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Unlocking the Longevity Dividend

Active and Healthy Ageing in India

FICCI HEAL 2025
HEALTH + ENTERPRISE + LEARNING

FOREWORD BY FICCI

India is standing at a transformative point in its **demographic journey**. By 2050, over 300 million Indians will be over 60 years of age, making this one of the largest senior populations globally. This is both a celebration of progress and a wake-up call to reimagine how we prepare for longer lives. **Healthy ageing** must now be recognised as a **national development priority** that goes beyond healthcare to encompass social participation, financial security, and environments that allow older persons to live with dignity and purpose.

This Knowledge Paper on **Active & Healthy Ageing** seeks to frame ageing as an opportunity rather than a challenge. Drawing on global frameworks such as the UN Decade of Healthy Ageing, led by WHO and extensive consultations with experts, it highlights the need for a **paradigm shift** — one where ageing is viewed as a time for continued contribution, agency, and fulfilment.

FICCI Task Force believes that the response must be **multi-dimensional and collaborative,** rooted in the Indian context. While government and industry have critical roles to play in strengthening health systems, expanding geriatric care, and building age-friendly infrastructure, the shift must also begin with **individuals, families, and communities** — through holistic health practices, intergenerational solidarity, and digital and social inclusion.

The message is clear: the time to act is now. If we delay, the gaps in care, financial security, and social support will widen, placing a heavier burden both on families and public systems. By working together — industry, policymakers, communities, social organisations and innovators — we can convert this demographic shift into an **advantage for India's growth story**, where every additional year of life is a year of health, dignity, and contribution.

We hope this Knowledge Paper, released during the 19th edition of FICCI's annual healthcare conference - **FICCI HEAL 2025** with the central theme ***"Care@25: Defining Moments in Healthcare",*** serves as a catalyst for dialogue, partnership, and coordinated action — helping India move from viewing ageing as a challenge to **realising the promise of longevity** as a driver of economic resilience and social progress.

Dr Harsh Mahajan

Chair, FICCI Health Services Committee and Founder & Chairman, Mahajan Imaging & Labs

Dr Arun Agarwal

Chair - FICCI Task Force on Active & Healthy Ageing; Former Dean - MAMC, Former Additional Director General Health Services, GoI; Medical Advisor - Innovation, Education & Clinical Excellence, Apollo Hospitals Group

Ms Malti Jaswal

Co-Chair, FICCI Task Force on Active & Healthy Ageing and Founder, Inspiring Seniors Foundation

Foreword by Chase Advisors

As India experiences one of the fastest demographic transitions across the world, the next critical frontier for policy reforms lies in the often-overlooked domain of senior care. With just two decades left for India to achieve its Viksit Bharat @ 2047 vision, the country faces an urgent challenge and a historic opportunity to reimagine care for its ageing population.

Traditionally, senior care has remained peripheral to India's policy discourse, overshadowed by priorities such as maternal and child health or communicable diseases. Yet, as life expectancy increases and the burden of chronic and age-related conditions grows, neglecting eldercare is no longer an option. India can unlock the longevity dividend by investing in bold reforms that span healthcare, pensions, social participation, and community support.

This paper titled '**Unlocking the Longevity Dividend: Active and Healthy Ageing' (AHA)** is a call to reimagine how India supports, empowers, and integrates its elderly population into the fabric of national development.

As a policy research and consulting firm, we are committed to advancing evidence-based, forward-looking solutions. We see immense potential in building a robust **silver economy**, investing in digital health innovations, developing elder-friendly infrastructure, and recognising seniors as contributors to the economy, society, and family life.

This paper is the result of a collaborative effort. We thank Dr. Arun Aggarwal, Ms. Malti Jaiswal, **FICCI Health Services team**, and all members of the Task Force and expert contributors for their invaluable insights. Together, we hope to have laid the foundation for a national conversation that is long overdue.

It is our belief that the reforms proposed here will not only address the vulnerabilities of India's elderly but also position the country as a global leader in ageing policy building systems that uphold dignity, expand opportunity, and ensure that longer lives are better lives.

Ms. Suryaprabha Sadasivan

Senior Vice President Chase Advisors

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1. Executive Summary

With life expectancy increasing to 70 years, India stands at the threshold of a profound demographic transition. By 2050, 319 million Indians (one-fifth of the population) will be over 60. Without systemic action, ageing could reduce GDP growth by 0.4–0.8 percentage points per year, leading to a loss of $5–8 trillion by 2050. High out-of-pocket spending for chronic and long-term care is already pushing millions into poverty annually. This is not a challenge to be feared, but an opportunity to transform longevity into a driver of growth, equity, and strength.

Inspired by the ancient shloka ***"Jeevet Sharada Shatam"***, this report celebrates the pursuit of not just long life, but a life marked by good health. The WHO framework for Active and Healthy Ageing (AHA) offers the right contemporary compass: enabling older people to do what they value by focusing on functional ability, participation, and supportive environments. Unlocking the potential of older adults through better health and active participation will add $300–600 billion annually to GDP and expand the silver economy to $476 billion by 2050. While grounded in global frameworks such as the UN Decade of Healthy Ageing and the Madrid International Plan of Action on Ageing, India's approach to AHA, as outlined in the paper, must be tailored to the Indian context.

Participation & Co-Design: Placing seniors at the centre of planning and service delivery
Equity & Inclusion: Closing rural-urban, gender, and socio-economic gaps
Dignity & Autonomy: Ensuring choice in where and how people age
Life-Course Approach: Promoting health and well-being from childhood through old age
Whole-of-Society Response: Engaging government, private sector, civil society, and families
Measurement & Accountability: Tracking health, participation, and quality-of-life outcomes
Caregiver Recognition: Supporting unpaid and professional caregivers with training and respite

Healthy ageing requires an integrated multi-dimensional approach across physical health, mental well-being, economic security, participation, and environment changes. The paper highlights that it needs a continuum of interventions around:

- Physical Health: Preventive, promotive, curative, rehabilitative, and palliative care
- Mental Well-Being: Geriatric mental health services, dementia care, and social connectedness
- Nutrition: Access to age-appropriate, affordable nutrition through public programs

- NCD Prevention & Management: Early detection and management, promotion of active lifestyle
- Economic Security: Universal pensions, social protection, re-employment and entrepreneurship
- Lifelong Learning & Participation: Platforms for seniors to reskill, volunteer, and contribute meaningfully, be an active part of economic, social, cultural and civic life
- Age-Friendly Environments: Housing, transport, and public spaces designed for accessibility.
- Technology & Digital Inclusion: Affordable devices, vernacular digital literacy programs
- Care Ecosystem: Trained caregivers, respite care, and community-based long-term care models.

India already has progressive policies, but implementation remains fragmented and underfunded. The National Programme for Health Care of the Elderly (NPHCE) is not fully scaled, geriatric services are concentrated in a few states, and mental health treatment gaps exceed 80%. Pension adequacy is low leaving many seniors financially dependent. Digital exclusion continues to block access to entitlements and telehealth, reinforcing inequality, especially among women and in rural populations. Realising the longevity dividend requires a coordinated response across all sectors.

The shift must begin with changing how people think, feel and act towards age and ageing. Additionally, communities, government policies, and programmes should foster the ability of older people. India's ageing population must be positioned as a pillar of national development. A holistic approach is required to turn demographic change into a dividend.

Stakeholder	Strategic Interventions
Government – Lead the Systemic Shift	Deliver integrated primary care. Expand geriatric health services and train geriatric professionals. Universalise social pensions and ensure benefit adequacy. Develop an integrated long-term care framework with funding for home- and community-based care, respite services, and caregiver support. Mandate age-friendly design in Smart City and Gram Panchayat plans. Launch special focus on elderly mental health. Allow use of public spaces and infrastructures for Senior Day Centers. Create National Silver Service for mainstreaming seniors into volunteering and economic activity.
Private Sector – Build the Silver Economy	Create flexible work and reskilling opportunities through phased retirement, remote and part-time roles for seniors. Innovate products such as affordable health insurance, assistive devices, senior-friendly housing, and financial tools. Use CSR funds to support telemedicine services, senior day centres, and digital literacy programs.
Civil Society & Communities – Foster Inclusion	Scale elder self-help groups, RWAs to build peer networks for financial and emotional resilience. Facilitate social participation by creating wellness clubs, intergenerational programs, and senior-led cultural forums and day centers. Deploy volunteer caregiver networks and replicate successful rural models of community-based care.
Academia & Research – Generate Evidence	Build real-time data systems and dashboards linking LASI and NFHS data for planning. Pilot innovative LTC financing models, preventive care packages, and tech-enabled service delivery solutions. Integrate gerontology and palliative care modules into medical, nursing, and social work curricula to build future capacity.
Families & Individuals – Embrace Prevention and Care	Promote preventive health through awareness, screenings, active lifestyles, and savings for retirement. Share caregiving responsibilities to reduce stress and economic burden. Strengthen intergenerational bonds through shared living, mentorship, and open family dialogue to sustain support networks.

India's ageing population is a national asset waiting to be mobilised. With the right policies and partnerships, seniors can remain healthy, engaged, and economically active — reducing care costs, boosting productivity, and strengthening communities.

Investing in AHA today will ensure:

- Healthier, more resilient communities with lower disease burden.
- Stronger economic growth, powered by active participation of older adults.
- Social cohesion and intergenerational solidarity, bridging divides across age groups.
- Global leadership, positioning India as a model for ageing societies worldwide.

The message is clear: the longevity dividend is within reach, but the time to act is now.

2. India's Demographic Shift And Ageing Population Trends

In India, life expectancy at birth has risen from 49.7 years in the 1970s to 70.3 years for the period 2019-2023[1]. By 2050, the country will have more than **319 million people aged 60 and above[2]** – accounting for over one-fifth of its population. Globally, the older population will double to 2.1 billion[3] by the same year.

Global Commitments and India's Alignment

India has consistently endorsed international frameworks that shape ageing policy including:

- **Madrid International Plan of Action on Ageing (2002)** – Prioritising participation, health, and security for older persons.
- **UN Principles for Older Persons (1991)** – Emphasising independence, participation, care, self-fulfilment, and dignity.
- **UN Decade of Healthy Ageing (2021–2030)** – Calling for global action to improve the lives of older people, their families, and communities.
- **Proclamation on Ageing (1992), Shanghai Plan of Action (2002), and Macau Outcome Document (2007)** – Reinforcing rights-based, inclusive approaches.

These commitments are reflected in India's own policy evolution, like the National Policy on Older Persons (1999) and the National Policy for Senior Citizens (2011), which focus on autonomy, social security, care, and dignity.

Why Active and Healthy Ageing Matters for India

Active and Healthy Ageing (AHA) is a concept developed by the World Health Organization to reframe ageing not as decline, but as opportunity. It emphasises enabling people to live longer lives in good health, with dignity, autonomy, and meaningful participation in society. Unlike narrow welfare approaches, AHA takes a holistic view that spans health, economic engagement, social inclusion, and supportive environments. Over the past two decades, it has become a guiding framework for countries to design policies that keep older adults at the centre of development strategies.

Despite this, global commitments and national policies have struggled to accommodate on-ground and local realities. Ageing in India is deeply shaped by:

- **Rural–urban divides** in access to healthcare, pensions, and infrastructure.
- The **feminisation of ageing**, with women living longer but facing higher poverty and widowhood rates.
- The erosion of traditional family support systems due to migration, rising cost of living and urbanisation.
- A growing population of elderly people living with chronic diseases and disabilities.

Against this backdrop, the **Active and Healthy Ageing** framework provides a supportive approach. Originally advanced by WHO, AHA focuses on optimising opportunities for health, participation, and security to improve quality of life in older age. For India, this means shifting from **reactive welfare** to **proactive investment** in health systems, social inclusion, and economic participation of the elderly.

India's demographic trajectory makes ageing both a challenge and an opportunity. If older people are supported to remain healthy, productive, and socially connected, they can contribute to communities, economies, and intergenerational solidarity. Conversely, failure to prepare risks overwhelming health systems and widening inequalities.

Thus, ageing must be positioned not as a marginal welfare issue, but as a **pillar of India's development strategy**, aligned with the UN Decade of Healthy Ageing and the country's vision of Viksit Bharat 2047.

2.1 HEALTH SPAN VS. LIFE SPAN: THE QUALITY OF AGEING

India's demographic triumph lies in achieving a life expectancy at birth of 70 years. Yet the challenge is not only how long people live, but how well they live. The **healthy life expectancy (HALE)**[4] lags by over 10.5 years (2022)[5], meaning that most Indians spend their final decade of life in poor health. This highlights the urgent need to shift from measuring success by longevity alone to ensuring quality of life in older age.

A Multi-Dimensional Challenge

Findings from LASI, NFHS, and NITI Aayog reveal that the experience of ageing in India is shaped by interconnected health, social, economic, and digital determinants:

- **Health Domain:** Every 4th Indian over 60 reports poor health. Nearly 75% live with one or more chronic diseases, 23.3% with multimorbidity, and 20% with mental health conditions. Malnutrition persists, with 2% underweight and 22% overweight/obese.[6] Environmental vulnerabilities compound risks: in 2018, India recorded 31,000 heat-related deaths among people over 65.[7] These factors significantly erode daily functioning, reported by 24% of older adults.
- **Social Domain:** The elderly face rising social vulnerability, reflected in a dependency ratio of 60 per 100 and a sex ratio of 1,065 women per 1,000 men,[8] underscoring gendered disadvantage. Nearly 71% of older persons live in rural areas with limited access to healthcare and social support. About 9% live alone due to divorce, separation, or desertion, and one-third report low life satisfaction. Illiteracy remains high (55%), limiting their ability to navigate entitlements, with only 28% aware of welfare concessions.[9]
- **Economic Domain:** Financial insecurity is widespread—70% of elderly individuals depend on others for daily maintenance, 78% live without pension coverage, and more than 40% belong to the poorest wealth quintile.[10] Out-of-pocket expenditure (OOPE) exacerbates vulnerability: seniors spend on average ₹8,028 for inpatient care in public facilities and ₹31,933 in private facilities.[11]
- **Digital Domain:** Although 87% of households have mobile phones, digital adoption among the elderly remains limited. This **digital divide** risks deepening exclusion as more services move online. Yet digitalisation also holds promise through assistive technologies[12], telemedicine, and smart home systems to enable ageing with dignity and independence.

Together, these domains illustrate that the challenge is not just extending years of life, but reducing years lived with disease, dependence, and exclusion.

Segmenting The Elderly: Recognising Diversity

Ageing is not a uniform experience. Policies must reflect the diversity within older populations, who differ not only by age but also by health status, socio-economic background, and gender. LASI and related studies suggest the following segmentation framework

From Segmentation to Strategy

Recognising these differences is critical for designing responsive policies. A **one-size-fits-all approach** risks leaving behind the most vulnerable particularly rural elderly, widowed women, and the oldest-old. Instead, policy must align with the lived realities of diverse ageing cohorts: protecting health, ensuring financial security, fostering social connectedness, and bridging digital divides.

The next step, therefore, is not only acknowledging the diversity of ageing but also making a compelling **economic case for healthy ageing** to demonstrate that investing in seniors' well-being is not a welfare burden but a driver of inclusive growth and intergenerational resilience.

2.2 Economic Case For Healthy Ageing In India

India's demographic shift represents not just a population trend but a structural change with profound implications for the economy, labour markets, healthcare systems, and social protection frameworks. Ageing multiplies the challenges of physical and mental health, and as traditional support structures erode, India faces the dual task of protecting its elderly and unlocking their untapped potential. The economic case is also based on the productive contributions of an elderly population which is fit and functioning rather than frail and feeble.

2.2.1 Demographics and Labour Force Dynamics

At its core, ageing is a developmental challenge. The traditional support structure is changing rapidly. The dependency ratio will decline dramatically from 10:1 working people per elderly person today to 4.6:1 by 2050. Yet 36% of elderly Indians remain economically active, with 50.9% of older men and 22% of older women earning income.[13] However, 95% work in informal employment without pension benefits, indicating substantial untapped economic potential.

The demographic shifts will see the working-age population reduce while the elderly segment increases. This will affect the labour force as it will tighten the market, leading to a loss or reduction in productivity, while potentially seeing shortages of appropriate skills across the country.[14] If policies that do not promote healthy ageing are implemented, dependency ratios across the country will rocket.[15]

Healthcare spending has doubled from $38.1 billion (2020-21) to $72.6 billion (2024-25), representing an 18% compound annual growth rate.[16] Families allocate 17.4% of their income to healthcare expenses, rising to 24.8% for the poorest families. This creates catastrophic health expenditure for 46.5% of elderly individuals.[17]

Infrastructure remains inadequate with only 1.3 hospital beds per 1,000 people and a doctor-population ratio of 1:1500, falling short of WHO's recommended 1:1000 ratio.[18] Clinical data shows 32% of elderly hospital visits involve cardiac issues, with substantial numbers presenting diabetes and hypertension complications. Only 18.9% of elderly Indians possess health insurance, while Indians pay 47.1% of healthcare costs out-of-pocket compared to 13-15% in developed countries.

However, recent policy developments offer hope. The expansion of the Ayushman Bharat scheme now provides health coverage to all senior citizens aged 70 years and above, potentially covering millions of seniors with substantial coverage amounts.[19]

2.2.2 Costs of Inaction

Countries that inadequately prepare for demographic transitions experience GDP growth reductions of 0.4-0.8 percentage points annually.[20] For India's economy, this could translate to cumulative losses potentially exceeding $5-8 trillion over three decades equivalent to 20-25% of India's projected economic potential.

Current healthcare spending includes approximately $15-20 billion for elderly care. With elderly population doubling by 2050, elderly healthcare costs could potentially reach $400-600 billion annually representing 1.5-2% of GDP. If India's growth rate drops from the current 7% to 3-4% due to ageing challenges, this would mean losing massive economic potential each year by 2050.

The most significant cost may be missed opportunities. Comprehensive age-friendly policies can generate 1-2 percentage points of additional GDP growth through increased elderly workforce participation and consumption.[21] For India's projected economy, this translates to $300-600 billion in unrealized annual economic activity by 2050, with cumulative missed opportunities potentially exceeding $8-12 trillion over the next two and a half decades.

Transforming the Labor Market

India's ageing workforce represents untapped productive capacity worth an estimated $238-357 billion annually if properly integrated[22]. Current employment rates of 50.9% for older men and 22% for older women indicate substantial underutilisation, particularly considering that 80% of men aged 60-64 remain physically capable of work. Research shows that active ageing policies emphasizing health maintenance, skills development, and productive engagement cost $357-$476 per elderly person annually but generate $1,190-1,786 in economic returns.[23] This 3-5:1 return ratio positions healthy ageing investment among the highest-yield policy interventions available.[24]

Countries like Germany and South Korea have set examples for this. While German automotive manufacturer BMW achieved 7% productivity increases through workplace modifications costing $595 per worker,[25] Japan maintains 25.2% employment rates for workers 65+[26]. Meanwhile, South Korea's framework sustains significant economic activity rates for older demographics, contributing $89 billion annually to their economy.[27]

Research demonstrates that companies with 10% higher age diversity exhibit 23% higher productivity and 7% higher profitability.[28] The key lies in flexible retirement systems and age-friendly workplace standards that could unlock substantial additional productive capacity annually.

Beyond Welfare: A Development Approach

The fundamental transition requires viewing elderly citizens as contributors rather than dependents. Nordic and East Asian countries demonstrate that this paradigm shift generates "longevity dividends" worth 1.5 percentage points of additional GDP growth. Sweden's comprehensive model maintains 13.8% employment rates for the 65-74 age group, generating additional annual contributions per active elderly person through reduced healthcare costs, continued tax contributions, and sustained consumption[29]. India's digital health market could expand from $7.14 billion to $30.2 billion by 2030, while elderly consumption could grow substantially from current levels.

Family Economics and Social Protection

The inadequate pension system forces 88% of elderly Indians to depend on family support, creating intergenerational poverty cycles. Only 12% of older men and 3% of older women possess formal pension coverage. Catastrophic health expenditure affects 46.5% of elderly households, with average out-of-pocket spending reaching $315 annually—nearly 25% of household income for the poorest quintile.

Informal caregiving imposes substantial costs, with research indicating 50-60 million people are forced into poverty annually due to medical expenses, with elderly care comprising 40% of such cases[30]. This represents significant wealth destruction that constrains investment in education, health, and economic advancement activities, creating cycles that trap families across generations.

Integrated Solutions

Comprehensive health coverage emerges as critical for breaking cycles of family impoverishment. Taiwan's National Health Insurance achieved 99.9% coverage with 6.4% of GDP spending, with elderly individuals using annual preventive care experiencing 16 fewer hospitalisation days and $765 lower expenses annually[31]. Thailand's Universal Coverage Scheme eliminated catastrophic health expenditure for 80% of the population while maintaining 3% of GDP spending[32].

India's expanded health coverage represents potential household savings worth hundreds of billions annually. Preventive care investments of **$12 per elderly person** annually could reduce hospitalisation costs substantially over five years, with prevention showing favorable return ratios through reduced acute care needs.

Strategic Imperatives

Countries in early stages of demographic transition have unique opportunities to plan effectively[33]. Research indicates that longer lives provide opportunities to reconsider how entire lifecycles might evolve, with health serving as the primary determining factor[34].

India's demographic transition requires coordinated action across sectors. Key priorities include expanding silver economy opportunities, increasing elderly workforce participation, improving financial inclusion, and enhancing healthcare accessibility.

India's demographic transition requires coordinated action across sectors. Key priorities include expanding silver economy opportunities, increasing elderly workforce participation, improving financial inclusion, and enhancing healthcare accessibility.

Preventive healthcare investments could save $119 billion over five years (2025-2030), while expanded coverage could prevent household savings losses of $357 billion annually by 2050.

The strategic choice remains binary: Comprehensive action now to create substantial silver economy opportunities, or demographic constraints limiting growth for decades. Evidence supports immediate investment in ageing infrastructure, workforce integration, health coverage expansion, and family financial protection.

2.2.3 India's Opportunity—the Longevity Dividend

Such transitions are viewed as a fiscal and social burden. Proactive work towards systemic reforms to improve healthcare access and cover marginalised sections of the elderly population need to be undertaken The Economic Survey 2024-25 highlights the impact of the COVID-19 pandemic on female employees leaving regular wage/salary work and taking up flexible work to take care of children who stayed at home due to school closures and elders who needed extra care and attention. By shifting from a welfare approach to a development-led approach, India can transform ageing into its demographic dividend.

2.3 Active And Healthy Ageing

The conceptual evolution of Active and Healthy Ageing (AHA) represents one of the most significant paradigmatic shifts in global health policy of the 21st century. Initially conceived by the World Health Organisation in 2002, Active Ageing was defined as "the process of optimising opportunities for health, participation, and security to enhance quality of life as people age"[35]. Importantly, the term "active" referred not merely to physical activity or labour force participation, but to continued engagement in social, economic, cultural, spiritual, and civic life.

WHO subsequently refined the concept to Healthy Ageing, defined as "the process of developing and maintaining the functional ability that enables well-being in older age[36]." This marked a clear shift in emphasis: from framing ageing in terms of disease avoidance, to recognising it as the capacity to meet basic needs, build and sustain relationships, learn and grow, and make decisions, supported by enabling environments that promote autonomy, security, and participation.

This reorientation gained global momentum with the UN Decade of Healthy Ageing (2021-2030), which provides the central framework for coordinated action[37]. Its four interconnected priorities combating ageism, creating age-friendly environments, delivering person-centred integrated care, and expanding access to long-term care represent a multi-stakeholder agenda involving governments, civil society, academia, media, professionals, and the private sector. The Decade represents an unprecedented opportunity to align theory, policy, and practice in improving the lives of older people worldwide[38].

2.3.1 Theories and Perspectives

Underlying these global frameworks are several theoretical perspectives that explain how and why people age well. These theories move the discussion beyond the absence of disease, emphasising instead how individuals adapt, function, and interact with their environments throughout life. Three critical perspectives stand out:

- **Hansen-Kyle's Process-Orientated Model (2005):** Defines healthy ageing as a process of gradual physical and cognitive slowing, balanced by resilience, adaptation, and compensation—allowing individuals to continue functioning optimally in physical, cognitive, social, and spiritual domains[39]
- **Life-Course Adaptation Perspective:** Views healthy ageing as a lifelong process shaped by dynamic interactions between intrinsic (personal) and extrinsic (environmental) resources. Ageing well, in this view, depends on adaptive strategies that sustain quality of life across personal, family, and societal levels.[40]
- **Health Outcomes Perspective:** Conceptualises healthy ageing as the cumulative outcome of these individual–environment interactions, measured in terms of healthy life expectancy and subjective well-being at any given time.[41]

Together, these perspectives demonstrate that healthy ageing is not a single state to be achieved, but an ongoing, adaptive process shaped by both personal resources and social contexts. They also reinforce the policy focus of the UN Decade: that ageing well depends as much on supportive environments as on individual resilience.

2.3.2 Defining Active And Healthy Ageing In An Indian Context

The international frameworks for Active and Healthy Ageing (AHA) are reinforced by several enabling tools that guide effective implementation.

- For instance, WHO's **Healthy Ageing Indicator Metadata Toolkit** provides 35 core indicators covering domains such as workforce and training, accessibility of services, intergenerational activities, and functional ability (see Annexure A), thereby supporting systematic monitoring of progress. [42]
- Similarly, the **AARP Liveability Index** assesses community well-being across seven domains: housing, neighbourhood, transportation, environment, health, engagement, and opportunity, demonstrating that healthy ageing extends beyond healthcare delivery to encompass a comprehensive societal transformation. [43]

India's demographic realities demand careful contextualisation of these global frameworks. The country is undergoing one of the fastest demographic transitions in the world: whereas European nations had nearly 150 years to adapt to ageing populations, India faces a compressed timeframe of only 20–30 years. [44] This accelerated shift magnifies the urgency of developing an ageing model tailored to India's unique conditions.

A contextualised definition of AHA for India can be articulated as "the process of optimising older people's **functional ability** — physical, mental and social — so they can do what they value most, by strengthening intrinsic capacities across the life-course and creating equitable, age-friendly environments, services and policies that protect dignity and promote meaningful participation in social, economic, cultural and civic affairs." Access to essential care and support systems that are culturally sensitive, financially accessible, and geographically available is a pre-requisite for active and healthy ageing.

The next phase of senior care policy in India must move beyond a welfare-delivery approach to build systems that enable **agency, resilience, and relevance**, laying the foundation for a nationally owned, equity-driven development model of ageing.

2.3.3 Core Constructs And Guiding Principles Of Active And Healthy Ageing

The framing of Active and Healthy Ageing must be rooted in both the lived realities of India's elderly population and global best practices.

International reference points such as the **UN Decade of Healthy Ageing**[45] and the **AARP Livable Communities Index**[46] provide conceptual scaffolding, but meaningful implementation in India demands adaptation anchored in equity, cultural relevance, and systems thinking.[47]

1. **Participatory and Co-Designed Ageing Systems:** Effective ageing policy must begin by centring older people around the design and delivery of services. Internationally, the *WHO Age-Friendly Cities framework* has shown that listening to older people's needs rather than assuming them is foundational to policy success.
2. **Equity, Inclusion, and Focus on the Most Vulnerable:** Older people are a diverse group with varying needs, and certain groups face worsened discrimination or challenges based on things like gender, ethnicity, or socioeconomic status. It calls for culturally sensitive and adaptive approaches that evolve with the population's needs and address these social determinants of ageing.
3. **Dignity, Autonomy, and a Shift from Passive Welfare to Active Agency:** Culturally, India reveres its elders, but in practice, this often translates into paternalistic service delivery that denies seniors autonomy over their health, finances, and life choices, besides being subject to elder abuse. True dignity lies in empowering older people as active participants, not passive recipients. Health services should enable choice and convenience; financial tools must support economic independence; and social programming must build and draw on the elderly's knowledge and experience, not sideline it.
4. **A Life-Course Approach to Ageing:** Healthy ageing is not an outcome of old age alone; it is the result of investments made across the life span, both at an individual and societal level. The life-course approach links child nutrition, adolescent health, adult disease prevention, and eldercare as part of a continuous policy arc. At individual levels, daily habits, timely health checks, and lifestyle choices across all ages play a vital role in shaping one's ageing experience.

5. **A Whole-of-Society Approach:** Shifting of paradigm in ageing requires a whole-of-society approach, which includes a robust synchronised response involving government, civil society, academia, private sector actors, and traditional institutions such as Panchayats and SHGs.
6. **Monitoring and Evaluation: Moving Beyond Output Metrics:** For AHA to succeed, its outcomes must be measurable. Careful monitoring, data collection, and evaluation practices for both new and existing healthy ageing interventions. This means developing a comprehensive M&E framework that tracks not only service delivery but also health outcomes, social participation, and quality of life[48].
7. **Supporting the Caregiving Ecosystem:** Supporting and growing the "care economy," paying specific attention to the needs of both paid care workers and unpaid family carers. AHA must formally recognise the role of informal carers, offering them training, respite services, financial assistance, and legal protection. Career well-being must be treated as an integral outcome of any ageing policy.

Together, these guiding principles provide the scaffolding for an Indian model of Active and Healthy Ageing, one that is equity-driven, culturally relevant, and capable of turning longevity into a national asset rather than a social burden.

> The future of eldercare in India must be anchored in dignity, autonomy, and community. Our approach is not just to provide welfare, but to empower our senior citizens as active participants in society with access to care, opportunities for contribution, and systems that recognise the diversity of their needs. We are committed to community-driven models and policy innovations that reflect the realities of ageing across both urban and rural India.
>
> **Shri Amit Yadav,**
> Secretary, Ministry of Social Justice & Empowerment (MoSJE), Government of India

2.3.4 Key Components Of Active And Healthy Ageing

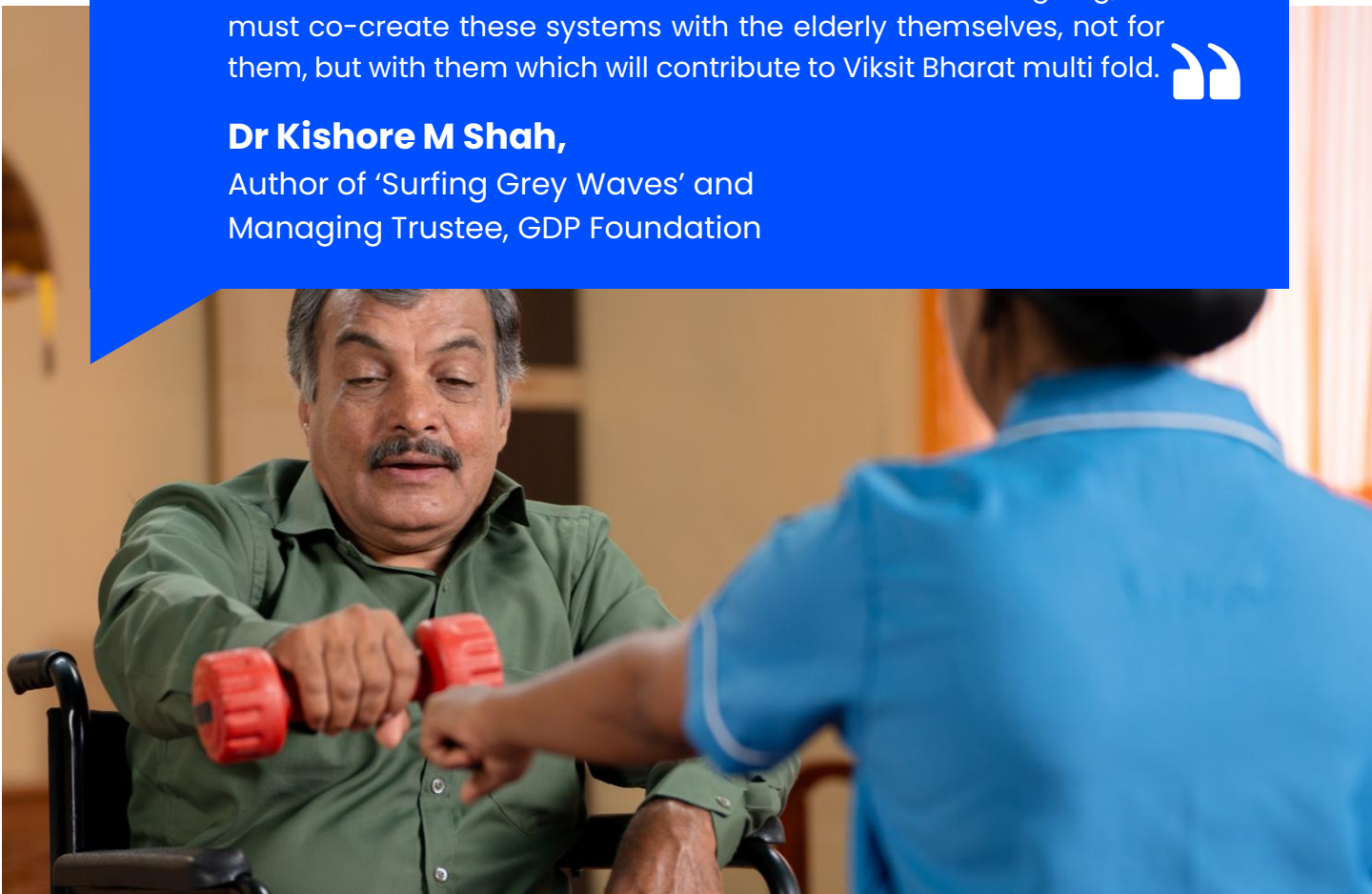
Delivering on these principles requires a continuum of care spanning prevention, promotion, treatment, rehabilitation, and palliative care. Interventions must address changing needs, cultural realities, and geographic diversity, while ensuring affordability.

1. **Mind & Body Wellness:** Preventive, promotive, curative, rehabilitative, and palliative services are essential. Integrated primary healthcare, geriatric assessments, and person-centered models help preserve independence and quality of life.
2. **The Integrated Continuum of Care:** Elder health needs, often characterised by multimorbidity, demand seamless coordination across healthcare levels. Comprehensive geriatric assessments and referral systems are essential.
3. **Nutrition:** Adequate nutrition with the right supplements across the life course underpins healthy ageing. Existing policies, such as the National Nutrition Policy for the Elderly and ICDS-Senior, need consistent and community-level implementation.
4. **Mental and Emotional Health:** Social connectedness, counselling, and stigma-free access to mental health services, including tele-mental health, are critical for addressing isolation, depression, and cognitive decline. Task sharing, community programs and training, combined with culturally rooted practices, can support resilience.
5. **Long Term and Palliative Care**: Sustainable systems must combine community-based care, caregiver support, and financing mechanisms to ensure dignity in advanced age and at the end of life.
6. **NCDs with focus on Prevention and Management:** The National Programme for Health Care of the Elderly (NPHCE) provides a foundation for NCD management, and it needs to be supported by adequate infrastructure, workforce, and functional facilities[49].
7. **Addressing Age-Related Conditions:** Vision, Hearing, Oral Health ensures optimal functionality, though not given adequate attention[50].
8. **Tailored interventions:** As per the requirements of different cohorts and diverse segments of the elderly, age, gender, geography and socio-economic status would ensure that policies are equitable and effective.
9. **Access and Affordability:** To ensure that seniors do not spend Out of Pocket and seek timely care, which will reduce burden and long-term costs
10. **Lifelong Learning and Economic Engagement:** Older people should have opportunities for reskilling, digital literacy, entrepreneurship, and flexible work. Their roles as mentors, caregivers, and volunteers remain economically and socially vital.

11. **Social Participation and Intergenerational Solidarity:** Participation in cultural, civic, and intergenerational activities builds belonging and reciprocity. Programmes that connect youth and seniors create mutual value.
12. **Age-Friendly Environments:** Cities, transport, housing, and digital spaces must be inclusive. Barrier-free design and digital accessibility enable older people to remain active and engaged.
13. **Technology and Innovation:** Telemedicine, assistive devices, wearables, and digital health records expand autonomy and access. India's digital ecosystem offers unique opportunities for scaling age-friendly innovation.
14. **Care Economy and Support Systems**: Recognising caregiving as both social and economic labour is key. Training, financial support, and respite for caregivers alongside professionalised care services will be central to India's ageing response

> Ageing is not a static problem to solve; it is a dynamic human phenomenon to be sensed, diagnosed to create a vibrant socio-economic -culturally sensitive ecosystem for elderly. We need platform & policies that go beyond healthcare and pensions, and instead build customised systems that resonate with elders as a function of their age, ability and desirability to ensure a dignified continuation. If we are sincere and serious about active ageing, we must co-create these systems with the elderly themselves, not for them, but with them which will contribute to Viksit Bharat multi fold.

Dr Kishore M Shah,
Author of 'Surfing Grey Waves' and
Managing Trustee, GDP Foundation



3. Current Policy Framework, Delivery Systems and Gaps

India's ageing policy landscape spans multiple domains health, pensions, community systems, technology, and rights. While the framework is extensive, it remains fragmented, underfunded, and poorly coordinated across ministries. As a result, older adults often fall through the cracks between schemes and delivery systems.

3.1 Governance, Health and Social Welfare Policies System

3.1.1 Rights and Constitutional Basis: Right to Health

The Indian Constitution does not guarantee health as a fundamental right, but Article 21 (Right to Life) has been interpreted by the Supreme Court to include health [51]. India's health and social care system for older adults is evolving, with several important schemes and institutional mechanisms in place. Yet, fragmentation across ministries, uneven implementation, and service delivery gaps continue to affect outcomes. This section outlines the current landscape, focusing on both the provisions and the areas where further attention is required.

3.1.2 Institutional Roles, Responsibilities and Fragmentation

India's policy framework for elderly welfare involves many ministries and departments. The Ministry of Social Justice and Empowerment (MoSJE) is the nodal body, but key roles also sit with the Ministries of Health, Rural Development, and Finance without a defined strategy or coordination mechanism.

Additionally, state-level delivery involves multiple actors, line departments, Panchayats, and municipal bodies. This setup leads to duplication of efforts and gaps between what is designed at the Centre and what reaches the ground. Without clear roles, better funding, and stronger execution at the state level, national policies often fail to translate into real-world impact for seniors [52].

3.2 Flagship Schemes and Policies

National Programme for Health Care of the Elderly (NPHCE)

NPHCE is India's dedicated geriatric care programme initiated in 2010, offering preventive, curative, and rehabilitative services [53]. The goal of this programme was to develop a facility entirely dedicated to adults aged 60 years and above [54], however, there have been shortcomings noted:

- **Institutional focus over community care**: Over 75% of the elderly depend on family caregivers, but NPHCE lacks structured training/support systems for caregivers. Home-based care remains underdeveloped despite 20% of the bedridden elderly in rural areas [55].
- **Funding inefficiency**: States underutilise allocated funds due to poor coordination, with only 131/3,269 targeted staff trained in Maharashtra (2015-16) [56]. The shift to a 60:40 funding ratio exacerbated implementation.
- **Geographic disparities**: 68% of elderly rural people lack access to geriatric services, with remote areas having no dedicated infrastructure.

National Mental Health Programme (NMHP)

The NMHP ensures the availability and accessibility of mental healthcare for all, particularly vulnerable populations. The programme aims to integrate mental health into general healthcare and reduce treatment gaps but lacks a geriatric-focused strategy.

Despite this forward-looking policy in place, there are key challenges which continue to persist in the areas of geriatric mental health:

- **Neglected geriatric mental health**: Only 0.75 psychiatrists per 100,000 population exist (vs required 3+), with 83% treatment gap for mental disorders [57]. Rural projects like SCARF's show 8.4% dementia prevalence but minimal state support [58].
- **Medicalised approach**: Programme focus on pharmacological treatments at the tertiary level while lacking community-based psychosocial interventions [59].
- **Funding mismatch**: Mental health receives <0.1% GDP allocation, with 93% of funds directed to tertiary care [60].
- **Escalating out-of-pocket costs**: 20% of Indian households fall into poverty due to mental health expenditure, which averages 18–19% of health budgets [61].

- **Weak Awareness & Persistent Stigma:** Stigma remains prevalent, even among educated individuals, influencing help-seeking and treatment adherence. Mental health literacy is low, particularly regarding ageing-related mental health conditions.
- **Inconsistent Programming & Limited Technology Use:** Short-term funding cycles through CSR or ad-hoc grants hinder long-term planning. Telepsychiatry remains underutilised despite its demonstrated potential.
- **Lack of Structural Integration & Outcome Tracking:** Absence of a life-course, holistic mental health model, unlike successful integrated designs seen at NIMHANS with interventions like Vayomanas Sanjeevani

National Action Plan for Senior Citizens (NAPSrC) and Atal Vayo Abhyuday Yojana (AVYAY)

India's flagship policy platform for elderly welfare, the National Action Plan for Senior Citizens (NAPSrC), operationalized through the Atal Vayo Abhyuday Yojana (AVYAY), suffers from design and implementation shortcomings. As a Centrally Sponsored Scheme, AVYAY places the onus of execution on state governments but does not create legal obligations for fund utilization. In 2022–23, only 42% of the ₹2,500 crore allocated under the scheme was utilized, reflecting both capacity and priority gaps at the state level. [62]

The Integrated Programme for Senior Citizens (IPSrC), one of AVYAY's major components, disproportionately channels resources into institutional care, which accounts for nearly 78% of its spending [63]. This is misaligned with demographic evidence showing that over 90% of India's elderly prefer to age at home or in familiar community settings. [64] The current target framework fails to support this overwhelming preference for ageing-in-place. Monitoring and evaluation mechanisms remain weak. There is no standardised framework to assess core indicators such as dignity, social participation, or quality of life. Infrastructure audits reveal that 63% of IPSrC-funded senior homes lack even basic disability-friendly features, undermining the objective of providing dignified and inclusive care. [65] India's legal and policy instruments for senior citizens have created a robust bulwark for building a comprehensive rights-based framework but demands revision and re-orientation such as expansion of thematic focus areas, moving from institutional care to community care, and ageing-in-place.



Ayushman Bharat

Ayushman Bharat is India's flagship health programme, combining two pillars:

PM-JAY: Provides annual coverage of ₹5 lakh per family. In 2024, eligibility was universally expanded to all seniors aged 70+, benefitting around 6 crore elderly across 4.5 crore families. However, those within the age group of 60-70 years, are not covered by AB-PMJAY.

- **Ayushman Arogya Mandirs (AAMs):** Formerly Health and Wellness Centres, these provide primary care—including elderly and palliative services—through screenings, medicines, referrals, and outreach by trained community teams.

3.3 Workforce and Caregivers

3.3.1 Eldercare Workforce Development

The PM Special Training of Geriatric Caregivers Scheme, which aims to create a professional cadre of eldercare workers. Implemented by the Ministry of Social Justice & Empowerment and NISD, it builds a skilled workforce capable of addressing holistic elder needs from chronic illness and mental health to palliative and spiritual care. Eligible citizens under 40 are trained through recognised institutions and registered via the Skill India Digital Hub (SIDH).

3.3.2 Re-Employment and Skill Training

Several initiatives by the Government of India have been in place with the aim to extend working lives and enable older adults to remain economically relevant:

- **SACRED:** Senior Able Citizens for Re-Employment in Dignity (SACRED), focuses on engaging older adults in economic activity. This online platform aims to leverage the skills and experience of older adults, helping them find meaningful engagement and supplement their income.

However, there are several challenges that these initiatives face due to structural, technological, and socio-cultural barriers:

- **Limited Digital Access and Literacy**: Platforms such as SACRED rely heavily on online registration, training modules, and job matching. Many older adults, particularly in rural areas, face low digital literacy, limited internet connectivity, and inadequate access to smartphones or computers, reducing their ability to participate.
- **Fragmented Program Delivery and Low Awareness**: Central schemes like SACRED operate alongside state programs such as Kerala's ASAP, but coordination is weak. Many potential beneficiaries are unaware of opportunities, eligibility criteria, or how to navigate the application process.
- **Insufficient Localisation of Training**: Training content often targets younger job seekers and may not reflect the interests, physical capacities, or prior experience of older adults. There is a shortage of tailored curricula, that align with seniors' skills and local market needs.

3.3.3 Infrastructure Gaps

- **Accessible India Campaign (Sugamya Bharat Abhiyan):** Launched under the Smart City Mission to create barrier-free public spaces. Yet a 2020 NCPEDP report revealed that disability and ageing considerations are frequently overlooked in urban development proposals.[66]
- **The Draft Minimum Standards for Senior Citizen Homes** guide infrastructure, medical care, psychosocial services, and resident rights. However, implementation and standardisation remain weak across both public and private facilities[67].

3.4 PENSION AND ECONOMIC SECURITY

Economic security in old age is a cornerstone of healthy ageing, yet India's pension and savings architecture remain patchy, uneven, and insufficient to meet the needs of a rapidly growing elderly population. India currently has three flagship schemes and initiatives for Pensions in India:

- **Atal Pension Yojana:** Launched in May 2015, the Atal Pension Yojana aims to build a universal social security system, particularly for the poor, underprivileged, and workers in the unorganised sector.
- **Indira Gandhi National Old Age Pension Scheme (IGNOAPS):** The IGNOAPS is a non-contributory scheme under the National Social Assistance Programme (NSAP). It provides financial assistance to Below Poverty Line senior citizens.
- **Senior Citizens' Savings Scheme (SCSS):** The SCSS is a retirement benefit programme designed to provide a regular income to individuals aged 60 years and above. Individuals aged 55-59 who have retired under specific schemes can also open an account.

3.4.1 Existing Gaps and Limitations in Pension Schemes

- **Long-term Unsustainable:** India's current pension system risks long-term unsustainability due to a potential mismatch between future liabilities (payouts) and current assets (contributions), especially as the population ages.
- **Inflation Adjustment:** Additionally, the amount received, when adjusted for inflation and minimum consumption, does not meet basic needs. That defeats the policy goal of basic income support in old age.
- **Low Participation:** The Micro-pension schemes often see low participation from poorer households, who tend to prioritize immediate needs over long-term savings due to limited financial resources [68].
- **Coverage remains limited:** Less than 30% of India's elderly are covered by any formal pension scheme, with rural women being the least protected [69].
- **State-level variations:** While states like Rajasthan and Kerala provide higher top-ups (₹1000–₹1200 per month), in many states the central contribution of ₹200–₹500 remains unchanged for over a decade [70].
- **Inadequacy of benefits:** On average, pensions under IGNOAPS represent less than 10% of elderly monthly consumption expenditure, making them inadequate to cover healthcare and living costs.

3.4.2 Addressing Dementia as a Public Health and Social Priority

Dementia represents one of the fastest-growing public health challenges in India, with estimates suggesting that over 5.3 million Indians live with the condition today [71], a figure projected to triple by 2050 [72]. Despite this crisis, India does not yet have a national dementia plan [73], and existing mental health programmes, including the NMHP, do not adequately address the unique needs of those living with dementia and their caregivers.

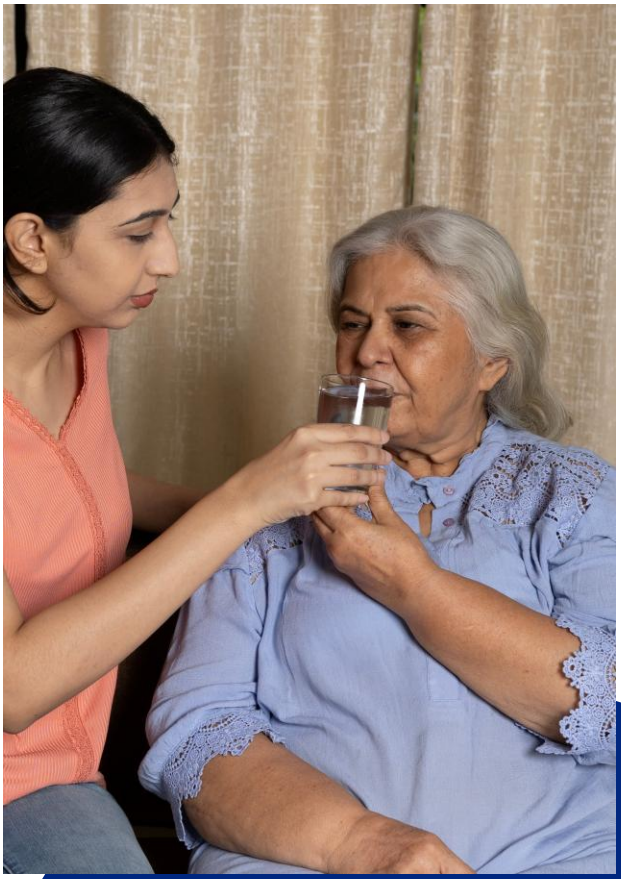
- **Absence of a National Dementia Strategy:** Unlike countries like the UK, Japan, and Australia [74], India lacks a dementia-specific framework for early diagnosis, treatment, long-term care, and caregiver support. Dementia care remains fragmented across isolated NGO initiatives (e.g., Dementia India Alliance) [75] without integration into state or national health systems.
- **Underdiagnosis and Limited Awareness:** Dementia continues to be widely dismissed as "normal ageing" rather than a medical condition. [76] According to Dementia India Alliance consultations, levels of community awareness lead to delayed diagnosis and high levels of untreated morbidity [77,78]. Stigma further deters families from seeking timely medical or psychosocial interventions.

- **Shortage of Specialists and Trained Workforce:** India has a severe shortage of geriatric psychiatrists, neurologists, and memory clinics[79]. A 2021 Alzheimer's and Related Disorders Society of India (ARDSI) report noted that less than 10% of people living with dementia receive a formal diagnosis[80]. Primary care physicians often lack training to recognise early symptoms, further widening the treatment gap.

> "Awareness must go beyond generic messaging—it must be community-sensitive, culturally appropriate, simple, and action-oriented. We need to normalise forgetfulness as a potential health issue, not a shameful part of ageing, and remind people that dementia is a medical condition, not a social or spiritual curse. By using regional languages, caregiver stories, and trusted community voices, we can shift the focus from the disease alone to the person and family enduring it, while also highlighting that prevention is possible and worth acting on."
>
> **Mr Shyam Viswanathan,**
> Co-Founder, Dementia India Alliance.

3.4.3 Unseen And Unsupported: The Role Of Female Caregivers

Up to 68% of daughters-in-law are the primary providers of physical care for elders, while over 55% of female caregivers take responsibility for emotional and psychological support. The burden is both emotional and economic[81]. 29% of caregivers report experiencing moderate to severe stress, and 15% report high caregiving strain[82]. Despite being a critical pillar of India's eldercare system, caregivers, especially women, are rarely provided with respite services, training, or economic recognition.



3.5 IMPORTANT ROLE OF PANCHAYATI RAJ INSTITUTIONS, COMMUNITY-LEVEL INITIATIVES, AND FAITH-BASED NETWORKS

Panchayati Raj Institutions (PRIs), urban local bodies (ULBs), civil society organisations, traditional healing systems, and faith-based networks are uniquely positioned to deliver interventions that are not only accessible but also culturally relevant and socially embedded.

3.5.1 Panchayati Raj Institutions And Local Self-governance For Promoting AHA

The 73rd Constitutional Amendment mandates PRIs to address sectors like health, social welfare, and care for vulnerable groups[83]. As the governance tier closest to citizens, PRIs have the potential to directly improve the quality of life of older adults through essential civic services.

Urban Local Bodies (ULBs) face parallel challenges. Rapid urbanisation has outpaced fiscal resources and infrastructure renewal, resulting in inadequate ward-level planning. Elder-specific considerations—such as accessible footpaths, barrier-free buildings, or safe transport—are rarely prioritised. Weak accountability, poor data systems, and limited social welfare integration leave urban seniors to navigate unsafe and exclusionary environments[84].

Gram Sabha Mechanisms and Local Innovations

The Ministry of Panchayati Raj's "Special Gram Sabha for Elders" initiative, rolled out across 750 Gram Panchayats in 2024, created a participatory mechanism for elders to contribute to Gram Panchayat Development Plans (GPDPs)[85]. Frameworks like the Atal Vayo Abhyuday Yojana (AVYAY) have designated PRIs as implementation partners for Integrated Programmes for Senior Citizens (IPSrC), yet operationalisation varies significantly across states.

Community Organisations and Scalable Rural Models

Complementing PRIs, community-led interventions are reshaping elder care at the grassroots. **Elder Self-Help Groups (ESHGs)**, inspired by the success of women's SHGs under DAY-NRLM, have emerged as low-cost, replicable mechanisms for financial and social resilience.

> There is no one-size-fits-all model for ageing in India. The country's vast regional, demographic, and cultural diversity means that policies and interventions must be context-specific. Urban and rural populations face distinctly different challenges, ranging from access to healthcare and social infrastructure to family structures and community support systems. A successful approach to active and healthy ageing must recognise these differences and adopt flexible, inclusive, and locally responsive frameworks that address the unique needs of older adults across India.
>
> **Dr Madan Gopal,**
> Advisor & Head- Public Health Administration, National Health Systems Research Centre (NHSRC), Government of India.

3.5.2 Senior Citizen Associations, Resident Welfare Associations And Urban Community Care

In urban and peri-urban areas, Senior Citizen Associations (SCAs) and Resident Welfare Associations (RWAs) provide parallel community platforms. While RWAs primarily focus on infrastructure maintenance and security, their organisational capacity and community reach present opportunities for elderly care integration. With appropriate support, these associations could expand into wellness programmes, peer-support networks and grievance redressal tailored to the needs of senior citizens.

IRELAND'S AGE-FRIENDLY PROGRAMME – LOCAL LEADERSHIP FOR NATIONAL IMPACT

Ireland's Age Friendly Programme, launched in 2009, is a nationally coordinated but locally led initiative aimed at creating inclusive, supportive communities for older people. Implemented through 31 local authority-led programmes and guided by the WHO Age-Friendly Cities framework, it embeds ageing priorities into mainstream planning and service delivery. Each local authority develops a county-level Age-Friendly Strategy based on consultations with older citizens. Key interventions include age-friendly housing, accessible transport, health services, employment support, and community participation platforms. A national Age Friendly Ireland office coordinates knowledge sharing and tracks progress across counties.

Key pillars include multi-agency alliances, Older People's Councils, and action plans focused on eight domains from housing and transport to social inclusion and health. A standout initiative is the Healthy Age-Friendly Homes Programme (2024), which helps seniors live independently with personalized, community-based support.

With every local authority committed, Ireland's model demonstrates the power of cross-sector governance, co-design with older citizens, and local implementation with national alignment—offering a scalable template for healthy ageing in both high- and middle-income countries.

3.5.3 Civil Society And Community-based Contributions To Elderly Care

Civil society-led models of elderly care are often rooted in community ownership, social solidarity, and adaptive delivery systems. Many operate through locally organised collectives of older people, enabling peer assistance, intergenerational exchange, shared economic activity, and community-based monitoring. More importantly, these efforts operate through frameworks that emphasize agency over charity.

3.5.4 Traditional Healing And Ayush Integration

Traditional medicine systems under AYUSH, particularly Ayurveda and Yoga, hold cultural resonance and high acceptance among older adults. According to LASI data, one in fourteen older adults utilise AYUSH services, particularly for chronic musculoskeletal conditions, neurological disorders, and lifestyle-related ailments[86].

Under the National AYUSH Mission (NAM), elderly-focused AYUSH units are being piloted in 23 geriatric clinics under CCRAS, with potential for scale.[87] A structured three-tier integration model has been proposed:

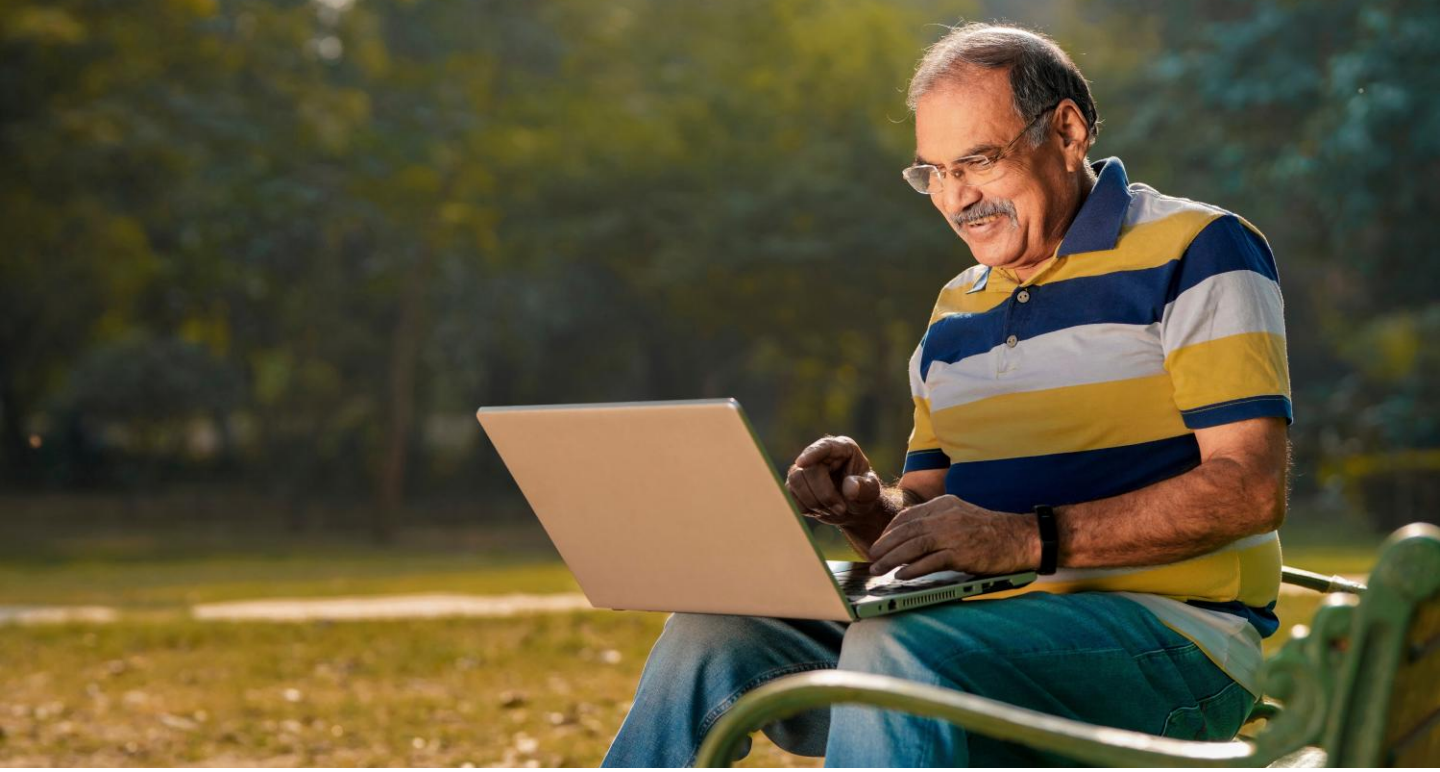
- **PHC level**: Weekly geriatric OPDs led by AYUSH practitioner
- **CHC level**: Panchakarma-based therapies and regular follow-ups
- **District Hospital level**: Full-scale AYUSH Geriatric Centers

Yet despite the latent demand, integration with the formal healthcare system is weak. Many AYUSH consultations occur outside government regulation, raising concerns around safety and quality control. Moreover, traditional systems are not routinely factored into geriatric care frameworks at the primary care level. Scaling the above model will require certified geriatric training for Ayush professionals, interoperability with allopathic systems and robust monitoring to ensure evidence-based care.

3.5.5 Faith-based Organisations And Spiritual Geriatric Care

Faith-based organisations (FBOs) have historically played a significant role in providing care and refuge to vulnerable populations in India, including the elderly. In many rural and semi-urban settings, religious institutions remain among the few accessible structures of organised care, particularly for destitute or abandoned seniors[88].

However, faith-based and civil society networks provide essential support for destitute seniors, but these efforts remain fragmented and often outside formal policy frameworks. Collectively, these shortcomings mean that while India's social and programmatic architecture is extensive, older adults continue to face inconsistent access, variable quality, and uneven protection across rural and urban settings.



3.6 HEALTH TECHNOLOGY AND DIGITAL INCLUSION FOR AHA

Technology holds immense potential for improving the quality of life of older adults in India. Yet, digital exclusion and structural inequities mean that many seniors remain unable to benefit from these advances. To unlock the full promise of digital health, elder empowerment, and community-based innovation, both access and adoption challenges must be addressed alongside scaling age-friendly technological solutions.

3.6.1 Digital Literacy And Access

India's ageing population is navigating a rapidly digitising society, yet older adults remain among the most digitally excluded groups. As more essential services move online from pensions and healthcare to social connection digital literacy becomes a prerequisite for healthy ageing.

- **Structural Inequities in Digital Adoption:** Despite India's notable digital advances, older adults remain largely excluded from the benefits of technology. In rural India, the digital divide is even more pronounced: only one in ten seniors is digitally literate, half own smartphones, and less than 10% use the internet to access health services. These figures point to more than just a technological gap. For older Indians, digital exclusion often translates into diminished access to services, social isolation, and lost economic opportunities.
- **Gendered Dimensions of digital exclusion:** Over 95% of elderly women lack digital literacy, limiting their ability to access basic services, apply for pensions, participate in health programs, or maintain social connections with distant family members.

- **Community-Based and Intergenerational Solutions:** A growing number of initiatives have sought to tackle this issue by embedding digital literacy into community models. In parallel, Digital Empowerment Centres in rural regions are helping elders access online portals for government schemes and livelihood information[89], fostering independence and inclusion through technology.
- **Startup Responses: Age-Friendly Design and Inclusive Interfaces:** Startups have begun tailoring digital services specifically for older users. *Khyaal*, now one of the largest senior-focused platforms in India, [90] integrates health tracking, community engagement, and financial services into a single interface designed for ease of use, complete with voice commands and intuitive navigation. Similarly, *Sukoon* leverages AI to offer digital companionship in over 100 Indian languages, creating a culturally familiar and emotionally intelligent user experience.[91] Platforms such as *Wisdom Circle* go a step further by connecting retirees to flexible job opportunities, creating pathways for seniors to re-enter the workforce while building their digital confidence.[92]

3.6.2 Health Technology And Advancements

While digital literacy ensures *access*, the next step is to harness **innovative health technologies** that improve the quality and delivery of eldercare. From decentralised diagnostics to AI-driven monitoring, these tools have the potential to transform eldercare from reactive crisis management to proactive, preventive, and personalised care.

- **Bridging the Care Infrastructure Gap:** The private sector, in collaboration with public research institutions, is increasingly developing affordable diagnostic tools and decentralized care models to respond to this demand. Senior health packages, now offered by many Indian diagnostic labs, focus on early detection of chronic illnesses and are becoming more accessible in tier-2 and tier-3 [93] cities. Startups like *Home Care Plus* [94] are creating digital ecosystems where families can connect with trained home care professionals, supported by wearable health devices that allow for real-time monitoring and alerts. *Samarth*, [95] Emoha offers personalized eldercare services through trained care managers, providing a combination of health, companionship, and safety support for independent living.
- **Integrating AI and Wearables into Preventive Healthcare:** AI is also emerging as a crucial component of India's healthy ageing landscape. Companies such as *Niramai* [96] are using artificial intelligence to provide non-invasive cancer screenings, while *mfine* offers remote diagnostic services using AI-driven interfaces. Senior-living providers like *Primus* and platforms like *Khyaal* now rely on predictive analytics to tailor care plans and detect early signs of health deterioration. *Wizio* [97] is also delivering home-based physiotherapy and remote rehab services using AI for seniors, enabling recovery and mobility support.

The growing availability of wearable health technology, ranging from smartwatches and fall detectors to sleep and heart rate monitors, is enabling round-the-clock care that is both discreet and efficient. These innovations are reducing the cost of long-term care and shifting the paradigm to home-and community-based care.

Digital literacy and health technologies together form the backbone of India's Active and Healthy Ageing agenda. By empowering seniors with the skills to navigate digital systems and leveraging innovations in AI, wearables, and home-based care, India can bridge structural inequities while building resilient models of eldercare. The task ahead is clear: to ensure that technology does not widen exclusion but becomes a tool for inclusion, dignity, and independence in later life.

SINGAPORE'S SENIORS GO DIGITAL – BRIDGING THE GREY DIGITAL DIVIDE

As part of its Smart Nation vision, Singapore launched the Seniors Go Digital programme to promote digital inclusion among the elderly. Since its launch, over 150,000 seniors have been trained in essential skills ranging from making video calls to using e-payments and accessing government services via SingPass.

The initiative is supported by SG Digital Community Hubs across public spaces, offering one-on-one coaching in multiple languages, structured into tiered learning modules with embedded cybersecurity tips. For digitally vulnerable seniors, ServiceSG Centres, mobile helpdesks, and subsidized devices ensure no one is left behind.

By 2023, **96% of seniors** were communicating online, up from 87% in 2017, highlighting the impact of Singapore's community-driven, multi-stakeholder model. With strong partnerships, targeted subsidies, and peer-led support, the programme offers valuable lessons for India's own digital ageing agenda.

3.7 LEGAL AND RIGHTS-BASED FRAMEWORK

India's approach to eldercare has historically been rooted in familial responsibility and welfare provisions, but the scale of demographic change now demands a robust rights-based framework. Legal and policy instruments are critical not only for protecting the elderly from neglect and exploitation but also for ensuring dignity, participation, and access to essential services. While important laws and schemes exist, enforcement gaps, weak monitoring, and misaligned priorities continue to limit their impact.

3.7.1 Maintenance And Welfare Of Parents And Senior Citizens Act: Enforcement Gaps

The Maintenance and Welfare of Parents and Senior Citizens Act, 2007, was enacted to legally oblige children and heirs to provide maintenance to senior citizens and parents. However, its implementation has been marred by procedural delays, limited awareness among the elderly, and inadequate institutional support.

- **Scope limitations:** Focuses on financial maintenance (Section 4) and property protection (Section 23), but lacks provisions for social participation, dignity, or healthcare access [98]
- **Enforcement Challenges:** The Act's provision for maintenance tribunals has not been effectively operationalised across all districts, and the processes often become cumbersome for elderly citizens to navigate.
- **Exclusion of non-family caregivers**: Does not address institutional care or support for seniors without biological heirs, despite 12% of elderly living alone [99]

Furthermore, legal recourse available under the Act frequently conflicts with cultural sensitivities around family relationships, deterring many elderly from seeking support through legal means even when facing neglect or abandonment.

4. Way Forward – Delivering Active And Healthy Ageing

Delivering on the vision of Active and Healthy Ageing requires India to shift from fragmented, welfare-driven approaches to coordinated, rights-based and people-centred systems. This section outlines the strategic priorities and government actions needed to translate global frameworks into actionable pathways for India.

4.1 STRATEGIC PRIORITIES AND GOVERNMENT ACTIONS FOR ACTIVE AND HEALTHY AGEING IN INDIA

The following priorities draw inspiration from the UN Decade of Healthy Ageing framework and grounded in India's context. This provides a blueprint for building a responsive, inclusive and future-ready elderly care ecosystem.

Priority 1: Changing How People Think, Feel And Act Towards Age And Ageing

Ageism, discrimination based on age, remains one of the most pervasive but least acknowledged barriers to active and healthy ageing. It shapes how healthcare workers, workplaces, communities, and even their families treat older people. Beyond external prejudice, older individuals internalise stereotypes that undermine their confidence, autonomy, and participation.

To counter this, India must adopt a multi-pronged approach that tackles the issue in legal, cultural, and behavioural levels. Additionally, governments, civil society, and private sector must organise public campaigns and educational initiatives that reshape social attitudes, promote intergenerational solidarity, and highlight the diverse contributions of older people to society. Researchers and policymakers should gather evidence on older adults' economic, social, and cultural roles and disseminate it to counter prevailing myths about ageing.

Strategic Interventions

- Integrate awareness of ageism into school curricula; Work with NCERT, UGC, and mass media to mainstream anti-ageism campaigns.
- Commission and fund research on ageism through ICMR to build an evidence base for policy and public messaging.
- Promote intergenerational activities and community programmes that encourage interaction, empathy, and mutual learning.
- Support self-awareness and empowerment initiatives that help older persons resist internalised stereotypes.

> *"Segmenting the elderly into functional, not just age-based, cohorts are critical. Health systems must differentiate between the active, the recovering, and the dependent."*
>
> **Dr Prasun Chatterjee,**
> Former Additional Medical Superintendent - National Centre for Ageing, AIIMS; Chief-Geriatric Medicine & Longevity Science, Artemis Hospital and TAG Member for the Decade

Priority 2: Ensuring That Communities Foster The Abilities Of Older People

India must create environments that allow persons to live with dignity, autonomy, and security is essential for translating healthy ageing into reality. This requires coordinated action across sectors, housing, transport, urban planning, health, social protection, and disaster management. Age-friendly cities and communities should prioritise safe housing, barrier-free mobility, accessible public transport, and digital inclusion.

Moreover, emergency response and disaster-preparedness plans must explicitly account for the vulnerabilities and capacities of older persons, with adequate resource allocation and monitoring mechanisms.

Strategic Interventions

- Leverage the Smart Cities Mission to build age-friendly infrastructure and service design.
- Direct the Ministry of Housing and Urban Affairs (MoHUA) and the Ministry of Panchayati Raj to intergrate elder-sensitive planning at both urban and rural levels.
- Incentivise state-level innovations by offering funding, recognition, and technical support for replicable age-friendly models.

Priority 3: Deliver Integrated Primary Care

Health systems must adapt to the realities of population ageing by moving beyond disease-specific approaches toward integrated, person-centred care. We need to adopt global guidance, such as WHO's Integrated Care for Older People (ICOPE), and tailor implementation to India's context.

Building resilient systems for older adults involves several elements: establishing robust age-disaggregated data systems; planning workforce needs based on demographic trends; and scaling up training for frontline health workers in geriatric care. Digital technologies can support service delivery by enabling remote consultations, monitoring, and data-driven planning. Governments must ensure that there is cross-sectoral collaboration to include marginalised groups such as disabled, rural, and migrant elders who often face systemic barriers in accessing care.

Strategic Interventions

- **Adopt ICOPE** under the National Health Mission (NHM) and Ayushman Bharat to standardise integrated care models.
- **Expand geriatric OPDs** at Community Health Centres (CHCs) and Primary Health Centres (PHCs) for wider coverage.
- **Upskill Community Health Officers and ANMs** in elder care to strengthen frontline service delivery and community outreach.

> The elderly are not a homogenous welfare category; they are a strategic social asset. Elder policy must move from protection to participation.
>
> **Dr G S Grewal,**
> Founder Chairman, Age Friendly India & Senior Consultant in Elder Care

Priority 4: Provision Of Long-term Care (LTC) For Older People

The absence of a structured LTC framework leaves older adults and their families vulnerable to financial strain, inadequate services, and uneven quality of care. We need to build a comprehensive system to establish clear legal, financial, and institutional mechanisms while leveraging families, communities, NGOs, and the private sector as partners in delivery.

Additionally, India must place emphasis on community-based care models, integration of assistive and digital technologies, and professionalisation of both formal and informal caregiving. Equally important is building a culture of care in the workforce, where support services such as respite, training, and flexible work arrangements are standard. Monitoring systems should track not just service delivery but also outcomes for dignity, inclusion, and financial security of older adults.

Strategic Interventions

- Establish a **national LTC framework and financing model** under MoHFW and MoSJE, with clear regulatory and accountability mechanisms.
- **Institutionalise caregiver training and certification** through NSDC, state skill missions, and accredited institutions.
- Introduce **respite services, peer-support groups, and financial incentives** to support family caregivers, particularly women.
- Deploy **digital health tools and assistive technologies** for monitoring, home care, and care coordination.
- Embed **care quality audits and outcome indicators** into national monitoring systems.

> Two initiatives (from Finland and Singapore) offer useful models. Though both are high income countries, the principles can be adapted to India. Launched in 2009, FINGER (Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability) was a landmark randomized controlled trial from Finland that demonstrated a multidomain lifestyle intervention—combining diet, exercise, cognitive training, and cardiovascular risk management—can improve cognitive function in older adults at risk of cognitive decline. Launched in 2009, the study's success showed that a combined approach to lifestyle is feasible and effective in preventing cognitive impairment and dementia. The FINGER model has since been adapted and tested globally in numerous follow-up trials, forming part of the World-Wide FINGERS network to broaden the impact of these preventive strategies. Singapore's approach to healthy ageing is a multi-faceted, whole-of-society effort, led by the Age Well SG national program, which aims to transform housing, transport, and care services to help seniors live well in the community. Key initiatives include the Healthier SG program, which promotes preventive care and personalised health plans with family doctors, and the expansion of Active Ageing Centres (AACs) to provide social, physical, and learning activities. Singapore also leverages technology, such as AI and telemedicine, and encourages senior volunteerism and lifelong learning to maintain active lifestyles and well-being.

Prof K. Srinath Reddy,
Founder, (Past) President and Honorary Distinguished Professor,
Public Health Foundation of India

4.2 GOVERNMENT ACTIONS AND INTERVENTIONS

The following actions represent a roadmap provided by UN Decade of Healthy Ageing to reorient national priorities and operational frameworks, enabling a responsive, inclusive, and future-facing elderly care ecosystem:

Policy and Governance

- **Establish Multistakeholder Mechanisms:** Create national, state, and local platforms to align multiple ministries and stakeholders, ensuring coherence, shared accountability, and integrated action.
- **Evidence-Based Policy & Monitoring:** Use disaggregated data to design tailored interventions, strengthen the Project Monitoring Unit under MoSJE, and evaluate implementation to identify what works.
- **Prevent Elder Abuse:** Fully implement the *Maintenance and Welfare of Parents and Senior Citizens Act, 2007,* with tribunals at state level for grievance redressal.
- **Leverage Faith-Based Institutions:** Formalise collaboration with faith-based organisations via regulated partnerships, technical training, and joint service delivery for counselling, nutrition, and geriatric outreach.

Healthcare and Caregiving

- **Integrated, Person-Centred Care:** Shift focus from disease-based treatment to prevention and early detection of functional decline, with Health & Wellness Centres (AAMs) as primary access points.
- **Workforce Development:** Scale up formal geriatric training - expand NISD diplomas, DGT programs, and integrate geriatric modules into medical, nursing, and allied health curricula. Mandate multidisciplinary teams (CHOs, ASHAs, MPWs) at AAMs.
- **Health Promotion Activities:** Regular sessions on elderly nutrition, yoga, memory care, and mental well-being embedded within AAM wellness activities.
- **Caregiver Support:** Structured programmes with training, peer-support networks, and respite services. Standardise home-to-hospital-to-home transitions with trained coordinators.
- **Post-Hospitalisation Follow-up:** AAMs to act as nodal points for systematic follow-ups to reduce readmissions.

Infrastructure and Community

- **Utilise Public Infrastructure:** Convert underused assets (RWA halls, libraries, temples, community centres) into walkable senior day hubs offering social activities, digital literacy, and intergenerational engagement.
- **Standardise Age-Friendly Infrastructure:** Launch an "Age-Friendly Certification" to promote universal design. Mandate *Elder Impact Assessments* for Smart City and urban projects.
- **Strengthening Oversight of Old Age Homes:** Establish mandatory accreditation and monitoring mechanisms for old age homes to ensure quality, safety, and accountability. Introduce periodic social audits and link funding eligibility to compliance with minimum standards of care.

Economic Security and Employment

- **Financial Security:** Strengthen social protection to ensure income security, especially for elderly women. Enable flexible re-entry into the workforce and expand skilling and re-skilling programs.
- **Lifelong Learning:** Support continuous learning opportunities, particularly for older women, to build confidence, digital fluency, and workplace adaptability.
- **Intergenerational Activities:** Encourage age diversity in workplaces, mentorship programs, and community learning initiatives.

Civic Participation and Volunteering

- **National Silver Service Cadre:** Establish a dedicated cadre of senior volunteers contributing to national causes such as education, healthcare, environment, disaster response, and organ donation. Offer stipends for select roles to recognise contributions. Expand the SACRED portal to integrate volunteering and civic opportunities alongside re-employment.

Technology and Innovation

- **Digital Health Solutions:** Scale up mAgeing (WHO–ITU) for preventive and behaviour-change communication through mobile platforms, integrating it into Ayushman Bharat and NHM.
- **Senior Citizens Database:** Create an Aadhaar-linked senior citizens' database as part of India's DPI to capture socio-economic data, skills, and preferences for targeted interventions, silver economy opportunities, and policymaking.

KOCHI'S INCLUSION IN WHO GLOBAL NETWORK OF AGE-FRIENDLY CITIES AND COMMUNITIES

In 2024, Kochi became India's first WHO-recognised Age-Friendly City, aligning its urban policies with global benchmarks across transport, health, housing, and social participation. The city conducted participatory needs assessments with elderly residents and launched targeted services such as 45 geriatric clinics, old age homes, tech training centres, accessible public transport, and senior citizen clubs. These are implemented in collaboration with NGOs, medical associations, and community-based organizations.

4.3 THE ROLE OF PRIVATE ENTERPRISE, STARTUPS, AND FINANCIAL INNOVATION IN SHAPING INCLUSIVE ELDERCARE AND ACTIVE HEALTHY AGEING

India's silver economy, valued at ₹73,000 crore[100] offers a platform for the private sector, startups, and financial innovators to shape eldercare systems that are inclusive, resilient, and future-ready.

4.3.1 Technology And Financial Innovation: Catalyzing The Silver Economy

The government has dedicated ₹100 crore to promote the silver economy in the country, including via funding support to startups.

- **Technology and Start-ups:** Over 100 eldercare startups have emerged in the last decade, targeting healthcare, senior living, employment, and social connectedness[101]. Startups like *Emoha*[102], *Goodfellows*[103], and *Khyaal*[104] are designing services that blend digital convenience with personal interaction, offering companionship, emergency care, curated experiences, and cognitive engagement.
- **Expanding Access through Fintech:** Financial innovation is at the heart of this transformation. Fintech companies are developing micro-pensions, digital annuity products, and low-cost investment plans targeted at senior citizens. These tools address one of the most persistent challenges in Indian eldercare: the lack of retirement savings coverage among informal workers and rural populations.

Key steps forward include:

- **Designing micro-pension and flexible annuity products**, tailored for informal sector workers and late joiners.
- **Expanding inclusive insurance models** with minimal exclusions, guaranteed renewals, and long-term care riders.
- **Senior-focused financial literacy programs**, covering fraud protection, digital transactions, and retirement planning.

4.3.2 FINANCING THE FUTURE: INNOVATIVE CAPITAL MODELS FOR ELDERCARE

New and innovative capital models are tested to expand the eldercare in India:

- **Social Impact Bonds and Blended Approaches:** Social Impact Bonds (SIBs), which have been implemented successfully in the UK[105], are gaining traction to fund eldercare innovations. In this model, private investors provide upfront capital, and repayment is contingent upon achieving verifiable outcomes, such as improved health metrics or reduced hospital admissions.[106]
- **Blended Finance Models:** These are the tools that pool resources from public, private, and philanthropic sources, are already being used to expand eldercare facilities in semi-urban areas and to scale grassroots care programmes. Early pilots and discussions, supported by institutions like **NITI Aayog**, have explored the feasibility of outcome-based financing in sectors such as education and maternal health, paving the way for its application in elderly care[107].
- **Reverse Mortgages and Care Credits:** Reverse mortgages, used in countries like Japan and the Netherlands, are slowly finding ground in India. These instruments allow seniors to convert housing assets into liquid funds without selling their homes, providing a financial cushion for healthcare needs[108]. Some states have also begun experimenting with care credits and government-backed eldercare funds to subsidise services for low-income seniors, creating a more robust safety net.
- **PPP-based Long-Term Care Insurance Pilots:** Public–private partnerships must pilot state-backed insurance models that cover long-term care costs, with shared risk pools and premium subsidies to ensure affordability for middle- and lower-income groups. Build structured PPP models to expand geriatric wards, telemedicine outreach, and mobile health units. Leverage private sector efficiency and public subsidies to ensure affordability and coverage, especially in Tier-2/3 cities and rural areas.

- **CSR-Backed Senior Day Centres:** Corporate Social Responsibility funds need to be channelled into establishing community-based senior day centres that offer healthcare, nutrition, and socialisation services, particularly in underserved districts
- **Credit Incentives for Senior-Friendly Housing:** Tax breaks and credit-linked subsidies for builders who incorporate universal design, barrier-free access, and assisted-living units can accelerate the growth of affordable, age-friendly housing stock

> With a rapidly ageing population, India faces an urgent need to rethink its approach to social security. Fragmented pension programs are insufficient to protect older adults from economic vulnerability. A forward-looking strategy should ensure universal income security, coordinated policy frameworks, and mechanisms that allow older adults to age with dignity and independence.

Prof. T V Sekher,
Prof of Sociology & Demography- International Institute for Population Sciences (IIPS), Mumbai and Former Principal Investigator - Longitudinal Ageing Study in India (LASI)

Table: Finance Models and Descriptions

Model	Description
Reverse Mortgages	Allow seniors to unlock home equity while continuing to live there
Social Impact Bonds	Private capital funds public care programmes with outcome-linked returns
Livelihood Funds	Promote elderly entrepreneurship, part-time work, or gig economy re-entry
Care Credits	Recognise and incentivize family/community caregiving through subsidies or tax breaks
Public-Private Funds	Blended capital for innovation in elder housing and services
Gap Financing	Seed funding for elder-care startups via CSR or impact funds

4.3.3 MENTAL WELL-BEING AND DEMENTIA CARE: BRIDGING CRITICAL GAPS

Mental health and cognitive decline are among the most pressing yet under-recognised challenges in India's ageing landscape. Older adults often face depression, anxiety, dementia, and social isolation, which remain underdiagnosed due to stigma, weak awareness, and lack of geriatric-focused services.

- **Early Detection and Screening:** Integrate cognitive and mental health screening into routine check-ups at PHCs, HWCs, district hospitals, and urban/rural health missions, ensuring timely identification of mental health conditions.
- **Community-Based Interventions:** Develop culturally appropriate public education campaigns to reduce stigma, increase mental health literacy, and promote community participation in mental well-being initiatives. Use lay counsellors and peer support networks in community settings.
- **Caregiver Support and Training:** Scale up structured caregiver training modules that enable families and community workers to recognise early signs of cognitive decline and provide home-based psychosocial support. Expand tele-mental health programmes to older populations where mobility is low. [109]
- **Policy Reform:** Formulate a **National Dementia Policy** embedded within broader NCD and Healthy Ageing frameworks, with a focus on prevention, treatment, rehabilitation, and social security. Incorporate mental health services within long-term care facilities/old age homes.

- **Resource Allocation:** Increase investment in community-based mental health services and expand integration of mental health into primary care through NHM and NPHCE platforms.
- **Expand Digital Inclusion Roadmap:** Introduce vernacular digital literacy programmes for seniors, subsidised assistive devices, and mandate age-friendly design of NDHM apps to bridge digital exclusion.

4.4 DELIVERING ACTIVE AND HEALTHY AGEING THROUGH COMMUNITY-LEVEL AND NGO INTERVENTIONS IN INDIA

Community and civil society interventions are central to embedding Active and Healthy Ageing (AHA) principles into India's social fabric. NGOs, community groups, and private actors already offer innovative practices that can be scaled through supportive policy and funding frameworks.

1. Promoting Dignity and Intergenerational Bonds

Shifting societal perspectives requires campaigns and platforms that place dignity at the core of ageing. Civil society and private initiatives already provide replicable models:

- **Wisdom Circle**[110] facilitates dignified re-entry of seniors into the workforce.
- The **Inspiring Seniors Foundation** engages elders as tutors, mentors, and storytellers for underprivileged children, providing academic support, life guidance, and emotional connections[111].
- The **Dignity Foundation** runs support groups, helplines, and community programs that reduce isolation and improve well-being[112].

Research shows that in non-metro cities, two-thirds of elders and 70% of youth report daily intergenerational interaction evidence of stronger family bonds compared to metropolitan areas[113]. India can leverage this social capital by expanding intergenerational programs and digital caregiver platforms. Low-cost digital models such as the **ASHA Caregivers Society** already connect caregivers and provide structured support in remote regions. National helplines and teleconsultation platforms can further amplify elderly voices in healthcare planning and policy design.

Recommendations:

- Institutionalise **positive ageing campaigns** to counter ageism and showcase elders as contributors to society.
- Incentivise **intergenerational initiatives** in schools, RWAs, and community centres.
- Expand **digital caregiver platforms** to provide training, respite services, and peer support.
- Strengthening and integrate **elderly helplines and consultation services** with government health and social welfare programs.

SENIOR CITIZEN WELLNESS INITIATIVE: A COMMUNITY-DRIVEN APPROACH TO HEALTHY AGEING FOR INDIA

Social Outreach Cell at AIIMS Rishikesh launched the Senior Citizen Wellness Initiative, a community-based model promoting holistic well-being among older adults. At its core is a team of retired professionals and educated elders, mobilized as volunteers to lead health monitoring, lifestyle screenings, and awareness sessions on non-communicable diseases. Trained with support from paramedics, they also engage in counselling, first aid, digital literacy, and orientation on social welfare schemes.

Early outcomes of the initiative have been encouraging. Participating seniors report an increased sense of self-worth, purpose, and inclusion, alongside better health-seeking behaviour and improved daily self-care. Communities, in turn, benefit from enhanced trust in local health initiatives, stronger intergenerational relationships, and more responsive local support structures. Importantly, the programme is not unidirectional; it creates a mutual benefit loop wherein older adults support preventive health and community welfare, even as they themselves gain access to psychosocial support and meaningful engagement.

By empowering older adults as active contributors, this initiative reflects WHO's Healthy Ageing framework and complements India's NPHCE goals. It demonstrates how localized, participatory models can transform seniors into agents of wellness and community resilience.

2. Community Digital Care Hubs and Lifelong Learning

The digital divide remains a critical barrier for older persons, particularly elderly women in rural areas. **Community Digital Care Hubs** can provide assisted spaces where seniors learn to navigate digital healthcare, financial services, and welfare schemes. In parallel, **senior citizen libraries and lifelong learning hubs** must serve as venues for both formal and informal education. Lifelong learning, already emphasized in global ageing policy discussions, enables elders to remain self-determined, engaged, and active contributors[114].

Recommendations:

- Establish **community digital hubs** in rural and peri-urban areas to support digital navigation in healthcare and welfare access.
- Provide **targeted digital literacy programmes for elderly women**, including assisted training and trust-building support.
- Integrate **lifelong learning hubs** into libraries, schools, and community centres to promote continuing education, skill-building, and cultural engagement.

3. Role of Civil Society Organisations and NGOs in Accountability

Civil society organizations play a crucial role in ensuring accountability and transparency in the implementation of welfare programs for older persons. International practices such as the **Older Citizen Monitoring (OCM)** approach show how seniors themselves can monitor entitlements, track delivery failures, and push for policy improvements[115]. Embedding this model in India would strengthen participatory governance and reinforce the right of elders to have a voice in shaping the services they receive.

Recommendations:

- Pilot **Older Citizen Monitoring models** to track the delivery of pensions, food security schemes, and healthcare entitlements.
- Support NGOs to act as **accountability partners**, generating data on gaps in service delivery.
- Create **community scorecards** to evaluate eldercare facilities and welfare schemes.

4. Gendered Dimensions of Ageing and Caregiver Support

Elderly women and family caregivers face compounded vulnerabilities that must be addressed systematically. Despite being central to eldercare, caregivers, particularly women, rarely receive respite, recognition, or training

> Elderly women face multiple challenges: health, economic, emotional and digital. Gender-responsive policy must be foundational, not incidental to ageing frameworks.
>
> **Ritu Rana,**
> Mission Head - Healthcare, HelpAge India

Recommendations:

- Develop **caregiver support policies** offering training, respite care, and financial recognition.
- Address the **digital gender divide** by creating targeted literacy and assisted-use programmes for elderly women.
- Recognise and incentivise **caregiving contributions** through tax credits, stipends, or community recognition systems.

5. Social Prescription: Linking Health to Community Life

Social prescription is a non-clinical intervention where healthcare professionals connect patients to social and community resources such as volunteering, arts, peer groups, or physical activity, addressing isolation, poor mental wellbeing, and lack of purpose. Widely adopted in the UK through the NHS, its benefits include reduced loneliness, improved self-management of chronic conditions, and lower demand on primary care services. The evaluations showed:

- **Improved mental well-being** and reductions in loneliness and anxiety.
- **Better management of chronic conditions** such as diabetes and hypertension.
- **Reduced demand on clinical services,** including fewer GP visits and emergency admissions.
- **Stronger community participation,** enhancing resilience and local cohesion.

THAILAND'S VILLAGE HEALTH VOLUNTEER MODEL – SCALING COMMUNITY-BASED ELDER CARE

Thailand's Village Health Volunteer (VHV) system is a flagship example of large-scale, community-based health delivery, particularly for rural elderly care. With over 1 million trained volunteers, each covering 10–15 households, VHVs operate in every province, supporting 23 million households nationwide.

Volunteers conduct health screenings, monitor chronic illnesses, and provide home-based care, including medication support, basic nursing, and rehabilitation for the elderly, especially those who are bedridden or disabled. Under the Long-Term Care (LTC) programme, VHVs receive specialized training as certified caregivers, working alongside local health professionals.

During COVID-19, VHVs played a critical role in contact tracing, infection control, and ensuring continuity of elderly care through enhanced home visits and medicine delivery. Funded through Thailand's Universal Coverage Scheme (UCS) and co-supported by local governments, the model has proven cost-effective, scalable, and deeply rooted in community trust.

Thailand's VHV system demonstrates how trained local volunteers, supported by national insurance and public health infrastructure, can deliver high-impact elderly care at scale—offering valuable lessons for countries like India

These outcomes are particularly relevant for India, where older adults often rely on overburdened primary care systems and face limited opportunities for structured community engagement.

India already has an extensive network of frontline health workers (ASHAs, ANMs, Anganwadi workers) and a vibrant civil society ecosystem. Together, they provide an enabling foundation for integrating social prescription into the healthcare system. NGOs, self-help groups, and Panchayati Raj institutions can serve as implementing partners to design and deliver activities that align with local needs and culture.

Models for Adaptation:

- **Link Worker Model:** Community-based coordinators (possibly trained ASHAs or NGO volunteers) create personalised action plans with seniors and connect them to activities like yoga classes, group walks, or storytelling sessions.
- **Referral-Based Model:** Primary care doctors or nurses refer patients to designated social prescribing services during routine check-ups.
- **Community Navigation Model:** Seniors are empowered to choose from a "menu" of locally relevant opportunities—such as cultural clubs, community gardens, or digital literacy circles—with minimal facilitation.

Potential Activities for Social Prescriptions in the Indian Context

- **Health-linked:** Yoga, group exercise, and nutrition workshops.
- **Social and cultural:** Storytelling circles, community theatre, or intergenerational cultural exchange.
- **Economic and purposeful engagement:** Volunteering in schools, tuitions, mentoring youth entrepreneurs, or supporting SHGs.
- **Digital engagement:** Peer-led classes on using smartphones, digital payments, and telehealth.

Recommendations for India

- **Pilot Programmes:** Introduce social prescription pilots in select districts through NHM and Ayushman Bharat Health and Wellness Centres.
- **Training Modules:** Develop training for ASHAs, ANMs, and NGO workers to act as link workers
- **Integration with Policy:** Embed social prescription into geriatric OPDs and community health planning frameworks.
- **Evidence Building:** Mandate monitoring of outcomes—mental health indicators, reduction in GP visits, improved self-rated health—to demonstrate value and enable scale-up.
- **Sustainability:** Fund activities through CSR partnerships, local government budgets, and collaborations with cultural and educational institutions.

> We need interoperable frameworks where AYUSH and allopathy co-design geriatric pathways, from early prevention to terminal care

Prof (Dr) Tanuja Nesari,
Director, Institute of Teaching & Research in Ayurveda, Government of India

4.5 EMPOWERING HEALTHCARE PROVIDERS AND CAREGIVERS

India's ageing transition poses a dual challenge: It generates a shortage of trained geriatric professionals and an overreliance on unpaid, informal caregivers. WHO projects that demand for long-term care (LTC) workers will rise by **60% in OECD countries by 2040**[116]**;** India faces an even more urgent workforce gap. Without systematic investment, the country risks leaving millions of older adults dependent on an overstretched and underprepared care system.

Source: World Report on ageing and health. WHO 2015.

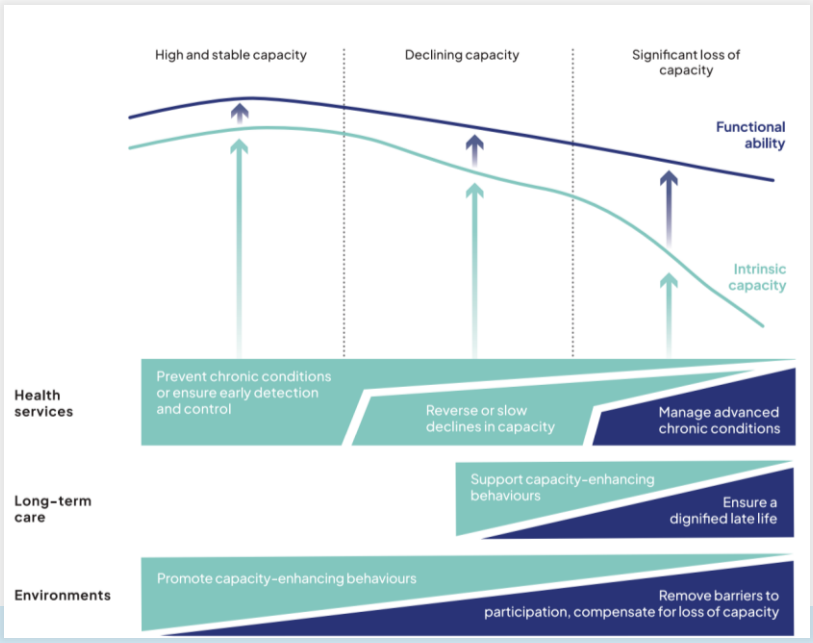


Figure: Public Health framework for healthy ageing: opportunities for public health action across the life course

India's **large healthcare workforce**, including AYUSH practitioners and community-level providers, must be reoriented towards eldercare. Informal caregivers predominantly women, family members, and grassroots workers, represent an untapped resource if equipped with training, recognition, and support.

The first step is to **equip all healthcare professionals with geriatric knowledge**, integrating gerontology and geriatrics into health and medical education. Specialised geriatric units can manage complex cases, while new roles such as *care coordinators* and *self-management counsellors* can support older persons more holistically. A more inclusive strategy would also train AYUSH professionals in preventive care, chronic disease management, and nutrition.

Recommendations:

1. **Strengthen the Formal Health Workforce**

- Integrate **geriatrics and gerontology** into medical, nursing, and allied health curricula.
- Expand MD/DNB programmes in geriatric medicine and align output with demographic projections.
- Establish **specialised geriatric units** in district hospitals and tertiary centres.
- Create new workforce roles—such as *care coordinators* and *self-management counsellors*—to provide holistic, person-centred support.

2. **Expand Preventive and AYUSH Integration**

- Train AYUSH professionals in **age-related preventive care, chronic disease management, and nutrition.**
- Embed yoga, dietary interventions, and lifestyle practices into wellness centres for cost-effective outreach.

3. **Prioritise Home-Based and Community Care**

- Develop a **cadre of trained geriatric attendants and home-care workers.**
- Upskill Community Health Officers, Medical Officers, and mid-level providers for geriatric care at the primary level.
- Train family caregivers to identify early signs of decline (dementia, hearing/vision loss, mobility issues) through simple toolkits and digital support.

4. **Recognise and Support Informal Caregivers**

- Scale the **PM Special Training of Geriatric Caregivers Scheme** to all districts.
- Introduce **stipends, respite services, or tax credits** to recognise family caregiving.
- Provide structured training modules for ASHAs, Anganwadi workers, and SHG members in geriatric care and mental health.

5. **Standardise Education and Literacy on Healthy Ageing**

- Create **toolkits in regional languages** for seniors, caregivers, and providers.
- Launch **public campaigns and online courses** to promote science-based ageing practices and combat misinformation.

6. **District Residency Programme (DRP) for Capacity Building of Medical Postgraduates**

- Integrate geriatrics into the DRP curriculum so that postgraduate doctors in Family Medicine, Community Medicine, and Internal Medicine are mandatorily exposed to elderly care in district hospitals. This will rapidly expand the pool of physicians with hands-on experience in geriatric health.

7. **Leverage SHGs and Elder Self-Help Groups (ESHGs)**

- Link SHGs with ESHGs to foster **peer support, health literacy, and economic security.**
- Provide seed funding and capacity-building for rural groups, particularly women-led collectives, to scale community-based caregiving

KERALA'S VAYOMITHRAM PROJECT

The Vayomithram Project, launched by the Kerala Social Security Mission in 2010-11, is a pioneering elderly care initiative rooted in Kerala's decentralized governance model, aimed at improving the health and well-being of senior citizens (65+) in urban areas. Implemented in close collaboration with Local Self Government Departments (LSGDs), the project ensures strong local ownership and service delivery tailored to community needs. Starting in Kollam and Thiruvananthapuram, it was scaled up in phases to cover 6 Corporations, 85 Municipalities, and 4 Block Panchayats by 2025. Vayomithram provides free mobile clinic services, medicines, home-based palliative care, counselling, and help desk support, along with medical camps and recreational activities in partnership with NGOs and local institutions. By 2016-17, the program had reached over 175,000 elderly citizens, with its decentralized, community-driven approach earning national recognition through the Central Government's Vayo Shreshtha Samman.

4.5.1 INTEGRATING FORMAL HEALTHCARE SERVICES INTO THE INFORMAL CARE ECONOMY

The **National Programme for Health Care of the Elderly (NPHCE)** already envisions home and community-based elder care through PHCs, home visits, and referral systems. Yet, the reality is that **families remain the primary caregivers** in India, and changing social dynamics smaller households, urban migration, and rising female workforce participation are placing increasing strain on this model. Without structured support, informal caregivers risk burning out and older persons risk inconsistent or delayed care.

This challenge also presents an opportunity: **integrating formal health services with the informal care economy** can create a more resilient and person-centred eldercare system. By leveraging India's grassroots workforce ASHAs, community health workers (CHWs), self-help groups, and NGOs India can bridge the gap between overstretched medical services, and the daily care needs of older persons.

Policy Recommendations:

- **Recognise and support family caregivers**: Provide structured training, respite services, helplines, and caregiver leave. The CCS (Leave) Rules, 1972 already allow central government employees 60 days of leave to care for elderly parents. [117] This provision should be expanded and integrated into wider leave policies across sectors.
- **Leverage community-based networks**: Platforms like the *CareASHA* app [118] demonstrate how technology can ensure caregivers are seen, heard, and supported. Embedding such models within PHC systems can enhance coordination and reduce isolation of caregivers.
- **Adopt global best practices**: Models such as *GRACE (Geriatric Resources for Assessment and Care of Elders)* and *IMPACT* show that integrating multidisciplinary medical teams with family and community caregivers improves outcomes and reduces avoidable hospital admissions. [119] India can adapt these models by building interoperable digital health systems under the Ayushman Bharat Digital Health Mission.
- **Scale pilot initiatives**: Ongoing Indian pilots training caregivers in chronic disease management and mental health first aid should be scaled up through NPHCE and NHM funding
- **Institutionalise caregiver support:**
  - Build **multidisciplinary care teams** at primary and secondary levels.
  - Embed **caregiver training and support services** within PHCs.
  - Use **digital health platforms** for seamless coordination and referral.
  - Provide **accessible respite and counselling services** to reduce caregiver strain.

4.5.2 IMPLEMENTING INTEGRATED, COMMUNITY-BASED ELDER CARE IN INDIA

The 5Cs Framework for Integrated, Community-Based Elder Care.

Building on NPHCE, Ayushman Bharat, and Health and Wellness Centres (HWCs), India can institutionalise a **5Cs Framework** for eldercare delivery.

1. **Contact – Ensuring First Point Accessibility**

Elderly individuals often face barriers to care due to distance, cost, or lack of awareness. Strengthening HWCs as the first point of trusted contact, co-locating services, and embedding culturally sensitive care can reduce delays and encourage early intervention.

Policy Recommendation: Expand geriatric service packages at HWCs, mandate ASHA/CHO outreach for elderly households, and ensure culturally responsive communication strategies.

2. **Continuity – Sustained Care Across the Lifespan**

Fragmented follow-up is a major gap in eldercare. Leveraging interoperable systems under the Ayushman Bharat Digital Mission (ABDM) can ensure continuity of care, while health literacy campaigns can empower families to engage actively.

Policy Recommendation: Link all elderly individuals to a longitudinal digital health record under ABDM; integrate elder health literacy modules into national IEC campaigns.

3. **Comprehensiveness – Beyond Curative, Towards Preventive and Supportive Care**

Most services remain disease-centric, overlooking prevention, mental health, and long-term care. An age-responsive package must integrate preventive screening, chronic disease management, rehabilitation, and home-based support.

Policy Recommendation: Design and roll out a national standardised "Elder Care Package" that includes preventive screenings, adult vaccination, nutrition counselling, rehabilitation, and palliative services at primary and secondary levels.

4. **Coordination – Bridging Families, Communities, and Facilities**

Older adults often "fall through the cracks" of the health system due to poor referral pathways and weak team-based care. Interdisciplinary teams and structured referral mechanisms can bridge this gap.

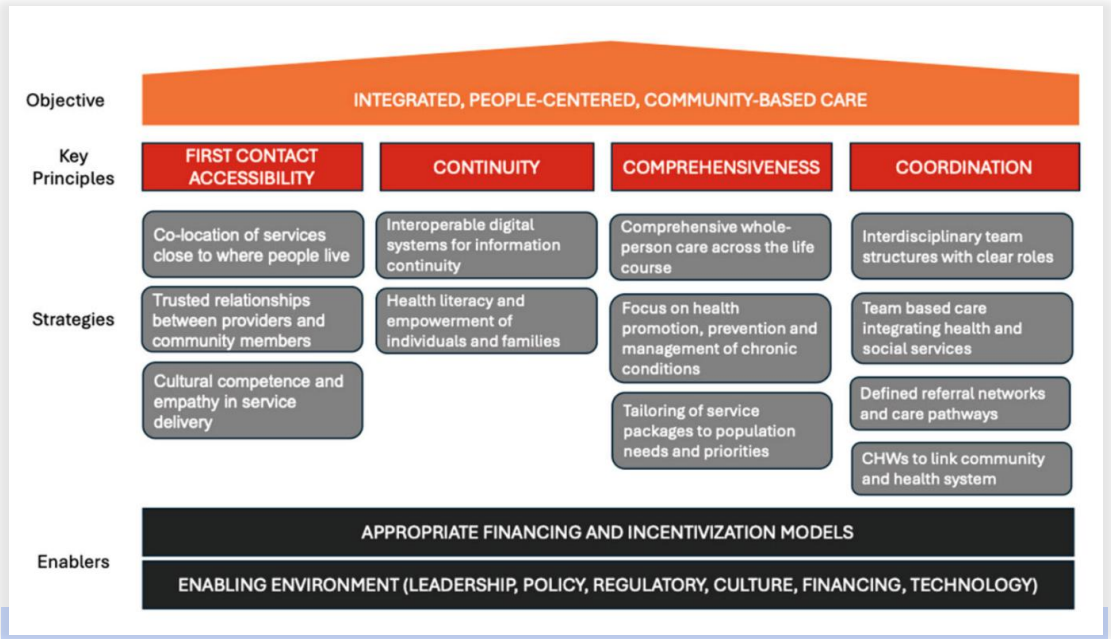
Policy Recommendation: Create multidisciplinary geriatric teams at the district level; develop clear referral protocols linking ASHAs, HWCs, PHCs, and tertiary centres

5. Community Empowerment – Building Local Ecosystems of Care

Families and community structures are the backbone of eldercare in India. Strengthening SHGs, Elder Self-Help Groups (ESHGs), and local volunteers can create sustainable networks of peer support, financial security, and social participation.

Policy Recommendation: Institutionalise Elder SHGs at the block level; provide structured training and seed funding to support caregiving, financial literacy, and digital inclusion initiatives.

The **5Cs Framework** provides a holistic policy lens—moving eldercare away from fragmented, hospital-centric services and towards **integrated, community-anchored, digitally enabled systems** that recognise families and communities as equal partners in care



Source: *Strategies for achieving integrated, people-centred, community-based care*

4.6 BUILDING AN AGE-INCLUSIVE ENVIRONMENT: WHAT INDIVIDUALS AND FAMILIES CAN DO

While policies and programmes create enabling systems, the real foundation of healthy ageing is laid in homes, families, and communities. Everyone- children, adults, and elders themselves has a role in shaping a society where ageing is not feared but embraced with dignity and purpose.

1. Shaping Attitudes: From Ageing as Decline to Ageing as Contribution

A culture shift is needed to move from viewing older people as dependents to recognising them as active contributors. Positive narratives such as Poonam Sapra's intergenerational wisdom notes or Dinesh Mohan's inspiring recovery [120] demonstrate that ageing can be about reinvention, not retreat. Families can nurture this perspective by:

- Encouraging intergenerational conversations and storytelling at home.
- Recognising and celebrating the achievements of older adults.
- Sharing local role models of active ageing in community forums, schools, and digital platforms.

2. Taking Action: Building Age-Friendly Spaces and Routines

Beyond attitudes, everyday actions can make ageing safer and more inclusive. Families and communities can:

- Advocate for elder-friendly public spaces—parks, libraries, religious venues—and push RWAs and local councils to prioritise accessibility.
- Create community-based activities such as walking clubs, reading groups, or hobby circles that reduce isolation and promote mental health.
- Make homes safer by removing slippery mats, improving lighting, creating rest zones, and ensuring easy access to essential facilities.
- Share caregiving responsibilities within families, preventing burnout and promoting collective responsibility.

Recommendations:

- Encourage RWAs and municipalities to adopt "Elder-Friendly Locality" certifications.
- Provide tax or policy incentives for communities that retrofit common spaces for accessibility.
- Promote local volunteering programs where youth support senior citizens with mobility, digital literacy, or companionship.

3. Practising the Core Habits: The Ten Commandments of Healthy Ageing

Living longer and healthier lives depends on small, consistent habits. Table 5 outlines the "Ten Commandments of Healthy Ageing,[121]" rooted in Indian traditions and science-based practices—from **Satvikta (balanced diet)** and **Shramta (physical activity)** to **Samparkta (social ties)** and **Swasth Parikshanta (regular health checkups)**.

Hindi Word	Meaning
Satvikta	Eat a vegetarian, balanced diet; stay hydrated; avoid overeating, excess fat/sugar/salt, and addictions
Shramta	Stay physically active: walk briskly, do yoga, engage in physical work
Sakriyata	Stay mentally and socially engaged: volunteer, pursue hobbies, help family
Samparkta	Maintain social ties: interact with peers, friends, and community
Shaithalyata	Cultivate inner peace through meditation, spirituality, optimism, and forgiveness
Shyanpurta	Practice good sleep hygiene: maintain a regular sleep schedule, avoid screen use or caffeine before bedtime
Sadhna & Adhyatmikta	Connect with spirituality: prayer, meditation, introspection, and purpose
Sanandta	Stay happy and content: express gratitude, enjoy small joys, reduce stress
Sakaratmakta	Think positively: forgive, be optimistic, and avoid negativity
Swasth Parikshanta	Get regular health checkups: monitor key vitals, follow medical advice

Recommendations:

- Disseminate these practices through multimedia campaigns in regional languages.
- Integrate the "Ten Commandments" into school curricula and community workshops.
- Train ASHAs and local volunteers to spread awareness of these habits through door-to-door campaigns

4. Preparing for Tomorrow: Assessments and Advance Care Planning

Simple **intrinsic capacity assessments**, lasting just 8–12 minutes, can help families identify early declines in memory, mobility, vision, or hearing. These assessments can be supported by community health workers or volunteers and linked to local health systems for follow-up care.

Equally important is **open dialogue** on:

- Financial planning and caregiving preferences.
- End-of-life care choices, including advanced directives or living wills.
- Adoption of digital tools like health apps and teleconsultations that improve access and continuity of care.

Recommendations:

- Integrate intrinsic capacity assessments into primary healthcare outreach.
- Provide families with simplified toolkits for advance care planning.
- Encourage health insurers and state governments to incentivise households that adopt preventive screening

A QUICK SELF-TEST FOR HEALTHY AGEING

On an individual and family level, one can do a **basic assessment** to identify loss of intrinsic capacity. This assessment can be completed within **8–12 minutes** and may be carried out by trained community health workers, volunteers, nurse assistants, nurses, doctors, social workers, or other frontline staff.

Stepwise process:

1. Assess all domains (cognition, vision, hearing, mobility, mood, vitality) together rather than individually.
2. For cognition, vision, and hearing, use a filter question.
3. If the answer is **YES**, move directly to Step 2 for in-depth assessment, skipping the rest of the basic test for that domain.
4. Tailor the assessment process to fit local health systems and the skills of available personnel.

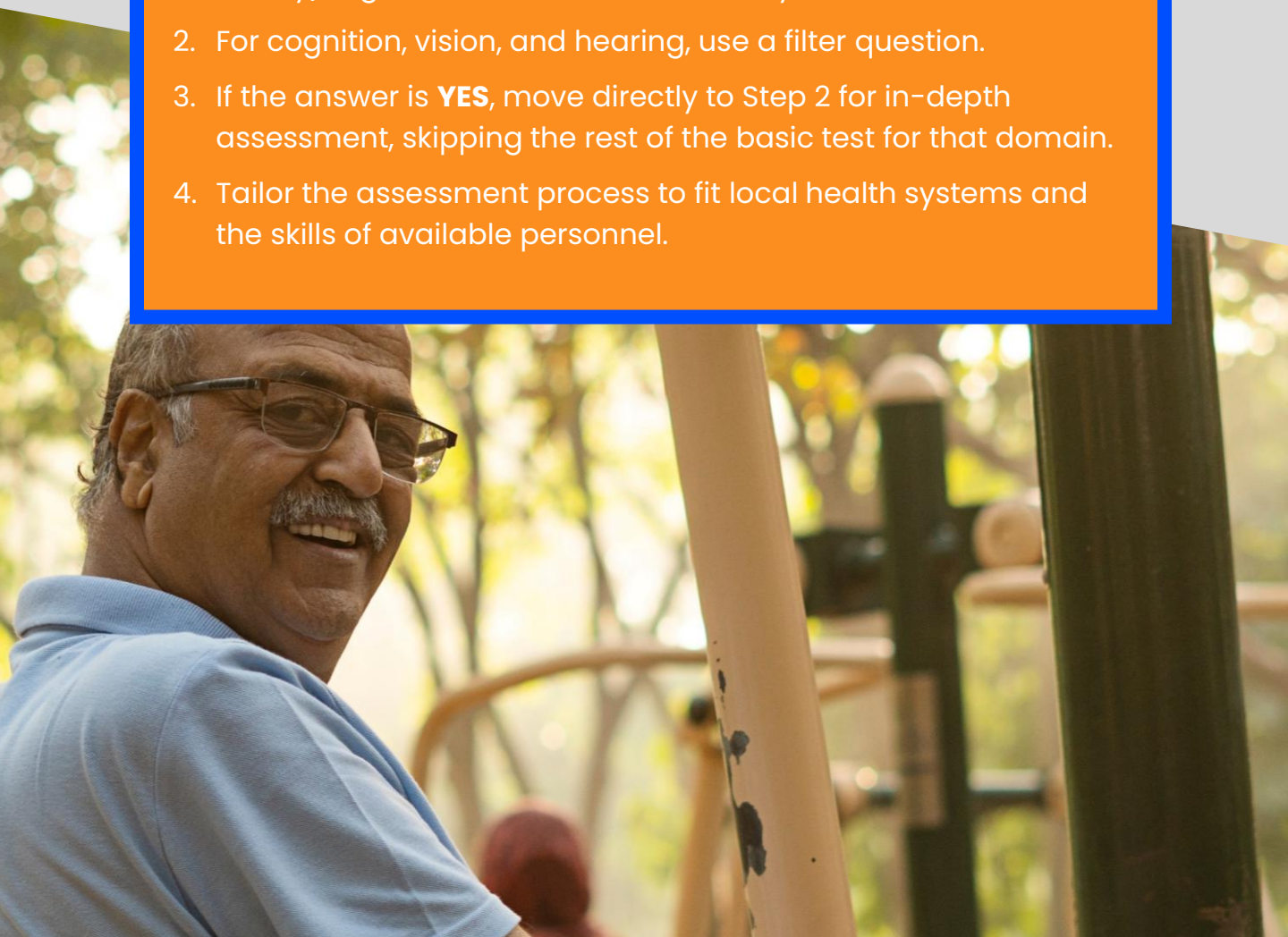


Table 6: Basic Intrinsic Capacity Assessment Table

Domain	Filter Question	Tests	Assessment Criteria
Cognitive decline (Cognition)	Do you have problems with memory or orientation (such as not knowing where you are or what day it is)?	1. Remember three words (use nouns, for example): flower, door, rice. 2. Orientation in time and space: What is the full date today? Where are you now (home, clinic, etc.)? 3. Recall the three words?	Assess fully any domain with a checked circle: • Correct to both questions
Limited mobility (Locomotor capacity)	Chair rise test: Rise from chair five times without using arms. Did the person complete five chair rises within 14 seconds?	Chair rise test	No: Fail Yes: Pass
Undernutrition (Vitality)	1. Weight loss: Have you unintentionally lost more than 3 kg over the last 3 months? 2. Appetite loss: Have you experienced loss of appetite?	1. Weight loss 2. Appetite loss	Yes to either: Fail No to both: Pass
Vision impairment (Vision)	Do you have any problems with your eyes: difficulty seeing far or near, eye pain or discomfort? Do you have diabetes, hypertension, or are you currently using steroids or eye medications?	External eye check 1. Visual acuity test using 2. WHO vision screening chart: • Distance vision (6/12 for each eye) • Near vision (N6 for both eyes)	Fail: One or both tests failed Pass: Both distance and near vision passed
Hearing loss (Hearing)	Do you have a hearing problem? (For those using a hearing aid, add 'even when using your hearing aids.')	Whisper test or Screening audiometry or Digits-triplet-in-noise test	Fail: One or both tests failed Pass: Both tests passed
Depressive symptoms (Psychological capacity)	Over the past 2 weeks, have you been bothered by either of the following: • Feeling down, depressed, or hopeless? • Little interest or pleasure in doing things?	• Feeling down, depressed, or hopeless • Little interest or pleasure in doing things	Yes to either: Fail No to both: Pass

Source: Sumi, Y., Albone, R., & World Health Organization. (2024b). *Integrated care for older people (ICOPE): guidance for person-centred assessment and pathways in primary care, second edition.*

1. Building Workforce and Institutional Preparedness

No blueprint or plan can succeed without a skilled and empowered workforce. India must invest in **capacity-building at every level,** from professional caregivers to informal family support.

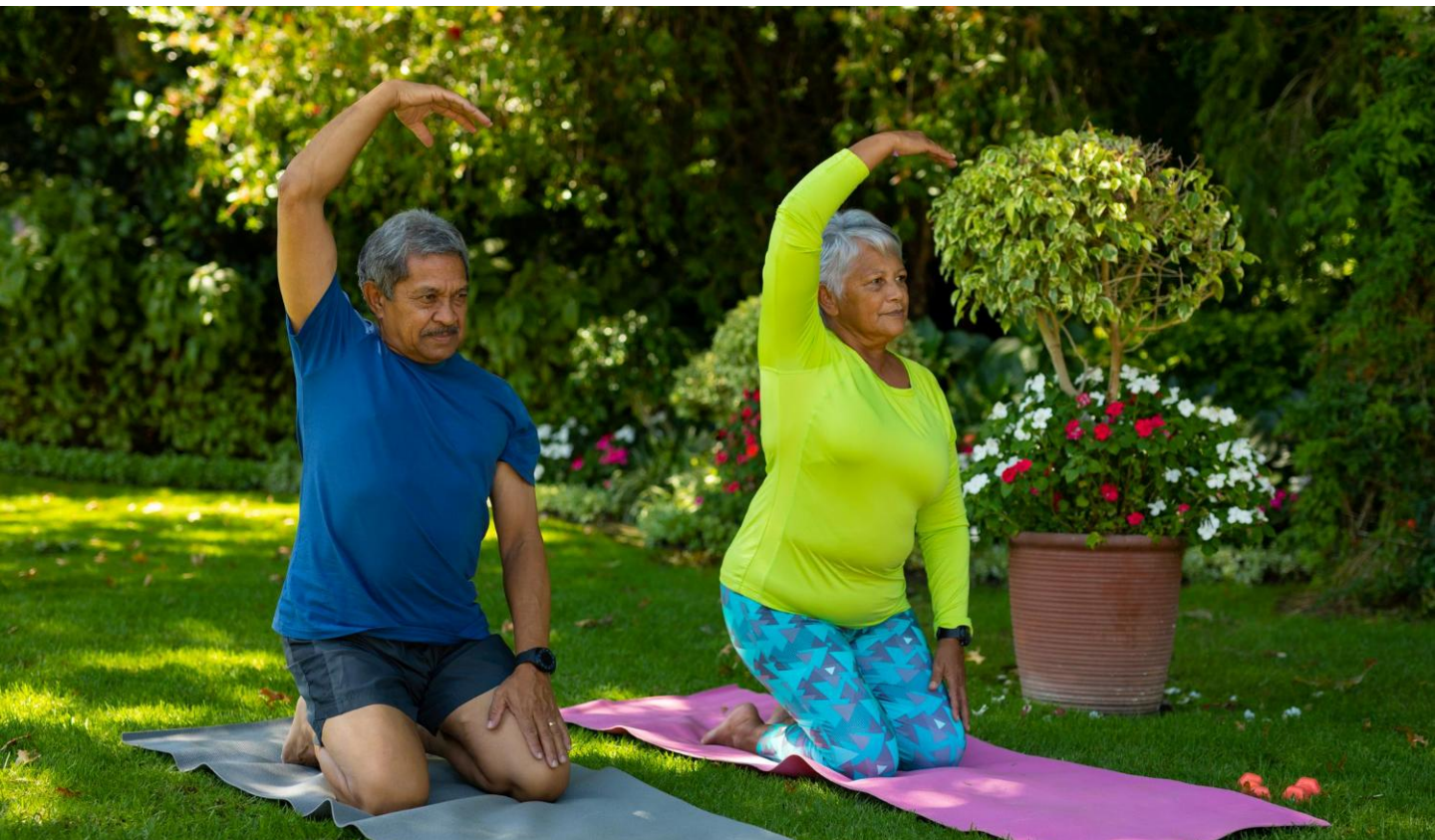
- **Education Reform**: Expand geriatric curriculum into medical, nursing, allied health, and social work education nationwide.
- **Skill Development**: Scale up caregiver training and certification programs through NISD, ISSD, and state skill missions. Empower these institutions to not just train but also **certify and place** elder care professionals.

- **Ongoing Learning**: Provide continuous skill upgrades for healthcare workers, social workers, and volunteers, especially in rural and underserved areas.
- **Primary Care Integration**: Create dedicated elder care teams within primary care systems—CHOs, ASHAs, and ANMs—trained in age-specific assessments and counselling.
- **Partnerships**: Develop public–private partnerships for geriatric skill development, with incentives for startups and care providers to innovate in elder care delivery.

2. Monitoring, Evaluation, and Impact Assessment

To ensure accountability, the roadmap must be backed by a **robust monitoring framework**. The UN Decade of Healthy Ageing provides a useful template, which India can adapt.

- **Structured Framework**: Align actions with measurable input, output, outcome, and impact indicators—covering perceptions, care access, financial security, and community participation.
- **Data Systems**: Use multiple sources—national surveys, administrative records, program data, and WHO campaign monitoring—to establish baselines and track progress.
- **Adaptive Learning**: Monitoring should not only measure progress but also enable mid-course corrections, ensuring that strategies remain responsive to older people's needs.
- **Impact Focus**: Assess not just program reach but also **real-world improvements** in older people's health, participation, and well-being.



India needs a concise set of indicators that can be monitored annually at national and state levels. The following six-to-eight indicators capture health, social, economic and environmental dimensions:

Table 7: Proposed Measurability and Accountability Index

Domain	Indicator	Target / Benchmark (by 2030)	Data Source / Frequency
Healthy Life Expectancy	**HALE at age 60 (years) – average number of healthy years a 60-year-old can expect to live.**	**+2-year gain over 2025 baseline**	**LASI, NFHS**
Economic Security	Old-age pension coverage (% of 60+ population receiving ≥national minimum pension)	≥70% coverage	MoSJE / NSAP dashboards
Long-Term Care Access	Availability of formal LTC services (registered home-care workers or beds) per 1,000 seniors	Double current density	MoHFW, State LTC registries
Preventive & Primary Care	Proportion of 60+ with annual NCD screening & functional assessment	≥80%	Ayushman Arogya Mandirs, HMIS
Digital Inclusion	Digital literacy rate among seniors (ability to use smartphone / access e-health & pension portals)	≥60%	MeitY, periodic digital survey
Social Participation	Share of 60+ engaged in paid work, volunteering or community groups at least monthly	≥40%	Periodic Labour Force Survey; community surveys
Caregiver Support	% of identified family caregivers receiving formal training/respite benefits	≥50%	MoSJE caregiver registry
Age-Friendly Environments	Cities/Gram Panchayats meeting "Age-Friendly" standards (housing, transport, public space)	100 Smart Cities + 1,000 GPs certified	MoHUA / Panchayati Raj audits

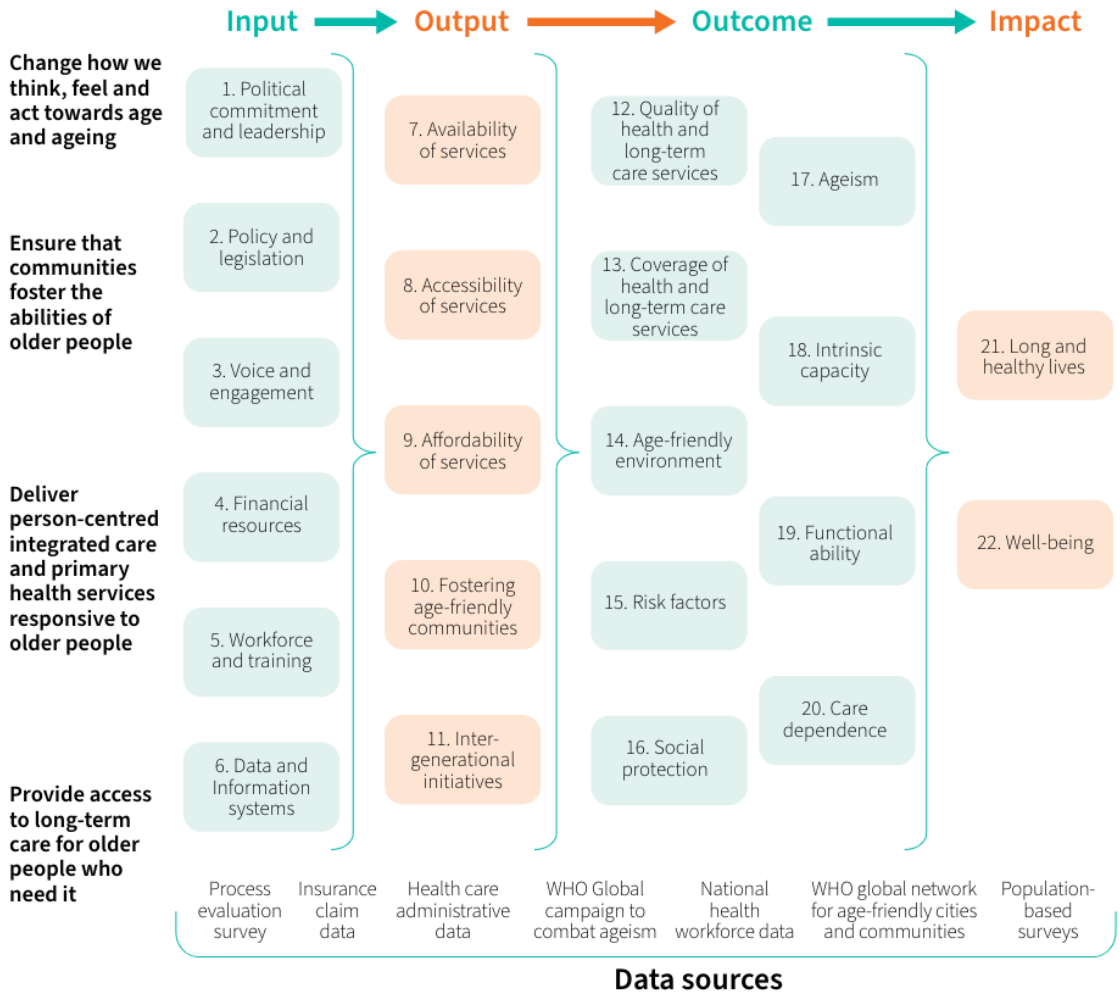


Figure 2: UN Decade of Healthy Ageing provided monitoring and evaluation framework.

By linking inputs, outputs, outcomes, and long-term impacts across domains such as perceptions of ageing, access to care, and community participation, it enables progress to be tracked, and strategies refined in real time. Leveraging data from national surveys, administrative records, and global benchmarks, India can establish measurable baselines and develop an **Active Ageing Index** tailored to its context.

The task ahead is to secure sustained political will, adequate financing, and rigorous monitoring so that these commitments move beyond paper to meaningful change in the lives of older people. If implemented with intent and consistency, this framework can position India as a global leader in evidence-driven, people-centered eldercare, fully aligned with the UN Decade of Healthy Ageing and Vision 2047.

5. CONCLUSION AND WAY FORWARD

This paper has demonstrated that the pursuit of Active and Healthy Ageing is not a sectoral concern, it is a national imperative that cuts across healthcare, social protection, housing, technology, finance, and community development.

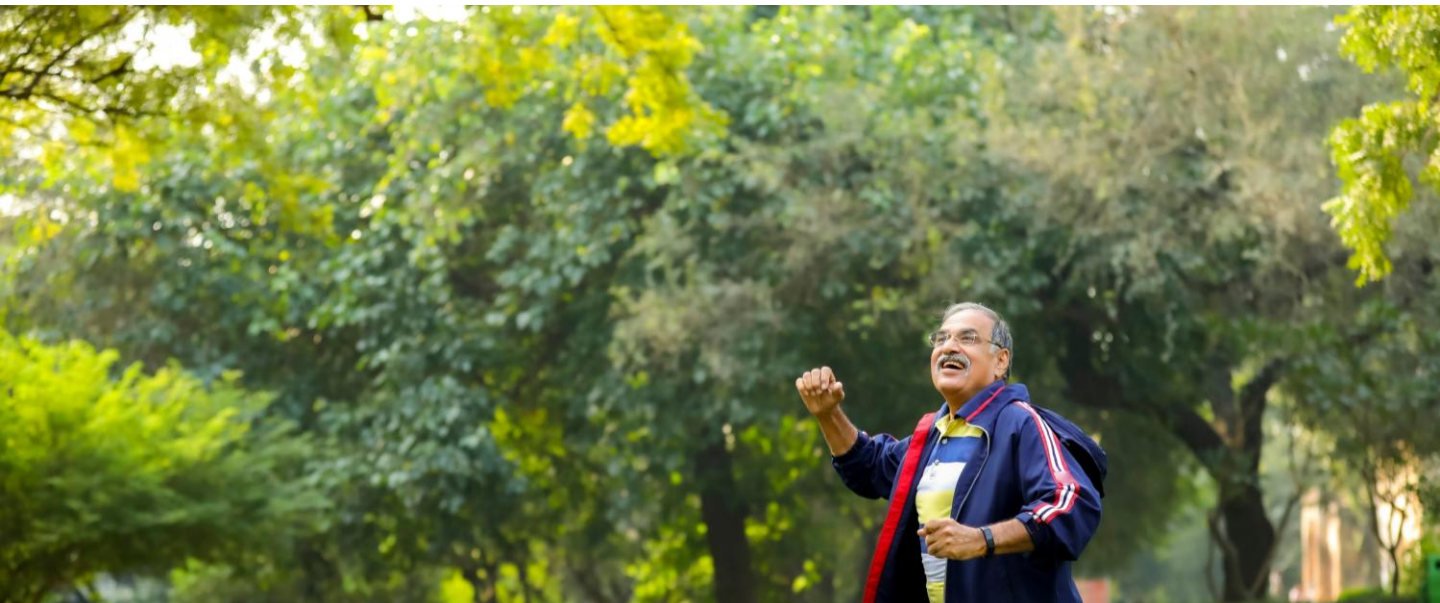
We have seen that despite progress through programmes like the **National Programme for Health Care of the Elderly (NPHCE)**, the **National Mental Health Programme (NMHP)**, and pension schemes such as the **Atal Pension Yojana** or **Senior Citizens' Savings Scheme**, critical gaps remain. The pension architecture remains fragmented, with nearly four out of five seniors living without meaningful income security. Gender inequities are stark, with older women disproportionately widowed, excluded from assets, and economically vulnerable. The digital divide and weak rural infrastructure threaten to marginalise many elders who live outside urban centres.

Yet, this demographic shift offers unprecedented opportunity. As this paper has argued, India's senior citizens can drive the silver economy, contribute to intergenerational knowledge systems, and remain active participants in labour markets, social engagement, and civic life. With the right investments in healthcare systems, social protection, financial inclusion, lifelong learning, and age-friendly environments, we can unlock a longevity dividend worth trillions of dollars over the coming decades.

The way forward requires **whole-of-society action**:

- **Government** must lead by integrating ageing into the centre of national development planning, ensuring adequate financing, and enacting anti-age discrimination laws that guarantee dignity and inclusion.
- **Healthcare providers** must pivot from fragmented, episodic treatment to integrated, life-course care, expanding geriatric medicine, long-term care, and palliative services.
- **Communities and civil society organisations** must build networks of support, awareness, and social participation, reducing isolation and stigma while empowering seniors as mentors, caregivers, and leaders.
- **Families and individuals** must embrace a culture of proactive health, planning, and intergenerational solidarity, recognising ageing as a shared journey rather than an individual burden.
- **The private sector** must invest in the silver economy—ranging from assistive technology and senior housing to digital literacy, employment, and financial products designed for older adults.

Decisive action will ensure that India's elderly population become a source of strength, resilience, and inspiration. As we look towards **Viksit Bharat 2047**, the commitment to Active and Healthy Ageing must be viewed as integral to the nation's growth story. The time has come to act with urgency, compassion, and foresight so that the story of ageing in India is written not in terms of vulnerability, but of dignity, vitality, and shared prosperity.



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Chair: Dr Arun Agarwal, Medical Advisor – Innovation, Education & Clinical Excellence, Apollo Hospitals Group, Former Prof. of Excellence ENT & Ex-Dean MAMC & Ex-Additional Director General Health Services, Government of India

Co-Chair: Ms Malti Jaswal, Founder, Inspiring Seniors Foundation

Members:

1. **Dr Arvind Mathur,** Geriatrics, Member WHO Clinical Consortium for Healthy Ageing, WHO Global Network for Long Term Care, Director, Asian Centre for Medical Education, Research & Innovation and Ex-Principal Dr. S.N. Medical College, Jodhpur
2. **Dr HCSC Reddy,** Head - Senior Citizen Division, National Institute of Social Defence (NISD), Ministry of Social Justice & Empowerment, Government of India
3. **Dr Suneela Garg**, Prof of Excellence, Ex Head (CM) Sub Dean, MAMC & Head Community Medicine, MS: Chair Program Advisory Committee NIHFW, Ex President- OMAG & IAPSM
4. **Dr Madan Gopal**, Advisor & Head- Public Health Administration, National Health Systems Research Centre (NHSRC), GOI, Ex Senior Consultant, Niti Aayog
5. **Dr Vinoy Singh,** Ex-Professor, Integrative Medicine, SVYASA University, Retd. Associate Professor, General Surgery, Patna Medical College
6. **Dr Shuchin Bajaj**, Founder Director, Ujala Cygnus Healthcare Services
7. **Dr Sanjay Kumar,** Population Dynamics & Research Specialist, UNFPA
8. **Prof (Dr) Ruchika Kuba,** Professor- School of Health Sciences, IGNOU
9. **Dr Meerambika Mahapatro**, Prof & Head, Department of Social & Behavioural Sciences, National Institute of Health & Family Welfare (NIHFW), Government of India
10. **Ms Amrita Agarwal,** Visiting Fellow, Centre for Social and Economic Progress (CSEP)
11. **Ms Swathi Kulkarni**, Head- Health Management, Aditya Birla Health Insurance
12. **Mr Himanshu Sikka,** Lead – Health, Nutrition & WASH, IPE Global
13. **Mr Aman Bhaiya,** Vice President, SBI Foundation

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1. **Dr Harsh Mahajan**, Chair- FICCI Health Services Committee and Founder & Chairman, Mahajan Imaging & Labs
2. **(Hony) Brig Dr Arvind Lal,** Chair- FICCI Swasth Bharat Task Force, Executive Chairman- Dr Lal PathLabs and Managing Trustee- ALVL Foundation
3. **Dr Anupam Sibal,** Co-Chair- FICCI Health Services Committee and Group Medical Director, Apollo Hospitals Group
4. **Mr Varun Khanna,** Co-Chair- FICCI Health Services Committee and MD, Quality Care India Limited (Care, KIMS & Evercare)
5. **Dr Narottam Puri**, Advisor- FICCI Health Services Committee; Principal Advisor- QCI; Board Member & Former Chairman- NABH; Advisor- Medical Operations, Fortis Healthcare Ltd.

FICCI Health Services Team

1. **Ms Shilpa Sharma,** Head- Health Services & Medical Devices
2. **Ms Sarita Chandra,** Additional Director
3. **Ms Aayushi Panwar,** Research Associate

Inspiring Seniors Foundation

1. **Ms Praneta Kansal,** Program Manager, Health, Inspiring Seniors Foundation

Chase Advisors Team

1. **Ms Suryaprabha Sadasivan,** Senior Vice President, Chase Advisors
2. **Mr Sainath Sunil,** Senior Account Director, Chase Advisors
3. **Mr Nikhil George,** Senior Manager, Chase Advisors
4. **Ms. Varsha Sriram,** Senior Associate, Chase Advisors
5. **Mr Anuj Pattanayak,** Associate, Chase Advisors
6. **Mr Albin K S**, Junior Associate, Chase Advisors

ANNEXURES

A. WHO's Healthy Ageing Indicator Metadata Toolkit Source:

World Health Organization. (2024). *Measuring the progress and impact of the UN Decade of Healthy Ageing (2021-2030): framework and indicators recommended by WHO Technical Advisory Group* (By World Health Organization

Domain	Indicators	Indicator Type	Data Collection Level	Tier
1. Political commitment and leadership	1.1 Percentage of countries with a national focal point for ageing and health in the ministry of health or equivalent	Input/Process	National	I
2. Policy and legislation	2.1 Percentage of countries with current national policy, action plan, strategy or programme on ageing and health 2.2 Percentage of countries with current national legislation and enforcement strategies against age-based discrimination 2.3 Percentage of countries with current national legislation, policies, strategies, frameworks, plans or programmes that include age-friendly environments 2.4 Percentage of countries with current national strategy, action plan, programme, policy and/or legislation that includes (incentives and resources) comprehensive assessments of the health and social care needs of older people 2.5 Percentage of countries with current legislation or regulation that provides older persons with access to assistive products from the WHO Priority assistive products list 2.6 Percentage of countries with current national strategy, action plan, programme, policy and legislation to support the implementation of long-term care for older persons	Input/Process	National	I

Domain	Indicators	Indicator Type	Data Collection Level	Tier
3. Voice and engagement	3.1 Percentage of countries with national multistakeholder forum or committee on ageing and health	Input/ Process	National	I
4. Financial Resources	4.1 Percentage of countries with a national budget and financial resources to support initiatives to combat ageism 4.2 Percentage of countries with a national budget and financial resources to support activities to promote age-friendly cities and communities 4.3 Percentage of countries with a national budget and financial resources to implement integrated primary health care services for older people 4.4 Percentage of countries with a national budget and financial resources to provide longterm care for older people (e.g. nationally budgeted financing schemes such as taxbased revenue or social insurance) 4.5 Percentage of countries with public insurance that covers the cost of health care services for older people 4.6 Percentage of countries that support incomegenerating activities for older people 4.7 Percentage of countries that provide free-ofcharge outpatient services in the public sector for older people 4.8 Proportion of total government spending on essential services (education, health and social protection) (SDG 1.a.2)	Input	National	I

Domain	Indicators	Indicator Type	Data Collection Level	Tier
5. Workforce and training	5.2 Number of geriatricians per 100 000 older people 5.3 Number of nursing personnel with competencies in geriatric care per 100 000 older people 5.4 Number of general medical practitioners with competencies in geriatric care per 100 000 older people 5.5 Number of community health workers with competencies in geriatric care per 100 000 older people 5.6 Number of formal care workers providing long-term care in various long-term care settings (including facilities and residential institutions) per 100 older people residing in long-term care facilities 5.7 Number of formal care workers providing longterm care for older people at home in the community, per 100 older people who need home-based long-term care 5.11 Percentage of countries with capacity-building plans to strengthen the geriatric and gerontology workforce	Input	National	II
	5.1 Number of medical and nursing schools with geriatric care (formal education) in undergraduate curricula 5.8 Percentage of countries with capacity building and social support programmes (in-person or online) for caregivers of older people 5.10 Percentage of countries with training programmes on agefriendly cities and communities	Input	National	I
	5.9 Number of physical therapists per 100 000 older people 5.12 Number of clinical social workers per 100 000 older people 5.13 Number of psychologists per 100 000 older people 5.14 Number of environment and public health workers			III

Domain	Indicators	Indicator Type	Data Collection Level	Tier
6. Data and information systems	6.2 Percentage of countries with any crosssectional survey(s) on healthy ageing with a nationally representative sample of older people 6.3 Percentage of countries with a longitudinal survey(s) on healthy ageing with a nationally representative sample of older people	Input/Process	National	I
7. Availability of services	7.1 Percentage of primary care or any other health facilities offering care services defined in the WHO ICOPE UHC packages of care services	Output	National	III
8. Accessibility of services	8.3 Percentage of older people who have forgone care due to cost, distance or sociocultural factors, over the past year	Input/Process	Population	III
10. Fostering agefriendly cities and communities	10.2 Percentage of cities, towns or rural areas working to become age-friendly communities that have completed a baseline assessment over the past year 10.3 Percentage of cities, towns or rural areas working to become age-friendly communities that have developed a strategy and action plan over the past year 10.4 Percentage of cities, towns or rural areas working to become age-friendly communities that have completed an evaluation over the past year	Output	National	III
11. Intergenerational initiative	11.1 Percentage of older people engaged in intergenerational initiatives over the past year	Output	Population	III
12. Quality of health and long-term care services outcome	12.1 Percentage of older people who have received cataract surgery and have a resultant good quality outcome (6/12 or better) relative to the number of people in need of cataract surgery over the past year 12.7 Percentage of older people who received surgical treatment for hip fractures within 48 hours after admission to the hospital, over the past year	Output	Population	II
	12.6 Percentage of older people who report age-based discrimination in health or longterm care services, over the past year	Outcome	Population	III

Domain	Indicators	Indicator Type	Data Collection Level	Tier
13. Coverage of health and long-term care services	13.4 Percentage of older people with declines in mobility or locomotor capacity who received rehabilitation services over the past year 13.7 Percentage of older people in need of hearing aids who received hearing aid services over the past year 13.8 Percentage of older people diagnosed with depression who received psychosocial, pharmacological, rehabilitation and/ or aftercare services over the past year 13.12 Percentage of informal caregivers (of older people in need of support) who received caregiving training over the past year	Outcome	Population	III
	13.13 Percentage of older people in need of long-term care services receiving longterm care at facilities or in their home in the community over the past year	Outcome	Population	II
14. Age-friendly environment	14.24 Percentage of older people who believe decision-making is inclusive and responsive over the past year Outcome Population II	Outcome	Population	II
	14.25 Percentage of older people living in agefriendly cities, towns or rural areas over the past year	Outcome	National	II
15. Risk factors	15.2 Percentage of older people who report insufficient physical activity, over the past year	Outcome	Population	I
16. Social protection	16.1 Percentage of older people living in poverty in all its dimensions according to national definitions over the past year 16.2 Percentage of older people effectively covered by a social protection “floors” or systems over the past year 16.5 Prevalence of undernourishment in older people over the past year	Outcome	Population	I
	16.6 Prevalence of moderate or severe food insecurity in the older people, based on the Food Insecurity Experience Scale over the past year	Outcome	Population	II
	16.3 Percentage of older people who did not have enough income to meet their basic needs without public or private assistance, over the past year 16.4 Proportion of older people living in a household with a disposable income above the risk-of poverty threshold over the past year	Outcome	Population	III

Domain	Indicators	Indicator Type	Data Collection Level	Tier
17. Ageism	17.1 Percentage of older people who report that others do not value their contribution, others may feel frustrated by them because of their age, and/or others make decisions for them because of their age (interpersonal ageism) over the past year 17.2 Percentage of older people limiting participation in discussion about things that affect them (self-directed ageism) over the past year 17.3 Percentage of older people who report that policies made by the government do not meet their needs, due to discrimination on age nested in the policy (institutional ageism) over the past year	Outcome	Population	III
18. Intrinsic capacity	18.1 Percentage of older people with higher intrinsic capacity, over the past year	Outcome	Population	III
19. Functional ability	19.1 Percentage of older people with higher functional ability, over the past year	Outcome	Population	III
21. Long and healthy lives	21.1 Life expectancy at age 60, over the past year 21.2 Healthy life expectancy at age 60, over the past year	Impact	Population	I
22. Well-being	22.1 Percentage of older people with higher well-being (subjective), over the past year	Outcome	Population	III

B: Table of WHO's key recommendations for healthy ageing, covering physical decline, geriatric syndromes, and caregiver support.

Category	Recommendation
Module I: Declining physical and mental capacities	
Mobility loss	Multimodal exercise, including progressive strength resistance training and other exercise components (balance, flexibility and aerobic training), should be recommended for older people with declining physical capacity, measured by gait speed, grip strength and other physical performance measures.
Malnutrition	Oral supplemental nutrition with dietary advice should be recommended for older people affected by undernutrition.
Visual impairment	Older people should receive routine screening for visual impairment in the primary care setting, and timely provision of comprehensive eye care.
Hearing loss	Screening followed by provision of hearing aids should be offered to older people for timely identification and management of hearing loss.
Cognitive impairment	Cognitive stimulation can be offered to older people with cognitive impairment, with or without a formal diagnosis of dementia.
Depressive symptoms	Older adults who are experiencing depressive symptoms can be offered brief, structured psychological interventions, delivered by trained health professionals with an understanding of older adult mental health.
Module II: Geriatric syndromes	
Urinary incontinence (Prompted voiding)	Prompted voiding for urinary incontinence can be offered to older people with cognitive impairment.
Urinary incontinence (PFMT)	Pelvic floor muscle training, alone or with bladder strategies and self-monitoring, should be recommended for older women with urinary incontinence.
Risk of falls (Medication review)	Medication review and withdrawal of unnecessary/harmful medications can be recommended for older people at risk of falls.
Risk of falls (Multimodal exercise)	Multimodal exercise (balance, strength, flexibility, functional training) should be recommended for older people at risk of falls.
Risk of falls (Home modification)	Following specialist assessment, home modifications to remove fall hazards should be recommended.
Risk of falls (Tailored interventions)	Multifactorial interventions combining assessment with personalized interventions can reduce fall risks.
Module III: Caregiver support	
Caregiver training/support	Psychological intervention, training and support should be offered to family and informal caregivers, especially where care needs are complex and caregiver strain is high.

About FICCI

Established in 1927, FICCI is the largest and oldest apex business organisation in India. Its history is closely interwoven with India's struggle for independence, its industrialisation, and its emergence as one of the most rapidly growing global economies.

A non-government, not-for-profit organisation, FICCI is the voice of India's business and industry. From influencing policy to encouraging debate, engaging with policy makers and civil society, FICCI articulates the views and concerns of industry. It serves its members from the Indian private and public corporate sectors and multinational companies, drawing its strength from diverse regional chambers of commerce and industry across states, reaching out to over 2,50,000 companies.

FICCI provides a platform for networking and consensus building within and across sectors and is the first port of call for Indian industry, policy makers and the international business community.

FICCI Contacts

Shilpa Sharma

Head - Health Services & Medical Devices

E: shilpa.sharma@ficci.com

Sarita Chandra

Additional Director

E: sarita.chandra@ficci.com

Aayushi Panwar

Research Associate

E: aayushi.panwar@ficci.com

Website: www.ficci.in

About Chase Advisors

At Chase Advisors, we aim to embody innovation, agility, and an unwavering commitment to impact-driven solutions.

Founded in 2011, Chase Advisors is a dynamic and forward-looking public policy consulting firm. With our extensive APAC market capabilities, growing network of global collaborators, and tech-powered policy advisory, we help our clients create business impact, mitigate risks, drive impactful campaigns, and build relationships with key stakeholders.

Chase Advisors has its India offices in New Delhi, Mumbai, Pune, Hyderabad, Chennai, and Bengaluru, supported by an expansive network of affiliate partners and consultants. Our Malaysia office is headquartered in Kuala Lumpur and is a step towards a larger APAC expansion.

Chase Advisors is a subsidiary consultancy of Avian We., a group company of We. Communications, one of the world's largest independent communications agencies, headquartered in Seattle, Washington. For more than 30 years, We.'s work has moved people around the world to positive action. The company's operations now span 100+ international markets, with 1,000+ employees and an ever-growing portfolio of global technology, health and consumer brands. Just as We. believes in uncovering the human need beneath every challenge, we at Chase Advisors are committed to creating connections that matter and solutions that last

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ABOUT INSPIRING SENIORS FOUNDATION

Inspiring Seniors Foundation (ISF) is a non-profit focussed on championing active and healthy ageing, and promoting purposeful and productive engagement of the seniors. The NGO envisions that longevity should be a gift, not a challenge, a time space where seniors thrive, inspire and contribute beyond retirement. ISF's mission is that with the right awareness, opportunities, and interventions, India's silver population can be turned into a golden asset for the families, society and the country.

ISF creates awareness and opportunities for the senior citizens for healthy ageing and its programs add health span to life span, ensuring that long years are lived in good health, with purpose, and active participation in society. It focuses on holistic well-being—physical, mental, and cognitive through programs that foster social engagement, productive ageing and intergenerational bonds. By unlocking the potential of India's retired population and tapping into their energy, education and enthusiasm, ISF aims to bring a paradigm shift in how ageing is perceived and experienced.

This new-age NGO is technology-first by design, using online programs to ensure ongoing digital inclusion and a wider reach among seniors. Its programs don't just empower seniors; they also provide them opportunities for mentorship, guidance and support to underprivileged students and youth, fostering intergenerational connections that create lasting social change. ISF actively collaborates with other stakeholders, working for the wellbeing for seniors, to create a collective movement for wider positive impact.

Website: https://inspiringseniors.org

Contact: +91-9315274243 |

Email: enquiry@inspiringseniors.org

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