month; awareness, application support, and uptake among eligible elderly remain limited.	MoSPI Elderly in India 2021[3]
6. Mixed Pension Experiences	Enrolled participants confirmed monthly transfers arrived but described amounts as functionally inadequate for urban living costs. Occasional unexplained delays caused acute hardship. No participant had received guidance on supplementary benefit stacking.	Tamil Nadu social security pensions pay a flat ₹1,000–₹1,200/month regardless of category; this quantum falls well below urban subsistence requirements in Chennai, prompting calls for cost-of-living-linked revision.	MoSPI Elderly in India 2021[3]
Cross-cutting: Publicly Funded Insurance Gaps	No participant reported that existing health insurance meaningfully offset their out-of-pocket pharmaceutical costs for chronic disease management.	Publicly funded health insurance in India provides only partial financial protection for the elderly; substantial OOP costs persist even among the insured, particularly for outpatient and medicine expenses.	Garg, Bebarta & Tripathi (2022)[13]
Cross-cutting: Food Insecurity Linkage	Several participants, especially women, reduced meal frequency or quality as a direct result of income shortfall.	Financial insecurity is a significant determinant of malnourishment and poor mental and physical health outcomes among older adults in India.	Banerjee, Sahoo & Govil (2023)[12]

CONCLUSION

Elderly men and women in urban and peri-urban Chennai are navigating a financial landscape marked by meagre pensions, high personal health costs, and welfare schemes that most have never been helped to access. This study gives qualitative texture to what national statistics already suggest: financial insecurity in old age is not an isolated economic problem — it is a public health issue that shapes when and whether older adults eat adequately, take their medicines, seek medical care, or feel they have a right to ask for help.

The three coping strategies that emerged leaning on adult children, liquidating cherished assets, and simply not going to the doctor are each unsustainable in the long run, and each represents a failure that formal social protection should be preventing. Meaningful change will require more than incremental adjustment. Pension quantum needs recalibration against urban cost-of-living data. Welfare outreach must reach older adults in their homes rather than waiting for them to navigate unfamiliar bureaucracies. Financial literacy should be woven into routine primary care contacts. And the CMCHIS, at minimum, should be extended to cover OOP pharmaceutical costs for elderly beneficiaries managing chronic conditions.

STRENGTHS AND LIMITATIONS

Strengths

Several features of this study strengthen confidence in the findings. Data were collected directly from elderly residents of one of India's largest cities — a population whose financial experiences are rarely centred in health research. Participant quotations are reproduced verbatim from Tamil, translated with care to preserve meaning, grounding the interpretive account in what participants actually said rather than in summary reconstructions. Methodological transparency was ensured through Braun and Clarke's six-phase framework and the COREQ checklist. Deliberate variation in the sample across sex, occupational background, income source, and residential locality increases the plausibility that findings are transferable to comparable urban elderly populations elsewhere in India.

Limitations

This study has certain limitations. As a single-city qualitative study with eleven participants, its findings reflect the experiences of urban Chennai's elderly and are not generalisable to rural or other settings. Participants' accounts of pensions and scheme awareness were also not verified against administrative records a direction for future mixed-methods research.

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