ILLUSTRATION:
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Is Bangladesh ready for ageing?

An old-age home in Gazipur. PHOTO: PRABIR DAS

Older people face higher rates of non-communicable diseases (NCDs), such as heart disease, diabetes, stroke, cancer, and chronic respiratory illnesses. Bangladesh already has one of the highest burdens of NCDs in the region. Managing these conditions requires long-term and continuous care, routine monitoring, long-term medication, and rehabilitation—something the current health system, which is heavily oriented toward acute and hospital-based treatment, is not fully prepared for.

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Bangladesh stands at a demographic turning point. For at least three decades, the country has benefited from a youthful population, declining fertility, and an expanding workforce, which is often referred to as a 'demographic dividend'. Over the last 30 years, this 'window of opportunity' supported rapid economic growth in Bangladesh, but it is now shrinking. At the same time, the population of Bangladesh is ageing at one of the fastest rates compared to many South Asian and developed countries. The question confronting policymakers is no longer whether this transition will happen, but how well the government is prepared for it.

According to an estimate, Bangladesh had roughly 16.5 million people aged 60 and above in 2024, representing 10 percent of the population. By 2050, the number of aged people will have more than doubled, reaching around 40 million people, or 19 percent of the total population. People may already be in despair thinking about their old age. It is a hard reality: people will get older, and children will often receive preference over older people. Even though an old woman or man has a solid legacy to contribute to this world, a child does not yet have a solid footprint in society. We need a balanced approach that considers both the incoming and outgoing age cohorts.

The demographic dividend is not a permanent gift. Bangladesh is now in the later stages of its dividend window, perhaps with a decade left, but no more. After that, rapid ageing combined with limited wealth, limited pension coverage, and limited health-system readiness will create vulnerabilities that could intensify over time. The old-age dependency ratio—the number of elderly persons per 100 working-age adults—is also set to rise sharply, indicating growing pressure on the workforce. Ageing is often misunderstood as a social or health-sector issue alone. In reality, it is also an economic challenge. The labour market of Bangladesh is already strained by low female labour-force participation, skills mismatches, and vulnerable informal work. In the future, with fewer young workers entering the economy, productivity gains must come from upskilling, technological upgrading, and absorbing more women into the labour force. If productivity does not rise, the shrinking workforce will struggle to support both economic growth and an expanding elderly population with diverse needs. Therefore, without investments in automation, skills development, and expanded participation of women, the economy may struggle to maintain momentum.

Older people face higher rates of non-communicable diseases (NCDs), such as heart disease, diabetes, stroke, cancer, and chronic respiratory illnesses. Bangladesh already has one of the highest burdens of NCDs in the region. Managing these conditions requires long-term and continuous care, routine monitoring, long-term medication, and rehabilitation—something the current health system, which is heavily oriented toward acute and hospital-based treatment, is not fully prepared for. As the aged population grows, the cost of care will rise, straining both households and the state unless primary-care systems are strengthened and made age-friendly, preferably at the community level.

Urbanisation, migration—both internal and international—and a shift toward nuclear family patterns in both higher- and lower-income households mean that more older adults are living alone or without traditional family-based caregivers. Bangladesh lacks a formal long-term care system, trained caregivers, day-care centres for seniors, or regulated home-based services. This increases the need for new models of community care, long-term care, and structured home-care systems. Without policy reform, the burden will shift to households, particularly women, thereby magnifying economic and social stress.

Conventionally, most older Bangladeshis rely on informal savings, family support, or small government allowances that are insufficient to meet basic needs. The formal pension system covers only a small fraction of the population, primarily government employees and a limited share of formal private-sector workers. Without a sustainable pension system that includes options for informal workers, fiscal pressure will intensify. As life expectancy increases and family structures continue to change, reliance on traditional care arrangements is weakening, placing millions at risk of falling into old-age poverty.

Bangladesh has taken steps to formulate policies, such as the *National Policy on Older Persons 2013*, aligned with international conventions, including the *Madrid International Plan of Action on Ageing (MIPAA) 2002*, the *Maintenance of Parents Act 2013*, the *National Committee on Older Persons 2017*, the *Action Plan to Implement the National Policy on Older Persons 2013*, and the draft *Probin Unnayan Foundation Act 2017*. The Constitution of Bangladesh, in Article 15(d), declares the introduction of a social security programme for elderly people, alongside the *Universal Pension Scheme Rules, 2023*. Some safety-net programmes have already been undertaken under the *National Social Security Strategy (NSSS)*, such as the *Old Age Allowance*, *Allowance for Freedom Fighters*, *Allowance for Widows and Husband-Deserted Women*, and *Vulnerable Group Feeding (VGF)*. Six government old-age homes are operated by the Government of Bangladesh under the Department of Social Services (DSS). The Ministry of Health and Family Welfare has improved NCD screening and developed policies on healthy ageing. The government has also shown willingness to discuss pension reform and long-term care strategies, but the scale of future demand far exceeds the scale of current preparedness.

First, the old-age allowance is too small to meet basic needs, and pension coverage remains low. Informal workers, who constitute over 85 percent of the workforce, have almost no long-term financial security. Second, primary health care and community-based care require more trained personnel in geriatrics, better referral pathways, affordable essential medicines for hypertension, diabetes, and arthritis, as well as trained palliative caregivers and community-based home-care models. For these, no formal regulatory or financing model currently exists. Third, skills development, re-skilling of older workers, and higher female labour-force participation remain urgent needs. Fourth, without actuarial projections, realistic costing of pensions, and long-term modelling of pension costs and health-system needs under ageing scenarios, future fiscal stress will be difficult to manage.

What can be done?

The transition to an ageing society is unavoidable, but the outcomes are not. Bangladesh can meet this challenge with a coherent and well-sequenced strategy, considering both *ex ante* (preventive) and *ex post* (reactive) interventions. Better preparation will ease the later part of life. During old age, not all older people will fall sick simultaneously, or with the same magnitude or nature of illness. At the same time, there will be some individuals who are able to support their families and society in many ways. To understand the management of this demographic group, analysis can be undertaken across several areas.

First, primary health care for older adults can be strengthened by integrating NCD management, rehabilitation, counselling, and community-based geriatric care into routine services, and by making medicines for hypertension and diabetes widely affordable. The Diabetic Association of Bangladesh may be an important case to explore for supporting other NCDs.

The transition to an ageing society is unavoidable, but the outcomes are not. PHOTO: STAR

Considering mobility restrictions, digital health services might be one option, particularly for follow-up treatment. There is also a need to encourage preventive health-care systems—such as recreational activities, inclusive religious practices, mental well-being, positive thinking, emotional intelligence, outdoor games, nutrition literacy, physical exercise, and active lifestyles—within health policy, giving them greater importance than curative treatment services, particularly for younger people.

Second, the government might reorient its existing pension schemes by expanding pension coverage through contributory micro-pension schemes for informal workers, combined with a gradual enhancement of the old-age allowance, if necessary. The Universal Pension Scheme in Bangladesh introduces four distinct schemes: *Progoti* (private sector), *Surokkha* (informal sector), *Somota* (below the poverty line), and *Probash* (Bangladeshis abroad). This system aims to provide financial security from birth to old age. While acceptance is still scaling up, the contributory scheme is expected to have far-reaching positive impacts for citizens. People should also prepare themselves for how they would like to live in their old age. This can be done through investment in pension schemes, insurance, or other facilities. Bangladesh can also explore the superannuation system in Australia, where a portion of salary is set aside in an investment fund for old-age benefits.

Third, considering IT-based technological change and global demographic shifts—particularly in developed and African countries—there is an urgent need to boost the size and productivity of the workforce by investing in skills, promoting automation in production, manufacturing, and service sectors, and raising female labour-force participation through childcare provision, safe transport, and flexible work policies. There may need to be a balanced approach to designating the workforce for both domestic and international labour markets. In addition to public interventions, there is a need to develop family-based eldercare models, community support programmes, caregiver training systems, and regulated public–private eldercare services. Bangladesh also requires greater private investment in establishing eldercare services, alongside more community-managed eldercare facilities. The *Probin–Nobin Interaction Centre* of the government-established *Palli Karma-Sahayak Foundation (PKSF)* can be explored in this regard.

Fourth, it is also important to conduct demographic–fiscal modelling to estimate future pension liabilities and healthcare spending, and to prepare evidence-based budget frameworks for ageing.

Bangladesh still has a decade left of favourable demographics, but that window is narrowing. If the country fails to prepare for rapid ageing, the gains of the last 30 years may weaken under rising social and fiscal pressure. If it acts decisively, investing in people, productivity, and protection, ageing can be managed and even turned into an opportunity for innovation in health, social care, and economic resilience. We have to remember that we must equip ourselves with specialised services that are not yet available at the scale required for an ageing population of 40 million within the coming 25 years. Bangladesh has shown repeatedly that it can tackle large national challenges with creativity and determination. The demographic transition ahead may be among the most significant, but it is one for which preparation cannot be delayed. It is inevitable, rapid, and unforgiving if ignored.

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