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AGEING POPULATIONS IN INDIA: TOWARDS INTEGRATED AND EQUITABLE GERIATRIC CARE

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ABSTRACT

The ageing population represents a transformative demographic shift in India. It is posing both challenges and opportunities for public policy. The growing elderly population, now exceeding 100 million, is projected to reach around 20% of the total by 2050. There is an emerging need for a holistic approach. Despite policy frameworks such as the National Policy on Older Persons (1999) and the National Policy for Senior Citizens (2011), India's approach to geriatric concerns remains fragmented and under-resourced. The Structural deficiencies, weak inter-sectoral coordination, and limited financial resources have constrained effective implementation. This paper critically examines the evolution and scope of India's social security policies. It analyzes policy planning and identifies systemic healthcare delivery and social protection gaps based on national data and comparative evidence. The paper concludes that achieving equitable geriatric care in India requires multisectoral collaboration, enhanced community-based service models, and sustained investment in preventive and long-term care infrastructure.

KEYWORDS

Active ageing, geriatric policy, public health, social protection, age-friendly environment

INTRODUCTION

The ageing population in India is one of the most significant social transformations of the 21st century. Improvements in life expectancy, with declining fertility rates, are resulting in a rapidly expanding elderly population across the Global South [1]. In India, persons aged 60 years and above are projected to constitute nearly one-fifth by 2050 [2]. This demographic transition has implications for health systems, social security frameworks, and intergenerational equity.

Unlike high-income countries with well-established institutional and community-based care systems, India's ageing population depends mainly on informal family support and traditional care structures [3,4]. Urbanisation, migration, and changing household dynamics have weakened these traditional safety nets. This is exposing older adults, particularly women, widows, and the rural poor, to vulnerabilities related to income insecurity, social isolation, and deteriorating health [5]. Overall, there are concerns for the care of the elderly in urban and rural areas. These policies are constrained by fragmented governance and inadequate coordination between health, welfare, and local administrative bodies [6].

Globally, the discourse on ageing has shifted from a welfare-based to a rights-based paradigm that emphasises autonomy, participation and productivity among the elderly [7]. Within this framework, India's challenge is not merely to extend lifespan but to ensure "healthspan", a period of life marked by physical, mental, and social well-being [8,9]. The paper critically examines India's evolving policy landscape for the elderly through the lens of access, equity, and integration.

METHODOLOGY

This review employed a narrative and integrative review design to synthesise existing literature on social security policies. The methodology aimed to capture both the range of policy evolution and the depth of implementation challenges concerning geriatric health and social protection.

A systematic search was conducted across multiple academic databases, PubMed, Scopus, Google Scholar, and JSTOR, as well as national policy repositories such as the Ministry of Health and Family Welfare (MoHFW), Ministry of Social Justice and Empowerment, and NITI Aayog archives. The review encompassed materials published between 1999 and 2025, spanning across the period following the launch of the National Policy on Older Persons (1999) to recent frameworks under the *UN Decade of Healthy Ageing (2021–2030)*.

Search keywords included combinations of *"ageing population," "geriatric health," "elderly policy India," "social protection," "active ageing," "NPHCE,"* and *"National Policy for Senior Citizens."* Both peer-reviewed journal articles and published documents (including government reports, policy briefs, research theses, and NGO publications) were included to ensure comprehensive coverage of the evidence base.

The inclusion criteria focused on studies and reports that addressed:

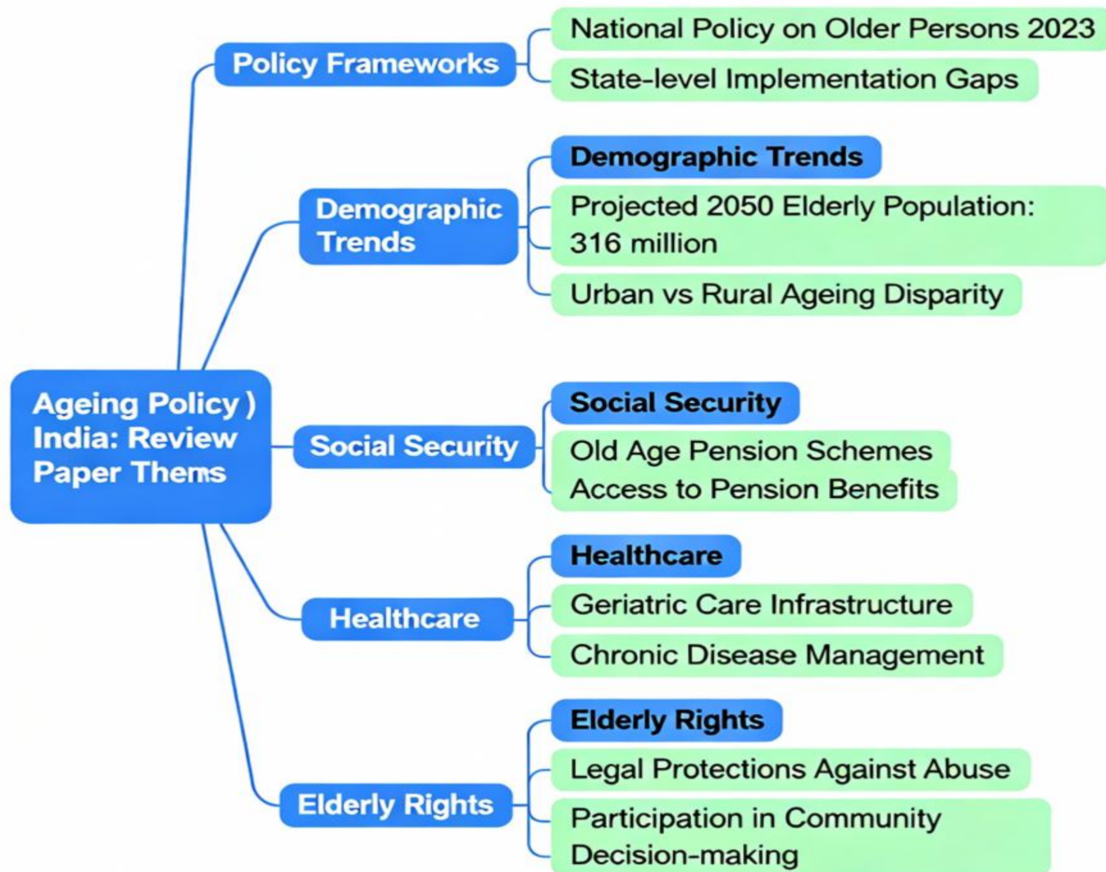
1. Health system responses to ageing in India.
2. Social security and welfare mechanisms for the elderly.
3. Policy implementation challenges and innovations in the Indian context.

Data extraction followed a thematic synthesis approach [10], allowing for the identification of recurrent policy themes, such as access, integration, equity, and active ageing. The findings were critically seen through the Levesque et al. (2013) [11] framework on healthcare access and the WHO (2020) model of healthy ageing.

DATA ANALYSIS FRAMEWORK FOR ELDERLY

The review adopted a thematic combination approach to analyse the collected literature, enabling integration of findings across diverse policy and empirical sources. All included documents were read in full, and themes and sub-themes were manually coded using inductive and deductive techniques. Deductive coding was guided by the Levesque et al. (2013) [11] framework on access to services.

FIGURE 1. THEMATIC FRAMEWORK



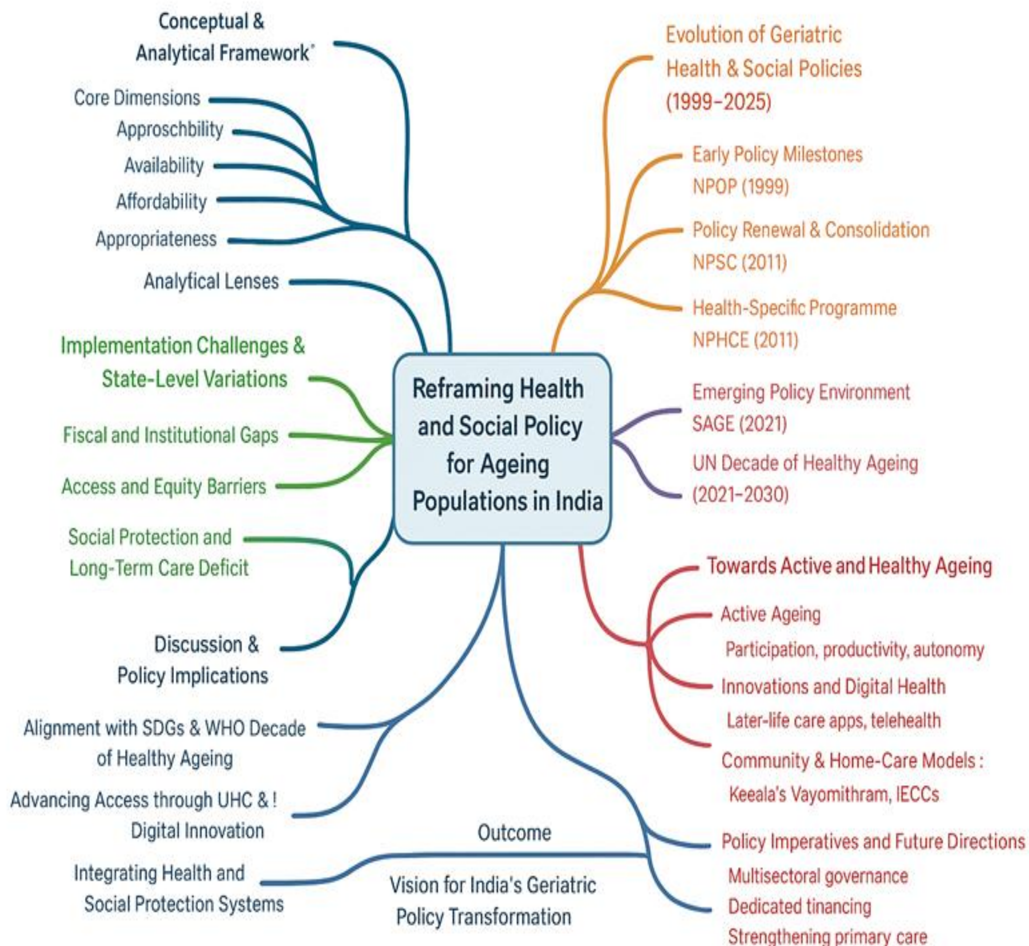
The coded themes and sub-themes were arranged accordingly: (i) Evolution of Geriatric Health and Social Policies in India (1999–2025), (ii) Critical Analysis of Implementation: NPOP, NPHCE and State-level Variations (iii) Health and Social Determinants of Elderly Well-Being in India (iv) Towards Active and Healthy Ageing: Policy Gaps and Innovations. Thematic convergence and discrepancy were identified across national and subnational policies. The synthesis process emphasised contextual interpretation and triangulation of policy texts, empirical studies, and implementation evidence, ensuring analytical rigour and relevance to India's evolving ageing policy (Figure 1).

CONCEPTUAL FRAMEWORK: ACCESS, INTEGRATION AND ACTIVE AGEING

The paper adopted a conceptual framework (Figure 2) rooted in access to care and system integration to analyse India's geriatric policy environment. Drawing on Levesque et al. (2013) [11] model of healthcare access, the paper considers access in five interrelated dimensions: approachability (ability to perceive services), acceptability (willingness to seek), availability and accommodation (ability to reach), affordability (ability to pay) and appropriateness (ability to engage). For elderly, ageing-friendly policies require integrating health and social services, as medical care alone is insufficient. Older persons face multiple chronic conditions, functional limitations, and social vulnerabilities [12]. Thus, social protection, community engagement and long-term care strategies must complement health system responsiveness. An active and healthy ageing framework enables older persons to remain socially engaged and economically productive [13, 14].

Applying this framework in the Indian context reveals persistent access and service delivery disparities. This is driven by demographic diversity, geographic variation and institutional capacity. The ensuing sections concern tracing policy evolution and critically assessing implementation gaps.

FIGURE 2. CONCEPTUAL FRAMEWORK REFRAMING SOCIAL SECURITY POLICY FOR AGEING POPULATIONS IN INDIA



EVOLUTION OF GERIATRIC POLICIES IN INDIA (1999–2025)

EARLY POLICY MILESTONES

India's first substantial policy for older persons, the *National Policy on Older Persons (NPOP)*, was adopted in 1999. It marked an essential commitment to social justice for the elderly, recognising them as citizens with rights rather than passive dependents [15]. The NPOP proposed social security, health care, housing, and age-friendly environments.

POLICY RENEWAL AND CONSOLIDATION

In 2011, the *National Policy for Senior Citizens* was endorsed to mainstream older persons, supporting ageing in place, promoting home and community care rather than institutionalisation, and enhancing financial and social security [16]. Programmes such as the Indira Gandhi National Old Age Pension Scheme (IGNOAPS) and the Pradhan Mantri Vaya Vandana Yojana (PMVVY) sought to provide cash support and insurance. The Ministry of Social Justice and Empowerment also introduced the Senior Care Ageing Growth Engine (SAGE) initiative in 2021 to promote innovation in elderly care services [17].

SPECIFIC PROGRAMME FOR HEALTH

In response to growing demands for geriatric health services, the NPHCE was launched to provide age-friendly primary, secondary, and tertiary services. It promotes screening, rehabilitative care, palliative care, and professional training [16]. A review of the NPHCE found that, while the programme has achieved, it faces critical challenges in human resources, infrastructure, and monitoring systems [6].

RECENT POLICY ENVIRONMENT AND INTERNATIONAL COMMITMENTS

India's ageing trajectory was reaffirmed in the Economic Survey, which highlighted the urgent need. It was noted that the concept of a "silver dividend" [18] was highlighted. At the same time, international frameworks, such as the Decade of Healthy Ageing (2021–2030), age-friendly environments, and innovation in long-term care [19]. Furthermore, the UNFPA's India Ageing Report 2023 projects that the elderly share will rise from 10.1% in 2021 to 20.8% by 2050 [20].

CRITICAL ANALYSIS OF IMPLEMENTATION

FISCAL AND INSTITUTIONAL GAPS

Although the policy rhetoric is commendable, several authors highlight systemic disconnects between the objective and implementation. For example, the public-facing assumption that informal family care will serve decreases [21,22]. It shows that around 30% of older persons live alone or only with another older family member, lacking younger household members for care [23]. Budgetary allocations to elderly care programmes remain modest and are often subsumed [24]. The Economic Survey noted that the Indian elder-care industry is valued at approximately USD 7 billion yet suffers from infrastructure deficits [25].

Governance fragmentation across ministries (Health, Social Justice, Rural Development, Finance) further complicates coordinated implementation. Without designated monitoring agencies and clear accountability frameworks, rollout remains irregular.

ACCESS AND EQUITY ISSUES

Using Levesque's access dimensions, substantial deficits are observed:

- Approachability & Acceptability: Awareness of geriatric services remains low in rural and marginalised communities; only 28% of older persons reportedly know of concessions for senior citizens in some surveys [26, 27,1].
- Availability & Accommodation: Infrastructure remains limited, especially in remote areas. While primary health centres may exist, geriatric-friendly design, dedicated wards, trained geriatricians, or rehabilitation services are rare [28].
- Affordability: Though pensions and insurance schemes exist, many older persons, especially outside the formal sector, lack cover. The reliance on out-of-pocket payments remains high [29,30].
- Appropriateness: Care models often remain hospital-centric rather than oriented towards home and community care. Multimorbidity, functional limitations and mental health issues require integrated care pathways, which are weakly developed [31,32].

The Longitudinal Ageing Study in India (LASI) reported that approximately 75% of older adults have at least one chronic disease, 24% have limitations in activities of daily living (ADLs), and 48% have at least one limitation in instrumental activities of daily living (IADLs) [33]. Moreover, around 70% of older persons depend on others for maintenance, and 78% live without pension coverage in certain poor cohorts.

STATE-LEVEL VARIATION

Implementation also varies significantly across states. Some states, such as Kerala, Himachal Pradesh and Goa, have developed relatively stronger systems of elder-care community services; others lag [34]. The differential in capacity, commitment and demographic profile means that national policy must be adapted to the state context rather than delivered as a one-size-fits-all model.

GAPS IN SOCIAL PROTECTION AND LONG-TERM CARE

While the pension schemes provide a minimal social floor (e.g., IGNOAPS), many older persons remain financially insecure. About half of the elderly in India reportedly have no source of income, and only 11% have access to old-age pensions [35]. Moreover, long-term care (LTC), including assisted living, home care services, rehabilitation, and palliative care, remains a promising area and is primarily delivered by the private sector or NGOs, rather than the public sector [23].

EPIDEMIOLOGY OF AGEING

The health needs of the elderly are shaped by multiple factors such as chronic disease burden, functional limitation, mental health, and disability [36]. Data from the NSSO 2014 indicate that sickness or poor health is reported by approximately 30% of individuals aged 60–69 years [37]. Earlier estimates found that 41.8% of the elderly in India suffered chronic diseases in 2007, increasing to 64.8% by 2011 [12]. Mental health is a crucial yet often overlooked aspect. The older women, the poorer elderly and less-educated older persons report higher rates of depression and anxiety [31]. In India, visual and hearing disabilities affect about 4% of the older population [38].

FUNCTIONAL CAPACITY AND ACTIVITIES OF DAILY LIVING

Functional limitations are key to elderly well-being and place demands on both health and social care systems. Activities of Daily Living (ADLs), such as feeding, bathing, dressing, using the toilet, and mobility, are foundational to living independently [1]. Studies show that bathing is often the most difficult ADL, followed by toileting, dressing and mobility [39, 40]. Among those aged over 80, about 27% were incapacitated, and one-third had restricted movement [41]. Other studies found that 13% of older persons suffer a disability affecting at least one ADL, 27% have mild disability, and 37% have higher disabilities [36].

SOCIAL DETERMINANTS

Social determinants such as living arrangements, economic status, and family support influence the well-being of the elderly. In India, one-fifth of older persons live with only a spouse; increasingly, the elderly live alone due to migration of younger adults or changing family structures [2]. Sub-national surveys indicate that around half of older persons have no income source, and only 11% have pensions [35]. Economic marginalisation is especially acute among older women, widows, rural residents and those in informal sectors [41].

Elder abuse is another critical issue in India. According to a 2015 survey by HelpAge India, nearly half of older persons reported some form of abuse by caregivers, family members, or others [5]. Such social vulnerabilities exacerbate health and care burdens and further emphasise the need for integrated social and healthcare responses.

ACCESS TO GERIATRIC CARE

Access to healthcare for the elderly population in India remains uneven and largely constrained by socioeconomic, geographic, and infrastructural factors. Despite the introduction of programmes such as the *National Programme for Health Care of the Elderly (NPHCE, 2010)* and the expansion of primary health infrastructure under Ayushman Bharat-Health and Wellness Centres (HWCs), the availability of dedicated geriatric services remains limited, particularly in rural and tribal districts [42[.

Physical accessibility remains a critical concern. According to the *Longitudinal Ageing Study in India (LASI, Wave 1, 2020)*, nearly one-third of the elderly report difficulty reaching a health facility due to distance, mobility issues, or lack of transportation. The shortage of geriatric specialists and age-friendly facilities at district hospitals and community health centres exacerbates this gap [43]. In Odisha and Chhattisgarh, for example, only a fraction of health facilities have trained geriatric staff or accessible infrastructure, limiting service uptake.

Economic access poses an additional barrier. Out-of-pocket expenditure (OOPE) on chronic disease management, medicines, and diagnostics remains high among older adults, with over 65% of elderly respondents reporting financial strain [37]. Although social health insurance schemes, such as Ayushman Bharat – PMJAY, have expanded coverage to include elderly-specific packages and long-term care, the coverage remains minimal [44].

Acceptability and awareness further influence the care-seeking behaviour of older adults. Traditional reliance on home-based or informal care, combined with limited geriatric literacy. Cultural norms emphasising self-reliance among the

elderly also discourage proactive health-seeking, particularly for mental health or functional disabilities [45]. These findings align with Levesque et al.'s (2013) [11] conceptualisation that access is not merely a matter of supply but an interaction between user capacities and service responsiveness.

INTEGRATION OF HEALTH AND SOCIAL POLICY

The ageing challenge in India is multidimensional, demanding coordination across health, housing, and labour sectors. However, policy analysis discloses fragmentation between health services and social protection systems. The *National Policy for Senior Citizens (2011)* advocates a life-course approach to ageing. However, rather than systemic integration, implementation remains limited to welfare-based interventions such as pensions, concessions, and old-age homes [46]. At the district level, weak interdepartmental coordination and the absence of shared data systems hinder the delivery of holistic services [47].

Emerging initiatives, such as the *Integrated Elderly Care Centres (IECCs)* and *Elderline Helpline (14567)*, demonstrate progress towards integrated service delivery by linking health, counselling, and social welfare services. Similarly, the *Decade of Healthy Ageing (2021–2030)* framework encourages convergence of health promotion. However, integration remains largely programmatic rather than systemic, lacking sustainable governance and financial mechanisms [48].

Policy consistency can be strengthened through the *Health in All Policies (HiAP)* approach, which aligns ageing concerns across ministries and local governance. Community-based models such as Kerala's *Vayomithram* project showcase the potential of integrating primary healthcare with social participation and home-based support [49].

EQUITY AND INCLUSION IN AGEING PROGRAMMES

Equity in geriatric health and social protection remains a central policy concern in India. The vast disparities across gender, socioeconomic class, and geography are a significant challenge. Older women, widows, and those in rural and tribal areas face intersectional vulnerabilities. This was reflected in poorer health outcomes, limited pension coverage, and higher dependency ratios [50]. Data from LASI (2020) indicate that older women are 1.5 times more likely to suffer from functional limitations and twice as likely to be economically dependent compared to men [22].

While national initiatives such as *Indira Gandhi National Old Age Pension Scheme (IGNOAPS)* provide a bare social security floor, benefit adequacy and coverage remain limited. Rural and informal sector workers, who constitute most of India's ageing population, are particularly excluded from contributory pension schemes and employer-based benefits [51].

From a health equity standpoint, the urban–rural divide persists. Urban centres offer better access to tertiary care and private providers, while rural areas depend heavily on under-resourced public facilities [52]. Caste and regional disparities further compound inequities; for instance, elderly populations in eastern and central India, Odisha, Chhattisgarh, and Jharkhand report lower service utilisation and higher unmet needs [53].

TOWARDS ACTIVE AND HEALTHY AGEING

THE CONCEPT OF ACTIVE AGEING

The active ageing paradigm emphasises the capacity of older persons to continue contributing to society economically, socially, and culturally rather than being passive recipients of care. The AgeWatch Index 2015 ranked India 71st among 96 countries for older-person well-being, behind neighbouring countries [5]. The shift from mere dependence to productive engagement is foundational to sustainable ageing policy [54].

Promoting volunteering, caregiving, paid or unpaid work, grand-parenting, and community engagement are all part of this agenda [55]. In India, older persons with higher socioeconomic status are less likely to be employed and more likely to engage in social or community activities, indicating a shift in what ageing can mean [54].

INNOVATIONS AND DIGITAL HEALTH

The pandemic recently enhanced digital health and care-support platforms for older persons in India. A study noted that app-based "later-life care" is growing, enabling the elderly to monitor their health and design care networks. It also raises concerns of digital exclusion among rural or lower-income older persons [56].

COMMUNITY-BASED AND HOME-CARE MODELS

The literature highlights that long-term care systems should support ageing in place rather than institutionalisation. For example, home-care models with trained caregivers, day-care centres, community clubs, and mobile clinics (such as the Vayomithram Project in Kerala) demonstrate locally adapted models [57,49]. The challenge lies in replicating such models at scale, particularly in rural and semi-urban contexts.

DISCUSSION

The demographic transition unfolding in India signifies an ageing population and a transformation in the country's social and health landscape. The findings of this review underscore three interrelated challenges: restricted access, fragmented policy integration, and deep-seated. Addressing these requires reimagining ageing within a life-course and systems approach, consistent with global frameworks such as the World Health Organisation's (WHO) Decade of Healthy Ageing (2021–2030) and the Sustainable Development Goals (SDGs).

ALIGNING INDIA'S AGEING POLICY WITH GLOBAL COMMITMENTS

Globally, the WHO defines healthy ageing as "the process of developing and maintaining the functional ability that enables well-being in older age." These framing shifts focus from disease management to functional ability, participation, and autonomy, which remain underrepresented in India's ageing policy discourse. The National Policy for Senior Citizens (2011) and the National Programme for Health Care of the Elderly (NPHCE) have made significant steps in recognising the multidimensional needs of older persons.

Integration with the SDG framework, particularly Goal 3 (Good Health and Well-being), Goal 10 (Reduced Inequalities), and Goal 11 (Sustainable Cities and Communities), offers a strategic pathway for India. It is mainstreaming ageing concerns into broader health and development agendas. Ensuring access to quality essential health services, reducing financial hardship from healthcare expenditure, are directly relevant to improving elderly well-being. The UN Decade of Healthy Ageing further encourages member states to operationalise ageing within the pillars of integrated care, long-term support, age-friendly environments, and combating ageism, all of which remain areas requiring substantial policy attention in India.

ADVANCING ACCESS THROUGH PRIMARY HEALTH SYSTEMS AND DIGITAL INNOVATION

The review findings highlight that geographic and economic barriers constrain access to geriatric care in India. In line with the Universal Health Coverage (UHC) roadmap, primary healthcare systems must serve as the foundation for equitable access to elderly services. Strengthening Health and Wellness Centres (HWCs) under Ayushman Bharat with trained geriatric personnel, assistive devices, and screening services for chronic and mental health conditions can improve reach and continuity of care.

Digital health innovations under the Ayushman Bharat Digital Mission (ABDM) can further enhance access. However, digital inclusion requires capacity-building and literacy initiatives to ensure that older adults can effectively utilise technology-enabled health services.

INTEGRATING HEALTH AND SOCIAL PROTECTION SYSTEMS

The disintegration between healthcare and social welfare remains a defining weakness in India's ageing response. Policy consistency must be built through an integrated governance framework that unites health, social justice, rural development, and labour ministries under a shared ageing agenda. Adopting a "Health in All Policies (HiAP)" approach would ensure that ageing considerations are embedded across housing, transportation, and social security sectors.

At the service delivery level, meetings between NPHCE, IPOP, and pension schemes (IGNOAPS) can be institutionalised through common beneficiary databases, integrated referral pathways, and shared monitoring systems. District-level Elder Care Coordination Units could be operational hubs linking health facilities, welfare offices, and community organisations. International experiences such as Japan's Long-Term Care Insurance System and Thailand's Community-Based Integrated Care Model demonstrate strong local governance, dedicated financing, and precise accountability mechanisms. India offers similar potential if supported by adequate fiscal transfers and administrative capacity at the panchayat and municipal levels.

ADDRESSING EQUITY AND GENDER DIMENSIONS

Equity remains the ethical and policy cornerstone of any ageing strategy. As revealed in this review, older women, rural poor, and socially disadvantaged groups experience disproportionately lower access. Embedding gender-sensitive and equity-based planning in geriatric programmes can mitigate these disparities.

Pension schemes like IGNOAPS require enhanced benefit amounts and improved targeting. Expanding contributory and hybrid pension models to cover informal sector workers will be critical for long-term financial security. From a health equity perspective, investments should prioritise underserved rural and tribal regions, including mobile geriatric clinics and community outreach models.

Promoting social inclusion and participation of older adults through self-help groups, intergenerational programmes, and local councils can enhance mental well-being and civic engagement. Recognising the elderly's active contributors rather than dependents aligns with the Active Ageing framework [58], emphasising participation, health, and security.

CONCLUSION AND POLICY IMPLICATIONS

The ageing of India's population is no longer a distant prospect; it is a present reality that demands urgent policy attention. Older persons must be supported to survive and succeed with dignity, autonomy, participation, and good health. While India has made significant steps in articulating policy commitments for older persons, implementation remains irregular, fragmented, and insufficiently resourced.

The reviews pointed out that improving the well-being of the elderly in India depends on enhancing access to age-responsive health services, integrating fragmented health and social systems, and ensuring equity across socioeconomic and gender dimensions. Although policy frameworks exist, their impact is diluted by poor institutional coordination, insufficient financing, and low community participation. Addressing these challenges requires a multisectoral, equity-oriented strategy that repositions ageing as a public health and social development priority associated with the SDGs and the UN Decade of Healthy Ageing.

This paper suggests that meaningful progress will require shifting from isolated schemes to integrated health-social care systems. The review also bridges the gap between policy and practice. People must be regarded as assets rather than burdens, and ageing must be embedded in the mainstream of national development planning rather than treated as an afterthought.

If India is to achieve its international and national commitments regarding ageing, the time to act is now. With the right policy architecture, financial commitments, and community orientation, the ageing challenge can become an opportunity for inclusive growth, lifelong health, and inter-generational solidarity.

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None declared

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