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Title:
Adding Life to Years
Building Care Systems for a
Life of Dignity and Quality

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by

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Preface

As the world ages, there is a growing realisation about the requirement for a comprehensive approach to address the complexities of needs relating to health and social care. The rise in chronic diseases and multimorbidities requires health services and social care as a continuum.

The World Health Organization (WHO) defines the continuum of care as an integrated system of health services that spans all levels of intensity of care. It ensures seamless transitions between providers and spans the entire lifecycle, from health promotion and disease prevention to treatment, rehabilitation and palliative care. With reference to older persons, the WHO recognises the continuum of care as an integrated system of services designed to meet evolving physical, cognitive and social needs over time. It focuses on transition between different levels of care—from independent living and in-home support to skilled nursing and hospice—promoting maximum independence and well-being. In order to live with growing physical, emotional and mental frailties, there is an urgent need for support services.

Whether it is caring for children or older persons, it is assumed that the family is responsible and within families it is women who bear the burden of caregiving. The growing nuclearisation of families due to migration and urbanisation has produced enormous stress on the structures for care. As a result, there is a growing 'felt need' for support and care in the home, largely owing to the prevalence of long-term conditions among older persons.

There is a shortfall in the provision of public health services and social care for the elderly. In the absence of public services, the market has responded to the growing demand by offering a wide range and variable quality of services that are at present unregulated.

This policy paper situates home-based care in India's health and social care landscape to examine the role of different ministries of the Central government and the private sector in provision of services. It provides a landscape of the programmes and services offered by the health and social welfare ministries for older persons. In addition, the authors provide insights into schemes at the state level that cater to the health needs and social care requirements, including targeted pension schemes and legal protection for older persons. The weakness in public provisioning of social protection and care services has resulted in the growth of markets. Care workers are hired directly by families or through placement agencies, nursing bureaus, hospitals, home healthcare companies and not-for-profit organisations, among others. The more organised ones among these train their workers and have a multidisciplinary team to attend to varied needs, including specialised nursing, palliative and end-of-life care at home. However, in the absence of any standards and regulations, the availability, accessibility, affordability and quality of services vary across states and locations. Home-based workers are poorly paid and overworked. The physical and emotional aspects of caregiving has a negative impact on the health and well-being of the care worker.

An important aspect that the paper addresses is the gap in skilling and certification of home-based workers. The lack of basic standards and skill set requirements for home-based care has resulted in the variable quality of services. As the authors observe:

> There is no unified registry, accreditation system or standardised career pathway for home-based caregivers. Upskilling and continuing education opportunities remain limited. Even organised private providers rely heavily on contract-based or gig workers, which limits job security and long-term engagement. Home care providers are often employed informally without any employment benefits (pp. 15–16).

The variable quality of services is attributable to the lack of regulation. The authors address this aspect in great detail. The regulatory landscape is fragmented and weak. For example, the Clinical Establishments Act 2010 does not cover healthcare delivered at home. Given the weak uptake of this Act for the private health sector by state governments, there is little hope of expanding its scope to include home-based healthcare. There have been legal initiatives by the Social Justice Department for addressing the regulation of home-based care, however these are still pending in Parliament.

The authors discuss the policy challenges in delivering healthcare at home in detail. The major challenges are the lack of availability of trained providers, poor working conditions of care workers, lack of safety for providers and recipients of services, lack of job security and benefits for workers and the cost of home-based care.

The Indian government is increasingly realising the need for developing an ecosystem for care for the young and the old. This is largely due to the desire to increase female workforce participation, as we aspire to be counted as an emerging economy globally. It would be worthwhile to study home-based care models from East Asia—their financing, provision and regulation. Within India, there have been public-sector innovations for integrating health and social

care in Kerala and Tamil Nadu. These models could be further expanded to see the role for private-sector engagement and its regulation.

In short, what we need is a comprehensive policy that defines the care ecosystem from a life course perspective. Emphasis ought to be laid on assessing the care needs, mapping the service landscape, and prescribing policy direction to meet the country's caregiving needs. An inter-ministerial committee of the Ministry of Women and Child Development, Ministry of Health and Family Welfare, Ministry of Labour and Employment, Ministry of Social Justice and Empowerment and the Ministry of Skill Development and Entrepreneurship would be ideal to initiate the process. We hope that the paper provides the basis for a meaningful policy dialogue to enable the prevalence and promotion of quality services that ensure dignity and support to older persons in India.

RAMA V. BARU

ADDING LIFE TO YEARS

Building Care Systems for a Life of Dignity and Quality

1. INTRODUCTION

With rising life expectancy in India, the public health question is no longer how long Indians live, but how well they age, with independence, dignity and quality of life. As per the *Sample Registration System (SRS) Statistical Report 2021*, life expectancy at birth in India is 69.8 years—68.2 years for males and 71.6 years for females (GoI, 2021). Coupled with a declining fertility rate, it is leading to a significant demographic transition. Every fifth Indian is projected to be over the age of 60 years by 2050, making up 20% of the total population. This means tripling of the older population (people aged 60+) from nearly 100 million currently to more than 300 million in the next 25 years (UNPFA and IIPS, 2023). This will also make India home to the second-largest older population, behind China, in the world. Data suggests that the old-age dependency ratio, that is, the number of older persons (aged 60 years and above) compared to every 100 working-age group persons (aged 15 to 59 years), is expected to rise from 9.5 in 1950 to 31.5 by 2050 (IIPS and NPHCE, 2020). This rise reflects an expanding share of older persons and rising caregiving demand on their families and the health system. The ageing index, that is the number of elderly persons (aged 65 years and above) per 100 children (aged 0–14 years), too is projected to increase

sharply from 8.4 in 1950 to 74.5 by 2050, indicating a narrowing base of younger population and higher demand for caregiving, age-appropriate health and social services, and financial security (ibid.). India is also experiencing the phenomenon of feminisation of ageing, that is older women outnumbering their male counterparts. The sex ratio among older persons (60 years and above) is 1,065 females per 1,000 males, indicating that older women may be living alone and dependent on their families for support (PIB, 2025).

In India, traditional family support systems are weakening due to reduction in household size, urbanisation and migration. Therefore, there is a felt need to reorganise the care system such that medical, functional and social needs of older persons can be appropriately addressed. According to a NITI Aayog report, three in four older persons (75%) have one or more chronic diseases and nearly one in four older Indians (23.3%) suffers from multimorbidity, i.e., a person living with two or more illnesses simultaneously (NITI Aayog, 2024). The *Longitudinal Ageing Study in India* (*LASI*) underscores the growing prevalence of neurodegenerative and non-communicable diseases among people aged 60 and above. The prevalence of heart disease, stroke, diabetes mellitus, chronic lung disease, and neurological problems such as Parkinson's disease are higher among older men; whereas older women are more likely to be diagnosed with hypertension, anaemia, bronchitis, depression, Alzheimer's disease, dementia and bone/joint disease. Malnutrition, a condition often ignored among older people, coexists with overweight and obesity, as more than 27% of older persons are underweight, 22% are overweight/obese and 4.7% are anaemic (IIPS and NPHCE, 2020).

Around 50% of older persons experience mobility restrictions, with 24% reporting limitations in

Activities of Daily Living (ADL), which includes routine self-care activities such as changing position from sitting to standing, walking, feeding, personal hygiene, etc.; and 48% reporting limitations in Instrumental Activities of Daily Living (IADL), which refers to tasks that are necessary for independent functioning though not necessarily related to the fundamental functioning of a person, such as cooking, shopping, making a telephone call, taking medications and getting around to nearby places (Gupta and Randhawa, 2023; IIPS and NPHCE, 2020).

Beyond medical and functional needs, older Indians increasingly grapple with social isolation, neglect and lack of companionship. As the traditional family support system weakens, living arrangements among older persons are shifting significantly. About 66% live with their spouse, either with or without their children or other relatives, about 28% live with their children but without a spouse and nearly 6% of older individuals live alone, particularly older women (IIPS and NPHCE, 2020).

The *Longitudinal Ageing Study in India* (*LASI, 2017–18*) states that 70% of older persons depend on others for daily maintenance and 78% live without any pension cover. Access to welfare schemes remains limited: only 18% are covered under any health insurance, 24% face challenges in providing documents to avail services and barely 12% are aware of the Maintenance and Welfare of Parents and Senior Citizens Act, 2007. Moreover, 5% of older persons reported experiencing abuse, which can be physical, psychological, financial or sexual, with older women in rural areas being especially at risk (IIPS and NPHCE, 2020).

The care needs of older persons lie on a continuum of *functional care* (ADL/IADL support, rehabilitation, preventive services), *social care* (community inclusion, financial protection and

safe living environments) and *medical care* (chronic disease, palliative and geriatric management), often oscillating between the three. Traditionally, intergenerational caregiving within families has been the mainstay of long-term care in India.[1] Indians overwhelmingly prefer to age in their own homes or familiar environments rather than institutional facilities. However, with changing household structures, families are not always able to provide the required care and may need external support. Home-based care is an emerging phenomenon in India, which is gaining popularity due to demographic, epidemiological and sociocultural changes. The COVID–19 pandemic further underscored the potential of home-based care. However, the sector remains largely urban-centric and unaffordable for most, highlighting the need for inclusive policy frameworks that bridge the gap between private innovation and public provision.

This paper situates home-based care within India's health and social care landscape, examining the roles of different Central ministries and the private sector in providing services for older persons. It explores the skilling and certification pathways for care providers, the regulatory mechanisms governing home-based care (or lack thereof), and the policy and implementation challenges in ensuring accessible, affordable and quality care at home. The paper is based on a desk review of secondary sources available in the public domain, including published literature, grey literature, policy documents and media articles. Key data sources include government reports such as the *Longitudinal Ageing Study in India* (*LASI, 2017–18*), NITI Aayog's *Senior Care Reforms in India* (2024), as well as operational guidelines and policy documents of the Ministry of Social Justice and Empowerment (MoSJE) and the Ministry of Health and Family Welfare (MoHFW). Insights are drawn

from state-level models, legislations and audit reports to understand the spectrum of services for older persons and the expanding role of home-based care. Findings of a primary study, titled *Home Healthcare: Emerging Phenomenon in India*, conducted by the authors to understand the need, scope, barriers and opportunities in delivering healthcare services at home in 2022, have also been referred to. The study comprised in-depth interviews with 24 key informants, and consultations with 16 experts and key stakeholders, such as users and providers of home healthcare, representatives of organisations that deliver such services, conduct vocational training of providers, or accredit home healthcare companies, government representatives, non-government organisations, researchers and academicians (Gupta and Randhawa, 2023).

2. SPECTRUM OF CARE SERVICES FOR OLDER PERSONS

A shift from disease-oriented to function-oriented healthcare is vital to enable people to age with independence and dignity. In India, the evolving needs of older persons are being addressed through a combination of government programmes and schemes, and a growing private sector that offers senior living communities and home-based care for older persons.

The Indian government has introduced various policies, programmes and action plans for the welfare of the older population, which are implemented mainly through the MoSJE, the MoHFW, and the Ministry of Skill Development and Entrepreneurship (MoSDE).

Some Key Central and State Government Initiatives

The MoHFW is the nodal ministry for delivering primary, secondary and tertiary care services to older persons, along with provision of health insurance.

MoHFW's National Programme for the Health Care of the Elderly (NPHCE) delivers primary and secondary health services for older persons through public health facilities, ranging from sub-centres to district hospitals. It also organises outreach camps for geriatric services and provides home visits to bedridden and home-bound older persons (GoI, 2011). For instance, in Chhattisgarh, primary care for older persons under the NPHCE is delivered through the *Siyan Jatan Clinic* organised monthly at Ayushman Arogya Mandirs (GoI, 2024). These clinics provide older adults with health cards for continuity of care, distribute assistive devices such as spectacles and walking sticks and provide specialist services along with wellness activities like yoga. Tertiary-level institutional services are delivered through designated Regional Geriatric Centres and National Centre for Ageing. The National Programme for Palliative Care (NPPC) is another example, that provides domiciliary and institutional support for bedridden older persons, including those in need of palliative care (GoI, 2017). However, findings from the recent MoHFW's Common Review Mission (CRM) reports and Comptroller and Auditor General of India (CAG) reports from states such as Odisha and Haryana highlight implementation gaps in the NPHCE. The programme continues to be underfunded, with low fund utilisation, inconsistent implementation across states and inadequate IEC efforts (Government of Haryana, 2024; Government of Odisha, 2024).

Complementing the MoHFW's efforts, the MoSDE and MoSJE play an active role in building a trained workforce for geriatric care and long-term care. The MoSDE, through councils under the National Skill Development Corporation (NSDC), and the MoSJE, through the National Institute of Social Defence (NISD), are strengthening the caregiving framework by training a workforce of geriatric care aides and domestic aides capable of supporting

older adults at home and in institutions (Gupta and Randhawa, 2023). Specifically through the Skill India Mission, the MoSDE is developing a cadre of caregivers and health aides to meet the growing demand for professional geriatric services. It also collaborates with the MoSJE under initiatives such as Elderline[2] and for developing training modules to build a cadre of professionally trained caregivers including geriatric care aides or assistants, nursing aides and home health aides.[3]

The MoSJE serves as the nodal ministry responsible for ensuring senior citizens live a healthy, happy, empowered, dignified and self-reliant life. Its flagship scheme *Atal Vayo Abhyuday Yojana* (formerly National Action Plan for Senior Citizens) aims to improve the welfare and well-being of senior citizens.[4] This is implemented mainly through the *Rashtriya Vayoshri Yojana*, which provides free assistive devices like wheelchairs, hearing aids and walking sticks to senior citizens from BPL households; and the Integrated Programme for Senior Citizens, which funds old-age homes, continuous care homes, mobile medical units and physiotherapy clinics.[5] Despite these efforts, implementation gaps persist due to limited coverage, funding shortfalls, delays and low awareness among seniors (Tripathi, 2022; Sekhar, 2022).

The Ministry of Housing and Urban Affairs (MoHUA) is working to make Indian cities more age-friendly and inclusive. It released *Model Guidelines for the Development and Regulation of Retirement Homes* to promote safe and comfortable housing for older persons, helping them live independently and with dignity (MoHUA, 2019). Through the Smart Cities Mission, which covers about 100 cities, MoHUA aimed to make public spaces safer and more accessible for everyone, including senior citizens. The city of Kochi in Kerala, member of the

WHO Global Network for Age-Friendly Cities and Communities, serves as a model for age-friendly urban features such as barrier-free walkways, accessible public transport and inclusive parks (WHO, 2024). However, these initiatives remain limited and unevenly implemented across cities. Japan's Nagayama model shows how friendly and supportive neighbourhoods can help older persons live comfortably in their own homes and communities. It brings together healthcare, social support and local activities so that seniors stay connected, active and cared for in familiar surroundings (Thang et al., 2023).

Financial protection is central to enabling older persons to age with dignity. The Ministry of Rural Development (MoRD) under its National Social Assistance Programme, supports older people through the Indira Gandhi National Old Age Pension Scheme, which provides monthly pensions to eligible senior citizens aged 60 and above and the Annapurna Scheme, which offers free food grains each month to those not receiving a pension. However, challenges persist, including limited identification and coverage of older persons. Further, the Central government's pension contribution has not been adjusted for inflation or rising living costs (PRS Legislative Research, 2014). The public health insurance scheme of the MoHFW, Pradhan Mantri Jan Arogya Yojana (PMJAY), primarily covers inpatient hospitalisation. While the scheme has expanded to include all seniors aged 70 years and above with coverage up to ₹5 lakh per year, outpatient, home-based, and long-term care remain largely unfunded; it continues to exclude older persons between 60–69 years. This leaves households exposed to high out-of-pocket expenditures, particularly for chronic disease management, rehabilitation and palliative care. Delays in hospital reimbursements and limited participation of

empanelled private healthcare providers further compromise access (Marathe et al., 2025).

The 'Maintenance and Welfare of Parents and Senior Citizens Act, 2007' is a pertinent legislation that creates the core legal framework for maintenance, old-age homes, medical support, protection of life and property, and penalties for abandonment. It defines 'maintenance' to include food, clothing, residence and medical care, and lets a senior citizen (age 60+ years) or parent claim maintenance allowance before a Maintenance Tribunal.[6] Besides the Central Act which applies to all states and UTs, some states have enacted their own legislation. The first to do so, even before the Central Act came into being, was Himachal Pradesh. The 'Himachal Pradesh Maintenance of Parents and Dependants Act, 2001' became the basis for the Central Act.[7] Assam enacted the 'Assam Employees' Parent Responsibility and Norms for Accountability and Monitoring Act, 2017', that makes employees of the Assam government and certain government-controlled bodies financially responsible for their dependent parents and disabled siblings (Government of Assam, 2017). The 'Telangana Employees Accountability and Monitoring of Parental Support Act, 2026' passed by the State Assembly in March 2026 authorises parents to claim a specified portion of their employed children's monthly salary if they are not financially secure (Sudhir, 2026).

Certain state-led programmes demonstrate how community-based approaches can be integrated with institutional care through timely referral and follow-up care. Kerala has pioneered several such models, integrating health and social support for older persons. The *Vayomithram* project delivers free check-ups, palliative care and counselling through mobile clinics, while the *Saantwanam* programme deploys trained women health workers to households

for NCD screening and follow-up, strengthening early detection and reducing catastrophic spending. Community-based initiatives such as Elder Self-Help Groups and the *Harsham Geriatric Care* project provide companionship, daily living assistance and basic home-based medical care, physiotherapy, wound dressing and oral administration of drugs, showcasing how social sector engagement can complement formal health services. Kerala is the first state to develop a state palliative care policy and programme. The policy recommends home visits by trained personnel, that is, doctors, nurses and allied health professionals for chronically sick or at-end-of-life-stage patients, depending on their condition (Government of Kerala, 2019). The palliative care programme, implemented jointly by the local self-government (LSG) and the health department, involves a home visit once or twice a month by the nursing staff (Government of Kerala, 2022).

The *Makkalai Thedi Maruthuvam* scheme, a flagship programme of the Government of Tamil Nadu offers a comprehensive model integrating community and institutional interventions to ensure continuity of care focusing on non-communicable diseases. Through doorstep delivery of medicines, physiotherapy, palliative care and regular screening, the scheme addresses preventive, promotive and chronic care needs, especially for older adults with functional limitations and multimorbidity. By leveraging women health volunteers, palliative staff nurses and population health registry, it demonstrates effective linkage between primary care, tertiary referral and community support.[8] Such community-based interventions also promote social inclusion, companionship and mental well-being, while integrating health monitoring and homecare services (Dakua et al., 2023).

3. HOME-BASED CARE FOR OLDER PERSONS

In response to India's rising older population, varying degrees of functional, social and medical care are provided at home by the rapidly expanding private home care sector. To define, home-based care is conceived of as services provided to someone in their home that enable them to maintain their health, quality of life and independence. In the Indian context, home care has been defined as 'users and patients of any age group, with any medical condition who use services at home which may be preventive, promotive, intensive care, rehabilitation care, palliative care, post-surgical/post-hospitalisation care, along with assistance with daily living activities, or diagnostic services' (Gupta et al., 2023). The home-based care market in India, valued at USD 8.8 billion in 2022, is projected to grow at a CAGR of 19.29% between 2023 and 2030.[9] Market drivers include the rising geriatric population, rising prevalence of lifestyle-related diseases, post-operative care needs, and the convenience of technology-enabled platforms.

The range of services provided at home comprise the most used ADL/ IADL assistance along with routine nursing care services such as monitoring of vitals, dressing of wounds and bedsores, intravenous or intramuscular injections, etc. There is a growing provision of post-surgical care, intensive care monitoring and stabilisation services through a hospital-like environment at home, palliative care, chronic disease management and physiotherapy services at home. The services are offered by individual providers independently as well as through organisations such as hospitals, home healthcare companies, non-profit organisations and nursing bureaus, among others (see Table 1).

In the sections that follow, we delve into the skilling and certification of care providers, regulation of services, and highlight the gaps and policy challenges in offering care services at home (see Table 2).

Table 1: Spectrum of Home Care Services for Older Persons in India

Type of Care	Functional and Social Care Services	Functional and Social Care Services	Functional, Social and Medical Care Services	Medical Care Services	Medical Care Services
Type of Providers	Mostly Family-based services	Community-Based Outreach and Domiciliary Support Workers; Not registered with any Professional Council	Trained non-medical aides; Not registered with any Professional Council	Nursing and Allied professionals; Registered with Professional Councils	Medical professionals and Specialists; Registered with Professional Councils
Examples of Providers	1. Family members such as spouse, children, siblings, or extended family members 2. Untrained domestic help assisting with day-to-day tasks	1. Community-based workers and volunteers under the Government (mostly ASHAs) and NGO programmes 2. Domiciliary visits or outreach through community platforms such as Self-Help Groups (SHGs) or Mahila Arogya Samitis (MAS)	1. Geriatric Care Aides/Assistants certified by Health Sector Skill Council (NSDC) 2. Home Health Aides, General Duty Assistants, and Nursing Assistants certified by Health Sector Skill Council (NSDC) 3. Trained domestic aides certified by the Home	1. Nurses (ANMs, GNMs, B.Sc. Nursing, Post B.Sc.) providing routine and geriatric nursing care 2. Allied Healthcare professionals such as physiotherapists, nutritionists, dietitians offering rehabilitative and supportive services	1. Medical doctors providing dedicated outpatient and inpatient care 2. Specialists trained through postgraduate Diplomas in Geriatric and Palliative care

			Management and Care Givers Sector Skill Council (NSDC) 4. NISD-trained frontline workers offering daily living assistance and emotional support		3. Dedicated Geriatric Wards and Regional Centres of Ageing under NPHCE
Scope of Service	Personal care assistance in the form of Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)	Community-level outreach, home visits and social or health support for older persons	ADL & IADL along with basic medical care tailored to geriatric needs	Routine nursing, paramedical, and rehabilitative care	Comprehensive medical and specialised geriatric care
Nature of Services	Assistance with bathing, feeding, mobility, cooking, cleaning and companionship	Identification of older persons needing care; Home visits; Linking to health and social services	Assistance with bathing, feeding, cleaning wounds, emotional well-being, vitals' monitoring (blood pressure, blood sugar), and medication intake	Basic patient care, medication support, mobility aid, wound dressing, physiotherapy	Outpatient and Inpatient geriatric care, disease management, palliative and cognitive support

Skilling and Certification of Care Providers

Care providers at home include professionally trained providers such as nurses (ANMs, GNMs, BSc Nursing) and allied professionals like physiotherapists, dietitians and occupational therapists who are important in managing chronic diseases, rehabilitation and palliative care for older persons. Specialist training in geriatrics remains limited, with only a few MD programmes at National Medical Commission-recognised medical colleges and distance-learning diplomas from institutions like IGNOU. With roughly 20 geriatricians trained annually for a population of 100 million older adults, the specialist workforce gap is significant in the country (Salagre et al., 2022). However, the largest proportion of care services at home is offered by trained aides who undergo varying types of vocational training, and a large pool of untrained workers who provide daily assistance.

'General Duty Attendants (GDAs) are medically trained and certified, they monitor blood pressure, check blood sugar, measure intake-output, give insulin injections and medication, but are not trained for other injectables,' says the head of a hospital's home care programme (Gupta and Randhawa, 2023: 21). Unlike professionally trained medical providers, trained aides such as GDAs, home health aides, geriatric care aides, home health assistants are trained to offer functional care (such as assistance with daily living activities and monitoring of vitals) but not medical care like surgical dressing, oxygen administration, catheterisation, Ryle's tube insertion, and handling of patients on ventilators, in emergency or in need of critical care. Vocational training courses are designed to generate an employable cadre trained to meet the functional needs of older persons. The ministries of Skill Development and Entrepreneurship, Social Justice and Empowerment, and Health and Family Welfare of the Government

of India, offer vocational courses of similar nature through their respective institutes. For instance, the Health Sector Skill Council (HSSC) and the Home Management and Caregiver Sector Skill Council (HMCSC) under MoSDE's National Skill Development Corporation (NSDC) define qualification standards to equip caregivers with standardised competencies, covering areas such as basic patient care, mobility support, hygiene management and communication skills. The MoSJE, through the National Institute of Social Defence provides certified training for workers to assist with hygiene, mobility, nutrition and emotional support.

Additionally, state governments, state medical universities and private organisations (for-profit and not-for-profit) also conduct such vocational courses with different eligibility requirements and course duration. The private organisations may not necessarily be affiliated with or recognised by the government. Some private organisations that offer home care services conduct their in-house induction training, which may range from a few hours to 14 days and could even go up to three or six months. It may include classroom sessions and on-site practical training as understudies (Gupta and Randhawa, 2023).

However, the training landscape remains fragmented with programmes operating in isolation and distributed unevenly across the country, leaving rural areas particularly underserved. Upskilling opportunities are limited, even though evidence demonstrates that expanding caregivers' competencies in dementia care, palliative care and reablement could improve safety and quality of life for older adults (Morrow et al., 2024).

There is no unified registry, accreditation system or standardised career pathway for home-based caregivers. Upskilling and continuing

education opportunities remain limited. Even organised private providers rely heavily on contract-based or gig workers, which limits job security and long-term engagement. Home care providers are often employed informally without any employment benefits. The growing reliance on home-based care models has brought the spotlight on the availability and preparedness of a skilled and reliable workforce, which is important in ensuring quality, safety and continuity of care for older persons. The current home-based care workforce faces multiple structural and operational gaps that limit quality, reach and sustainability (Gupta et al., 2023). Most caregivers remain in the informal sector, often without certification, benefits, or defined job roles (Gupta and Randhawa, 2023; Gupta et al., 2023).

Regulation of Home Care Services

Currently, care services at home have minimal regulation in India. The organisations that offer home care services are registered under regulations such as the Companies Act, 2013, the Societies Registration Act, 1860, or the Shops and Establishments Act, 1954. Such registration merely grants the organisations a legal status to operate in the country but does little to regulate the delivery of home care services. It is interesting to note that the Clinical Establishments (Registration and Regulation) Act, 2010, does not regulate healthcare services offered at home. Some organisations operate without any legal standing, especially those that provide domestic workers who double up as care workers for older persons in the household.

The amendment proposed through the Maintenance and Welfare of Parents and Senior Citizens (Amendment) Bill, 2019, is a step towards regulating home-based care. The Bill aims to improve the maintenance and welfare of senior citizens and

provide standardisation of home care services. In response to the questions raised by the Standing Committee on the 2019 Bill, the MoSJE stated, 'Home care services can have a very large scope – Home healthcare aides, diagnostics, doctor visits, physiotherapy services, food and nutrition and food supply, dialysis, terminal (end of life) care, counselling and emotional support to such senior citizens' (MoSJE, 2021). The Bill also proposes the registration of institutions providing home care services for senior citizens and prescribing minimum standards for them. The Department of Social Justice and Empowerment published model draft rules for home care and hospice care in June 2022 (MoSJE, 2022). The rules list minimum standards for home care organisations to register. Once the Bill is passed, it will be up to the states to implement it and draft their own rules, which may be informed by the model rules. Similarly, the Elder Persons (Care and Protection) Bill, 2024 (Private Member Bill) seeks to protect older persons' rights, including financial autonomy, protection from abuse and access to specialised care. Notably, Chapter VI, Clause 12 addresses caregiver rights and proposes the establishment of National and State Elder Commissions to oversee implementation.[10] However, neither of the Bills has yet been passed by the Parliament.

In the absence of any standards and regulations, some organisations have opted for accreditation, introducing voluntary quality checks in the home care sector. The Quality and Accreditation Institute (QAI), a private healthcare and laboratory accreditation body, has granted accreditation to eight home care companies so far, but as of April 2026, only three retained valid accreditation.[11]

At the state level, the Kerala State Elderly Commission Act, 2025 prescribes the establishment of an Elderly Commission to provide guidelines,

implement welfare schemes, rehabilitate older persons and leverage their skills for public benefit; becoming the first Indian State to establish a regulatory commission to protect the rights of older persons (Government of Kerala, 2025).

Gaps and Policy Challenges in Offering Care Services at Home

NATHEALTH, a federation of private healthcare providers in India, estimates that the homecare sector could create 2.6 to 3.1 million jobs by 2025, while recognising that most of the workforce remains in the unorganised sector (NATHEALTH, 2022). The rapid growth of home care in a largely informal and unregulated environment raises questions about quality, safety, affordability and workforce preparedness.

Inadequate providers: There is a lack of trained providers with appropriate attitude and aptitude required to offer care to older persons in their home for long hours. Often the providers are either untrained or poorly trained. The training ecosystem lacks uniformity and standardisation with training programmes varying in quality and duration. Irregularities such as fake attendance, ghost trainees and inflated billing were found in NSDC's flagship livelihoods training programme, *Pradhan Mantri Kaushal Vikas Yojana*. As a result, 178 training partners were blacklisted in 2025 on alleged corruption charges (Sarin, 2025). The mismatch between job roles and candidates' expectations is another reason for the high dropout rate post-training. Care services for older persons with conditions such as dementia, Alzheimer's disease or Parkinson's disease are particularly scarce in India (Sinha et al., 2020).

Poor working conditions: Safety of providers at users' homes is a concern. Incidents of physical and sexual abuse were reported by both male and female

providers. Sometimes, the families ill-treat or harass the providers, insisting that they be available round-the-clock and reluctant to give them time off even for a short period without a replacement. The care providers are expected to assist in household chores, kitchen work or market-related work. Other concerns are related to the families' discriminatory behaviour such as asking providers to use toilets outside the home, restricting the use of certain utensils, not offering freshly cooked food or adequate meals in case of 12- or 24-hour shifts (Gupta and Randhawa, 2023).

Lack of job security and opportunities for career progression: Most care providers, whether employed directly or through an organisation work on a daily wage basis. They are not entitled to employment benefits such as fixed salary, paid leave, provident fund, health insurance, etc. Though some home healthcare companies began their operations with a permanent staff model, they shifted to hiring majority providers on-demand for reasons of sustainability, legal liability and increasing operational costs. The head of a hospital's home care programme shared,

> We cannot have more staff on our rolls, then we have to follow PF, ESI, need to give paid leave, etc., our charges will then increase. We have 10–15 nurses working through a vendor. We recruit them, train them and hand them over to the vendor who provides uniforms and maintains all records. The vendor takes about 10 per cent commission (Gupta and Randhawa, 2023: 25).

Further, there are few opportunities for career progression as care providers. Some organisations may promote their permanent staff to the supervisory cadre. The other option is to migrate to other countries that offer higher remuneration, for instance

the Government of Japan's 'Specified Skilled Worker' programme.[12]

Safety of service users: Usually, there is no written documentation between the users and the care providers, rather it is based on mutual understanding and trust. Some organisations verify the providers' identity and educational background and facilitate their police verification before deploying them. However, the organisations take little responsibility for the providers' conduct and absolve themselves of the same in the written contract with the users. A couple of incidents of theft at users' homes were also reported. To protect against such incidents, organisations may opt for Professional Indemnity Insurance and Fidelity Guarantee Insurance, but few do so. There are no specific grievance redressal mechanisms for home care users (Gupta and Randhawa, 2023).

Affordability of home care services: Bulk of care services at home are provided by the private, for-profit sector, which limits its use to a small proportion of the population who can afford them. There are almost no government programmes or schemes that offer subsidised care or financial assistance to avail care at home. The coverage of home care services under health insurance is confined to certain conditions. Services such as specialised nursing, medication, diagnostics, and physiotherapy sessions are covered for 30 to 60 days, post-hospitalisation, based on the doctor's prescription. Disease-specific coverage is available, for example, in the case of dengue, COVID–19, or chikungunya but it is usually only for 3–4 days of home care and for a limited amount. Since these services generally go on for longer, effectively they are as good as not covered.

Management of biomedical waste (BMW): A concern in home healthcare is the disposal of BMW. In most cases, the biomedical waste generated at

home is disposed of along with the regular household waste. Care services at home are not recognised as 'healthcare' or any other such service that fall within the purview of the Pollution Control Board which is responsible for ensuring BMW management. Besides, a practical challenge is the collection of BMW waste from homes as the collection agency is unlikely to visit hundreds of individual homes.

Table 2: SWOT Analysis of Home Care Services for Older Persons

Strengths	**Weakness**
• Growing recognition of geriatric care as a national priority • Expanding cadre of providers and private sector engagement • Emerging skill-building initiatives (HSSC, NISD, IGNOU). • Technology platforms for service delivery and monitoring	• Workforce is concentrated in urban areas • Shortage of trained and certified caregivers, including geriatric specialists • Low wages, high attrition and limited job security and career progression avenues • Lack of standardised processes. • Weak regulatory and accreditation mechanisms; limited integration with health system
Opportunities	**Threats**
• Growing demand for home care services • Availability of a young workforce that can be equipped to meet the rising demand • Technological advancements that enable expansion of home-based services through telehealth platforms, point-of-care devices, and digital tools for training, supervision, and coordination.	• Continued dependence on untrained caregivers • Quality and safety risks for users due to weak oversight • Caregiver exploitation and burnout • Financial inequities due to out-of-pocket costs may lead to suboptimal use of home care services

Lack of regulations and standardisation: There is no regulation of the home care sector with regard to the qualification of providers, their job roles, standard treatment protocols (SOPs), costing, safety and grievance redressal mechanism for both users and providers. Though some organisations have developed their own SOPs, there are no minimum common mandatory standards to be followed universally. Unaware of what to expect from home care services, both the users and providers are unable to demand accountability from each other.

4. CONCLUSION AND RECOMMENDATIONS

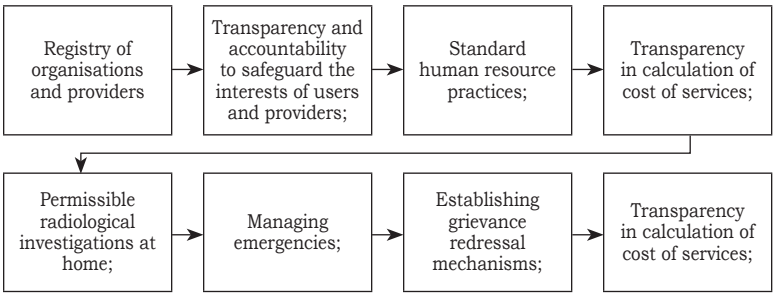
Globally, countries with well-established homecare systems, such as Sweden, Ireland, Germany, Japan and South Korea, faced similar challenges as India around workforce retention, regulation, and financing. Their experience highlights the need for structured training pathways, accreditation of providers, adoption of standardised processes and integration of home healthcare into the formal health system to reduce fragmentation and inequities (Morrow et al., 2024). Furthermore, India could gain from the experience of countries such as Japan, China and Thailand in promoting community-based solutions to offer integrated care to older persons (ADB, 2020; Thang et al., 2023; Chen et al., 2024). Building on the growing demand for geriatric care and increasing scope of home-based care in India, the following measures are recommended to comprehensively address the functional, social and medical needs of older persons:

1. Promote an integrated care model that brings together functional, social and medical care services as a continuum of care. Social well-being of older persons is as critical as their functional and medical condition.

Beyond disease management and functional support, ageing well requires inclusion, companionship, protection from neglect and financial security. Examples such as Kerala's *Vayomithram* and Tamil Nadu's *Makkalai Thedi Maruthuvam* demonstrate how partnership between the public system and the community can deliver comprehensive care to elderly populations close to where they live. States could encourage hybrid models involving public institutions, private providers, and community-based organisations to deploy integrated teams of doctors, nurses, physiotherapists, counsellors and care workers.

2. Develop a comprehensive policy on home care for older persons. A policy document outlining the vision for home care is vital to recognise it as a formal mode of delivering care. The policy needs to incorporate aspects like creating a registry of organisations and providers of such services; ensuring transparency and accountability in the provision of services to safeguard the interests of users and providers; adopting standard human resource practices; transparency in the calculation of cost of services; permissible radiological investigations at home; managing emergencies; establishing grievance redressal mechanisms; biomedical waste management; insurance coverage, among others (see Figure 1). Particular attention needs to be paid to the requirements of single older women who are likely to outnumber older men in the coming years.
3. Develop a National Elder Care Workforce Framework to define standards for training, certification and career pathways across

Figure 1: Aspects to be Considered for a Comprehensive Policy on Home Care for Older Persons



all cadres, while ensuring continuous professional development, fair wages and social protection for care workers.

4. Recognise 'home' as a place for providing care and as a 'place of work' for care providers. This is crucial to legitimise home care as a formal mode of service delivery. It has implications for the rights and safety of users and providers. The fact that Insurance Regulatory and Development Authority of India (IRDAI) and insurance companies acknowledge domiciliary care under certain conditions supports such a step. The MoHFW may call for stakeholder consultations and form an expert group for preparing a Model Bill to recognise and regulate home care. The states could then adapt the Bill according to their context.
5. Develop standardised processes to deliver care for different conditions at home, and protocols specific to the type of care such as elder care, intensive care, palliative care, dialysis, assistance with daily living activities, etc., as each has distinct requirements. The MoHFW could develop such protocols as an extension of the standard treatment guidelines it has already prepared.[13]

6. Integrate home-based elder care systematically within the public health framework through the existing national health programmes and implement it through primary health facilities (Ayushman Arogya Mandirs). Integration with digital health systems such as Ayushman Bharat Digital Mission (ABDM) would facilitate interoperable electronic health records, remote monitoring and follow-up through eSanjeevani, Government of India's teleconsultation programme.
7. There are almost no government programmes or schemes that offer subsidised care or financial assistance to avail care at home. Covering home care services under the public health insurance schemes, such as Government of India's Ayushman Bharat PMJAY would help in reducing inequities and expand the reach of home care services to a larger population.

Notes

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