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# The State of Geriatric Care, Challenges and Solutions in India

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**Abstract**

Geriatric care in India represents a growing public health challenge as the elderly population expands rapidly, projected to reach 400 million by 2050. This study explores the state of geriatric services, analyzing global, national, and local perspectives to highlight gaps in infrastructure, trained workforce, and policy implementation. Using a cross-sectional qualitative design with 40 telephonic interviews across children, elderly individuals, nursing professionals, and service providers, the research identifies common themes of concern: inadequate training, financial limitations, caregiver fatigue, and trust in professional care. Findings reveal that young adults prefer flexible, part-time arrangements due to economic constraints, while elderly participants require medical, emotional, and mobility support. Nursing professionals and caregiving agencies reported high attrition, lack of skills, and low financial incentives as key barriers.

The study emphasizes the need for integrated solutions combining family support, professional caregiving, and digital innovations such as telemedicine and remote monitoring. Policy interventions like the National Programme for Health Care of the Elderly (NPHCE) are acknowledged but remain under-implemented due to insufficient funding and reliance on family-based models. Recommendations include flexible caregiving models, tiered pricing, structured training programs, competitive wages, and intersectoral collaboration. Strengthening these areas can foster sustainable, affordable, and high-quality eldercare systems, reduce caregiver burden and improving the dignity and quality of life for India's aging population.

***Keywords:*** Geriatric care, Elderly health, Caregiving models, India, Aging population, Public health policy

## Introduction

### Background

Geriatric care is the contentment of the necessary needs and requirements that are unique to elderly people. It is multidisciplinary in nature, with the primary goal of improving overall health and quality of life while maintaining dignity and independence. Aging is accompanied by diverse socio-economic and health-related changes that require qualified medical and social interventions (World Health Organization [WHO], 2015). The average life expectancy of people has increased substantially due to significant advances in medicine, public health, and technology. In 2020, the global population aged 65 and over made up about 9.3%, and this influential sector is projected by the United Nations (UN, 2020) to rise to about 16.0% by 2050. Such demographic changes highlight the urgent need for comprehensive geriatric care services. As older adults often experience multiple chronic conditions, physical limitations, and cognitive decline, a coordinated approach involving physicians, nurses, social workers, and family caregivers is essential (Beard et al., 2016).

Beyond the medical aspects, geriatric care must also address psychological well-being, social inclusion, and economic security. Many elderly individuals face loneliness, ageism, and inadequate access to health facilities, particularly in low- and middle-income countries (Lloyd-Sherlock et al., 2014). Community-based initiatives, home-based care, and policies that support age-friendly environments are increasingly recognized as effective ways to address these challenges (WHO, 2021). Furthermore, digital health technologies such as telemedicine, wearable devices, and remote monitoring systems have shown promise in enhancing accessibility and continuity of care for older adults (Marston et al., 2020). The integration of these approaches into health systems can not only improve the quality of geriatric services but also reduce the financial burden on families and health institutions. Taken together, these measures underscore the importance of adopting a holistic and forward-looking strategy in preparing societies for the rapid growth of the elderly population.

**Research Gap**

While numerous studies have examined geriatric care in India and globally, most focus narrowly on health infrastructure or policy frameworks, with limited attention to the lived experiences of elderly individuals and their families. Additionally, many studies overlook the perspectives of caregiving professionals and service providers who directly shape eldercare delivery. This study addresses these gaps by incorporating insights from multiple stakeholders children, elderly individuals, nursing professionals, and service providers through qualitative interviews. By capturing the intersection of family-based caregiving, professional services, and policy implementation, the study provides a more holistic view of challenges and solutions in geriatric care.

**Global Perspective**

Most developed countries continue to have consistent measures of caring for the elderly throughout the entire world. Unlike developed nations, for example, Japan, the U.S., EU countries have established an adequately defined long-term care system consisting of health care, social care, and nursing homes (OECD, 2020). The World Health Organization's Decade of Healthy Aging (2021-2030) emphasizes the expansion of eco- environments, social participation, and integrated systems of importance to deliver healthy aging globally (WHO, 2021). Geriatric care had been diverse principles and skills for managing the unique needs of elderly people. Geriatric care focuses on the health, well-being, and quality of life of older people while identifying that they experience a combination of physical, emotive, cognitive, and communal changes. With the cumulative global life expectancy, high-quality geriatric care has become a keystone of health care systems, allowing older adults the possibility of leading healthier lifestyle. Elderly care comprises a range of services that cater to the various needs of the elderly.

**Challenges in Developing Countries**

Some countries rely heavily on insufficient infrastructure and family-based care. The challenges are a lack of education in geriatrics and trained professionals, limited accessibility to health care in rural areas, and financial constraints that make geriatric services unattainable (Gupta et al., 2020). Most NRIs and expatriates face difficulties when it comes to the proper care of elderly parents back in their home countries. Consequently, this has driven demand for professional elder care, assisted-living facilities, and technology that facilitates long-distance caregiving (Chokshi et al., 2021). In many low- and middle-income countries, the demographic transition has outpaced the development of health and social systems, leaving older adults vulnerable to neglect and poor quality of life (United Nations, 2019).

Globally, movements like the World Health Organization (WHO) Decade of Healthy Aging (2021–2030) are striving to create age-friendly cities and to support active aging (WHO, 2020). These methods emphasize the need for integrative models of health care, social care, and community involvement. In particular, WHO advocates for community-based care, capacity building of health workers in geriatrics, and the use of digital health tools to bridge gaps in service delivery (WHO, 2021). Moreover, evidence suggests that strengthening family caregiver support

through training and financial assistance can significantly improve health outcomes for older people (Charles & Sevak, 2021). A shift towards coordinated policies that combine medical, social, and technological approaches is considered essential to address the growing global aging population (Beard et al., 2016).

**National Perspective (India)**

In 2021, with approximately 138 million persons over the age of 60, India is home to one of the world's largest populations of the elderly, anticipated to peak at 400 million in 2050 (United Nations, 2020). With this change in mind, it poses huge problems providing the country with suitable geriatric care. Some significant barriers are the omissions of geriatric education in medical educations, the inadequate healthcare systems, and the lack of access to services in the rural settings. (Shankar et al., 2019) The Indian Government has already addressed some of these difficulties through several policies such as the National Policy on Older Persons (1999) and programs such as the National Programme for Health Care of the Elderly (NPHCE), which aim to strengthen health care services for the aged including providing free medical insurance and telemedicine services (Geriatric Society of India, 2020). The policies themselves are poorly implemented because of insufficient funding, and the family-based model of caregiving is the problem that is hindering its efficacy (Shankar et al., 2019). Inventions such as wearable health gadgets and caregiver mobile phone applications are being developed as proposed supports for elder care in India. Partnering these with care systems at the community level in the form of care volunteer programs and public sensitization programs could completely revolutionize not only the access to but the quality of Geriatric care services all over India (NIA, 2021).
The situation in India illustrates the complexity of balancing traditional family-centered caregiving with the urgent need for institutional and technological solutions. While government policies such as the NPHCE show promise, the gap between policy formulation and on-ground implementation continues to undermine progress (Kumar & Agarwal, 2020). The heavy reliance on family caregivers, many of whom are untrained, leads to caregiver fatigue and inconsistent quality of care, especially in households with limited financial means (Rajan & Balagopal, 2017). Integrating community-based initiatives with digital health innovations could help alleviate some of these pressures, but this requires targeted investments in infrastructure, workforce training, and public awareness campaigns (Barik & Thorat, 2015). Unless India strengthens both policy execution and public-private partnerships, the projected growth of its elderly population will place unprecedented strain on its healthcare and social systems (Kumar, 2019).

**Methodology**

This research utilized a telephonic interview technique to collect data from participants across the country within one month. 40 participants were interviewed, and datasets relating to children, old people, and caregiving services were contributed. Explicit inclusion and exclusion criteria were used to assure the relevance and reliability of the data obtained.

**Study Design**

The study used a cross-sectional design with a qualitative strategy, utilizing structured telephonic interviews for data collection. Participants were selected according to predetermined inclusion and exclusion criteria unique to each data set. Interviews were administered between [01/01/2025] and [28/01/2025], such that all 40 participants were interviewed within the one-month period.

**Participant Selection**

**Children's Dataset**

The research covered participants between the ages of 21 and 24 who were away-students and who were contributing to caregiving from afar. It did not cover individuals who lived with their parents or who were not actively engaged in caregiving work.

**Senior Dataset**

The research involved participants 53 years and above who were living separately from their children and either in use or in need of caregiving services. It did not involve the elderly who lived with their children and those who had no need for caregiving services.

**Caregiving Services Dataset**

The analysis encompassed caregiving agencies with partnerships in hospitals offering services and did not include independent non-hospital-based agencies. The analysis encompassed caregiving agencies with partnerships in hospitals offering services and did not include independent non-hospital-based agencies. In nursing staff, it covered nurses having experience in or with geriatric care in the past or presently and did not cover those who lack it.

**Data Collection Procedure**

**1. Preparation**
Carefully crafted structured interview questionnaires were designed to meet research aims and inclusion criteria for each data set.
**2. Recruitment**
Participants were recruited using purposive sampling in order to obtain a varied representation within the inclusion criteria. Agencies and caregivers that met the criteria were approached directly to participate.
**3. Interview Process**
Participants were called at their convenience for telephonic interviews. Each interview was around 20 to 30 minutes. Interviewers made note of answers after participants had given consent to be recorded.
**4. Ethical Considerations**
Informed consent through verbalization was elicited from all the participants prior to starting the interviews. Confidentiality and anonymity were also ensured during the study.

**Data Analysis**

Verbatim transcriptions were done on recorded interviews to ensure accuracy. Thematic analysis was used to identify emerging themes and patterns. Emerging themes were coded systematically to answer the research questions.

**Limitations**

1. The use of telephonic interviews might have limited the possibility of observing non-verbal behavior, which might be useful to understand in context.
2. Results are specific to the context and might not be generalizable to populations outside of the pre-defined inclusion criteria.
This approach allowed for a systematic and organized process of data gathering with strict inclusion and exclusion criteria to ensure the reliability and validity of the results.

Table 1: Children Living Away from Parents

| Aspect | Details |
|---|---|
| Demographics | 10 participants (5 males, 5 females), ages 21–24 (mean: 23.3 years), all students, 70% BBA graduates. |
| Living Arrangements | All live away from parents: 20% (<1 year), 50% (1–5 years), 30% (>5 years). |
| Key Concerns | Parents' health and medical needs (100%), safety (30%), companionship (10%). |
| Challenges | Coordination of healthcare services (40%), ensuring safety (30%), scheduling appointments (10%). |
| Caregiving Preferences | 60% willing to pay for caregiving; preferred budget: ₹10,000–₹20,000/month. All prefer home-based care. |
| Feedback | Need for part-time caregivers (20%), better training (30%), experienced professionals (10%). |

The research had 10 respondents with 5 males, 5 females and aged 21–24 (mean: 23.3 years), mostly BBA graduates (70%), all living away from their parents as 20% for less than a year, 50% for 1–5 years, subsequently 30% for more than 5 years. The most significant apprehensions were parents' medical needs and health (100%), safety (30%), and companionship (10%). Problems encountered were coordination of healthcare services (40%), safety (30%), and fixing appointments (10%). Although 60% would pay ₹10,000–₹20,000/month for caregiving, all wanted home-based care. Feedback pointed towards the need for part-time caregivers (20%), improved training (30%), and experienced professionals (10%).The research had 10 male participants aged 53–60 (mean: 56.5 years), living in Baroda (60%) and New Delhi (40%), all living away from their children for varying lengths of time: 10% for less than a year, 40% for 1–5 years, and 50% for more than 5 years.

Table 2: Elderly Living Away from Children

| Aspect | Details |
|---|---|
| Demographics | 10 male participants, ages 53–60 (mean: 56.5 years), residing in Baroda (60%) and New Delhi (40%). |
| Living Arrangements | All live away from children: 10% (<1 year), 40% (1–5 years), 50% (>5 years). |
| Caregiving Needs | Medical assistance, emergency care, mobility support, emotional care, and medical monitoring. |
| Comfort with Caregivers | 40% comfortable with part-time caregivers; 20% comfortable with full-time caregivers. |
| Financial Willingness | 50% willing to pay for caregiving; budgets: 30% (₹10,000–₹20,000), 30% (₹20,000–₹30,000). |
| Concerns | Trust, privacy, safety, cost, and loss of independence. |
| Feedback | Need for affordable and well-trained caregivers with trust-building measures. |

Their caregiving requirements were medical care, emergency care, mobility aid, emotional care, and medical monitoring. Although 40% were happy with part-time caregivers and 20% with full-time caregivers, only 50% would pay for caregiving, with budgets divided between ₹10,000–₹20,000 (30%) and ₹20,000–₹30,000 (30%). Most important concerns were trust, privacy, safety, cost, and loss of independence. Feedback pointed towards the need for low-cost, well-trained caregivers with trust-building strategies.

Table 2 included only male participants in the elderly dataset due to purposive sampling within the limited timeframe of data collection. Female participants could not be recruited within the study period. This presents a

limitation, as the findings may not fully represent the gendered dimensions of caregiving needs and experiences among elderly women. Future research should include both male and female participants to ensure broader generalizability.

Table 3: Nursing Professionals and Service Providers

| Aspect | Details |
|---|---|
| Nursing Professionals: Demographics | 10 participants (5 males, 5 females), ages 29–48 (mean: 37.8 years), qualifications: B.Sc. and M.Sc. Nursing. |
| Workforce Challenges | High attrition rates, lack of skilled candidates, recruitment costs, competition from agencies. |
| Financial Insights | Monthly earnings: ₹15,000–₹20,000 (60%); expectations: over ₹30,000. |
| Training Needs | Demand for better training programs in elderly care. |
| Service Providers: Demographics | 10 participants, ages 25–51 (mean: 38 years), cities: Andhra Pradesh (60%), Gujarat (40%). |
| Experience | 80% have less than 3 years of experience; 20% have over 3 years. |
| Financial Insights | Monthly earnings: ₹20,000–₹30,000 (50%), over ₹30,000 (30%). |
| Challenges | High client expectations, lack of specialized training, competition in caregiving. |
| Key Traits | Empathy, patience, respect, and understanding emphasized as essential caregiving traits. |

The study involved 10 nursing professionals (5 males, 5 females) aged 29–48 (mean: 37.8 years) with B.Sc. and M.Sc. Nursing qualifications, and 10 service providers aged 25–51 (mean: 38 years) from Andhra Pradesh (60%) and Gujarat (40%). Among nursing professionals, workforce challenges included high attrition rates, a lack of skilled candidates, recruitment costs, and competition, with 60% earning ₹15,000–₹20,000 monthly but aspiring to earn over ₹30,000. They highlighted a need for better training in elderly care. Service providers, with 80% having less than 3 years of experience, reported monthly earnings of ₹20,000–₹30,000 (50%) and over ₹30,000 (30%). Their challenges included high client expectations, limited specialized training, and competition, while empathy, patience, respect, and understanding were identified as essential caregiving traits.

The combined results, discussions, recommendations, and conclusions for children, elderly, service providers, and nursing emphasize the interrelatedness of caregiving needs among different populations.

**Results and Discussion**

**Demographic Insights**

The research included varied participants, such as young adults aged 21-25, aged people with a mean age of 54.5, service providers who are mostly from the urban sector, and nursing personnel with a mean age of 31.8. The young adults tended to reside away from their elderly parents and showed immense demand for specialized caregiving services. The older respondents had recurring health problems, reflecting a serious need for custom-made medical services. Service providers pointed out shortage of staff and low salaries, whereas nursing staff stressed career advancements in the midst of financial troubles.

**Caregiving Needs**

Major findings reveal that both young people and older adults demand flexible caregiving arrangements. Young people preferred part-time services owing to economic factors, while older adult respondents required situational support. Providers cited the shortage of skilled staff as a major challenge, while nursing professionals wanted specialized training to develop their competence in caring for older adults.

**Recommendations**

Flexible caregiving models should be designed to accommodate both part-time and full-time arrangements, ensuring that families can choose options that fit their specific circumstances. Young adults managing careers or living abroad may prefer flexible schedules, while elderly individuals with chronic conditions may need round-the-clock assistance. To support this, training programs must be comprehensive, covering not only medical care and emergency response but also psychological and emotional support. This helps bridge the workforce skill gap and prepares caregivers to handle the multifaceted needs of aging populations. Certification and continuous professional development can further raise the standard of care and professionalize the sector.

Financial planning and incentives are equally important to ensure accessibility and sustainability. Tiered pricing schemes can make services affordable for families across income levels, while competitive salaries and benefits help retain skilled caregivers. At the same time, technology integration such as remote health monitoring, mobile apps for care coordination, and AI-assisted reminders can streamline caregiving and make it more responsive. Finally, intersectoral collaboration among governments, caregiving agencies, and academic institutions can align training, establish clear service guidelines, and improve the overall quality of eldercare. Such partnerships can create a unified framework that ensures consistency, affordability, and efficiency in caregiving systems.

**Conclusion**

The findings underscore a growing acceptance of professional caregiving services among young adults with aging parents and highlight the necessity for tailored solutions in eldercare. Addressing the needs of both caregivers and recipients through flexible models, enhanced training, and better financial support can significantly improve the quality of life for the elderly while ensuring job satisfaction among caregivers. In many contexts, caregivers report burnout and stress due to the emotional and physical demands of the job, which makes supportive policies such as counseling services, peer support groups, and structured rest periods crucial. Governments and private organizations alike have an important role to play in creating certification programs, setting minimum standards of care, and providing financial incentives that attract and retain skilled professionals in the field.

The limitation of this study is that the elderly dataset (Table 2) included only male participants. This gender imbalance restricts the generalizability of the findings, as elderly women may have different caregiving needs, health-seeking behaviors, and socio-cultural challenges compared to men. The absence of female perspectives limits the ability to fully understand the diversity of experiences in geriatric care. Future research should therefore include both male and female participants to capture a more balanced and representative view of eldercare requirements in India.

By implementing these recommendations, the caregiving sector can evolve into a more sustainable and effective system that meets the demands of all stakeholders involved. This transition also requires investment in technology, such as remote monitoring systems and telemedicine, which can reduce the burden on caregivers while improving health outcomes for older adults. Community-based networks that bring together healthcare providers, social workers, and volunteers can further strengthen the continuum of care. Over time, such integrated approaches not only improve the well-being of the elderly but also foster intergenerational solidarity, reduce healthcare costs, and create a workforce that views caregiving as a respected and viable profession.

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