THE INDIA SENIOR CARE REPORT 2026

Mapping the Ecosystem of Ageing, Healthcare and Housing in India

"Senior care is an ecosystem, not an industry."

PEOPLE
The Senior
At The Centre

PRODUCTS
Where Seniors
Live / Receive Care

SERVICES
What Seniors
Receive

DELIVERY MODELS
How Care
Is Delivered

ENABLING ECOSYSTEM
What Supports
The System

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About This Report

The India Senior Care Report 2026 is an independent, annually updated reference publication examining India's senior care ecosystem — the housing, healthcare, workforce, technology, financing and policy systems that together shape how Indians experience later life.

This report is intended for policymakers, healthcare providers, investors, senior living operators, insurers, researchers, students, journalists and families navigating care decisions. It brings together demographic projections, market data and policy analysis from government, multilateral and industry sources, alongside an original framework developed by NEMA Academy — the Five Pillars of Healthy Ageing — for thinking about what healthy ageing requires beyond medical treatment.

Chapter 8 presents NEMA Academy's own experience building an integrated senior care model in India, offered as a case study for critique and learning rather than as promotional material.

"Senior care is an ecosystem, not an industry."

Every statistic in this report is drawn from a named, publicly available source and referenced in Appendix C. Where credible estimates diverge — as they frequently do in an early-stage, under-researched sector — this report presents the range rather than a single figure, and says so explicitly.

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About NEMA Academy

NEMA Academy, an academic offshoot of NEMA Eldercare is the publisher of this report and, as described in Chapter 8, NEMA Eldercare is an operator of an integrated senior care platform in India. NEMA's stated approach — organising independent senior co-living, assisted living, memory care, home healthcare, caregiver education and an emerging technology marketplace around a single continuum of care — is the practical experience this report draws on in developing two of its central ideas: that senior care functions as an *ecosystem, not an industry*, and the *Five Pillars of Healthy Ageing* framework set out in Chapter 10. Both are presented throughout this report as analytical tools for the sector as a whole, not as descriptions of NEMA specifically.

As of 2026, NEMA's operating platform spans independent senior co-living, assisted living and memory care, home healthcare, and an in-house caregiver-training academy, with a post-operative recovery carehome and a caregiver-marketplace platform (NEMA CareHub) under development; NEMA 38, the post operative recovery carehome is scheduled to launch in October 2026. According to the Association of Senior Living India's (ASLI) public member directory, NEMA Eldercare is among the few member organisations listed across five distinct market segments — co-living, assisted living/memory care, home healthcare, post-acute/rehabilitation and digital platforms — rather than a single line of business (see Appendix A.4).

Chapter 8 presents NEMA's own account of building this model, including its limitations, as a case study for critique rather than promotion. As with every figure and claim in this report, NEMA's self-reported data is clearly labelled as such and has not been independently audited; readers evaluating any senior care provider, including NEMA, should seek independently verified data on outcomes, staffing and pricing before making care decisions.

Foreword

India is ageing faster than almost any large country in history has aged before it. For most of the last seventy years, India's economic story has been a story about the young: a demographic dividend built on a large, growing working-age population. That story is not ending, but a second one is beginning alongside it — the story of a population that, having lived longer and healthier lives than any previous generation of Indians, must now be supported by systems that scarcely exist yet.

This report was commissioned in the belief that India does not yet have a shared, evidence-based vocabulary for talking about senior care. Retirement housing, home healthcare, dementia care, caregiver training and insurance are usually discussed as separate industries, by separate trade bodies, in separate conferences. Families experience them as one continuous, often confusing, journey.

Our aim is to give policymakers, investors, operators and families a common map of that journey — grounded in the best available demographic and market data — and a shared sense of urgency about the decade ahead.

A note on this report's origin: NEMA Academy, its publisher, is an academic offshoot of NEMA Eldercare, an operator in this sector. Chapter 8 presents NEMA's own experience as a case study, offered for critique rather than promotion, and every NEMA-related figure in this report is labelled as self-reported and not independently audited. Further detail on this relationship appears in *About NEMA Academy*, immediately preceding this Foreword.

If this report leaves the reader with one idea, it should be this: senior care is an ecosystem, not an industry. Every chapter that follows — on housing, on services, on delivery models, on policy — is an attempt to make that single idea concrete and actionable.

We do not claim to have final answers. We offer a framework, a set of priorities, and an invitation to an ongoing conversation that this report intends to continue annually.

— Sanjeev Kumar Jain

Promoter, NEMA Academy

How to Read This Report

This report is designed to be read selectively as well as cover to cover. Depending on what brought you here, the following paths may serve you better than a linear read:

Investors and financiers

Start with Chapter 6 (The Indian Senior Care Industry Landscape) for market sizing and segment analysis, then Chapter 5 (Care Delivery Models) for unit economics, and Appendix A for the underlying data.

Families choosing care

Chapters 3–5 (Senior Living Products, Senior Care Services, and Care Delivery Models) describe the practical options available today, in plain language, with their advantages and limitations.

Policymakers and public health officials

Chapters 7–9 (The Future of Senior Care, the NEMA case study, and the National Roadmap) set out the systemic priorities and a phased 2026–2035 agenda, building on India's existing policy framework.

Senior care operators and entrepreneurs

The report is written for you end to end — the ecosystem framework in Chapter 2 is intended as a strategic lens for every subsequent chapter.

Researchers and journalists

Appendix A (Statistics), Appendix B (Glossary) and Appendix C (Methodology and References) are built as standalone reference material, citable independently of the narrative chapters.

Throughout the report, a recurring idea ties every chapter together: senior care is an ecosystem, not an industry. Wherever you start reading, that is the thread to follow.

Executive Summary

India is undergoing one of the fastest and largest demographic transitions of any country in history. In 2022, an estimated 149 million Indians — 10.5% of the population — were aged 60 or above. By 2050, the United Nations Population Fund (UNFPA) and the International Institute for Population Sciences (IIPS) project this will more than double to roughly 347 million people, or 20.8% of the population — meaning one in five Indians will be a senior citizen. India's elderly population is expected to overtake its population of children (aged 0–14) by 2046.

This transition is not evenly distributed. Southern and western states are ageing faster than the national average; the population aged 80 and above is projected to grow by roughly 279% between 2022 and 2050, driven disproportionately by widowed women living with limited financial security. UNFPA data shows more than 40% of India's elderly are in the poorest wealth quintile, and roughly one in five have no personal income at all.

Against this backdrop, India's organised senior care industry — spanning retirement housing, assisted living, memory care, home healthcare, caregiver platforms and insurance — remains small relative to need, but is growing rapidly from a low base. Independent market research firms differ meaningfully in their estimates (a pattern typical of an early-stage, loosely defined sector), but converge on three conclusions: the market is growing at 20–30% annually, current organised supply meets roughly 1–2% of potential demand — Chapter 3's senior-living-specific estimate of 1.3% sits within this range — compared with over 6% in mature markets such as the United States and Australia, and the home healthcare segment is scaling faster than residential senior living.

India's dementia burden is also larger and better documented than commonly assumed. A 2023 nationally representative study using the Longitudinal Ageing Study in India (LASI) estimated that 7.4% of Indians aged 60 and above — roughly 8.8 million people — live with dementia, with higher prevalence among women and in rural areas. This is markedly higher than earlier, smaller-sample estimates from the 2010s, underscoring how recently India has begun to measure this problem accurately.

This report argues that senior care should not be understood as a single industry, but as a four-layer ecosystem — **products** (where seniors live), **services** (what they receive), **delivery models** (how services reach them), and **an enabling ecosystem** of hospitals, insurers, government, civil society, skills institutions and technology. Senior care is an ecosystem, not an industry: that single idea is this report's central argument, and it recurs in every chapter that follows. The 2026 NITI Aayog report on caregiving reinforces a critical part of this argument: India cannot build the care ecosystem it needs without professionalising and strengthening its caregiving workforce.

To make “healthy ageing” concrete rather than aspirational, this report also introduces an original framework, revisited in the concluding chapter: the Five Pillars of Healthy Ageing —

1. Health (preventive, acute and long-term care),
2. Home (safe, age-friendly living environments),

3. Human Connection (family, friendship and community),
4. Hospitality (comfort, dignity and nutrition), and
5. Hope (lifelong learning, independence and optimism).

Chapter 9 proposes an eleven-point national roadmap for 2026–2035 built on this foundation.

The report closes with three data appendices intended to make it useful as a working reference: a statistics compendium, a glossary of senior care terminology, and a transparent account of methodology and sources.

KEY TAKEAWAYS

✓ India's 60+ population will roughly double from ~149 million (2022) to ~347 million (2050) — UNFPA/IIPS.

✓ The 80+ population is projected to grow ~279% between 2022 and 2050, disproportionately among widowed women.

✓ An estimated 8.8 million Indians aged 60+ live with dementia (7.4% prevalence) — LASI-based national estimate, 2023.

✓ Organised senior living and home healthcare markets are growing 20–30% annually but meet only 1–2% of estimated demand (1.3% for senior living specifically).

✓ Senior care is best understood as a four-layer ecosystem, not a single industry.

Chapter 1

India's Silver Economy — The Demographic Transformation Reshaping Healthcare, Housing and Society

1.1 Introduction

India stands at the threshold of one of the most significant demographic transitions in its history.

For decades, the country's economic narrative has been shaped by its youthful population. Today, another equally important story is unfolding. Improvements in healthcare, nutrition, sanitation and living standards have increased life expectancy, while declining fertility rates are steadily changing the country's population structure. The result is a rapidly growing population of older adults whose needs, aspirations and expectations differ markedly from those of previous generations.

Ageing is no longer a niche social issue affecting a limited section of society. It is emerging as one of India's defining economic, healthcare and public policy challenges.

This demographic shift presents a dual reality. On one hand, it places increasing pressure on healthcare systems, families and social infrastructure. On the other, it creates one of the largest long-term economic opportunities of the coming decades — the Silver Economy.

1.2 India's Demographic Transition, in Numbers

India is home to one of the world's fastest-growing ageing populations, and already the world's second-largest in absolute terms.

Indicator	Figure	Source
Population aged 60+ (2022)	~149 million (10.5% of population)	UNFPA / IIPS, India Ageing Report 2023
Population aged 60+ (2024, est.)	~153–157 million	UNFPA; JLL-ASLI, 2024
Projected population aged 60+ (2050)	~347 million (20.8% of population)	UNFPA / IIPS, India Ageing Report 2023
Growth of population aged 80+ (2022–2050)	~279%	UNFPA / IIPS, India Ageing Report 2023
Year elderly population overtakes children (0–14)	2046	UNFPA / IIPS, India Ageing Report 2023
Life expectancy at birth	42.9 years (1960) → 70.4 years (2020)	Registrar General of India, SRS Life Tables
Additional life expectancy at age 60	18.3 years (men); 19.0 years (women)	India Ageing Report 2023, based on LASI

Longer life expectancy represents one of the country's greatest developmental achievements. Yet longevity also changes the pattern of healthcare demand. Older adults are more likely to live with chronic illnesses, require rehabilitation following hospitalisation, experience mobility limitations and

need long-term support. Unlike acute illnesses that can often be treated through a single episode of care, ageing requires continuous and coordinated support extending across many years.

The transition is also gendered. The sex ratio among the elderly has been rising steadily since 1991 as women increasingly outlive men — in central India, for instance, the ratio rose from 973 women per 1,000 men in 2011 to 1,053 in 2021. UNFPA notes this implies a growing population of "widowed and highly dependent very old women," a group facing distinct financial and social vulnerabilities: over 40% of India's elderly sit in the poorest wealth quintile, and roughly one-fifth have no income of their own.

Consequently, India's healthcare system must evolve from a model centred primarily on treating disease to one that supports healthy ageing throughout later life.

1.3 Changing Family Structures

For centuries, Indian families provided care for older parents within the joint family system. Economic development, urbanisation and migration have gradually transformed this model.

Adult children increasingly live in different cities or overseas. Nuclear families have become more common. Dual-income households leave less time for full-time caregiving, even where emotional commitment remains strong.

These changes do not imply that families care less. Rather, they indicate that families increasingly require organised support to complement the care they continue to provide.

Modern senior care therefore should not be viewed as a replacement for families. It should be viewed as an extension of family care.

1.4 Beyond Healthcare

Ageing affects much more than health. It influences housing, urban planning, transportation, financial security, technology, employment, insurance, hospitality, social participation and mental wellbeing.

Consequently, senior care cannot be understood solely as a healthcare industry. It is an ecosystem connecting multiple sectors of the economy.

1.5 Loneliness — The Silent Epidemic

Among the many consequences of demographic change, loneliness remains one of the least visible and least discussed.

Many older adults live independently while family members work elsewhere. Others lose spouses or long-standing social networks. Physical limitations may gradually reduce community participation.

Research increasingly links prolonged loneliness with depression, cognitive decline, reduced physical activity and poorer health outcomes.

This shifts organised senior care beyond medical treatment. Healthcare alone cannot solve loneliness. Community can.

Meaningful engagement, companionship, purposeful activities and opportunities to remain socially connected are increasingly recognised as essential components of healthy ageing.

1.6 The Silver Economy

The growing senior population is creating an entirely new economic sector. Often described as the Silver Economy, it encompasses every product and service designed to improve the quality of life of older adults.

Its scope extends far beyond retirement housing. It includes:

- Healthcare and Home Healthcare
- Assisted Living and Memory Care
- Rehabilitation
- Technology and Digital Health
- Insurance and Financial Services
- Nutrition and Hospitality
- Mobility
- Caregiver Training
- Community Platforms

Collectively, these industries represent one of India's largest emerging long-term markets.

1.7 A New Way of Looking at Senior Care

Historically, organised senior living has been viewed primarily as a real estate sector. Buildings, however, represent only one component of successful ageing.

A thoughtfully designed residence contributes little without compassionate caregivers. Likewise, excellent clinical care alone cannot overcome social isolation.

Healthy ageing requires the integration of housing, healthcare, hospitality, rehabilitation, technology, community engagement and family participation.

This report therefore adopts a broader perspective. Rather than examining isolated services, it explores India's senior care ecosystem as an interconnected system supporting older adults throughout the ageing journey.

Chapter Summary

India's ageing population is reshaping healthcare, housing and society. The emergence of the Silver Economy reflects both a demographic necessity and an economic opportunity. Meeting the needs of older adults will require integrated approaches extending well beyond hospitals or retirement housing.

PUBLISHER'S INSIGHT

India's greatest ageing challenge is not longevity — it is loneliness. For decades, public discourse around ageing has focused on diseases, pensions and healthcare infrastructure. While these remain important, one of the most profound yet under-recognised challenges is social isolation. Organised senior care must therefore be designed not merely to treat illness, but to foster belonging, purpose and meaningful human connection.

— NEMA Academy, Publisher

Chapter 2

Understanding India's Senior Care Ecosystem — Products, Services and the Continuum of Care

Instead of treating senior care as one industry, this report explains that it is an ecosystem with four interconnected layers.

Layer 1 — Products: Where seniors live or receive care

- Retirement Housing
- Independent Living home
- Assisted Living home
- Memory Care home
- Post-operative Recovery home

Layer 2 — Services: What seniors receive

- Nursing
- Home Healthcare
- Physiotherapy
- Rehabilitation
- Hospitality
- Mental Wellbeing
- Nutrition
- Emergency Response

Layer 3 — Delivery Models: How services reach seniors

- Home-based Care
- Residential Communities
- Hospital Outreach
- Digital Platforms
- Caregiver Agencies

Layer 4 — Enabling Ecosystem: What supports the system

- Hospitals
- Insurance
- Technology
- Government
- Skill Development
- NGOs
- Academic Institutions

Confusing products with services leads to poor policy, weak investment decisions and fragmented care. The central idea of this report is that continuity of care — not any single building or service — is what determines outcomes for older adults.

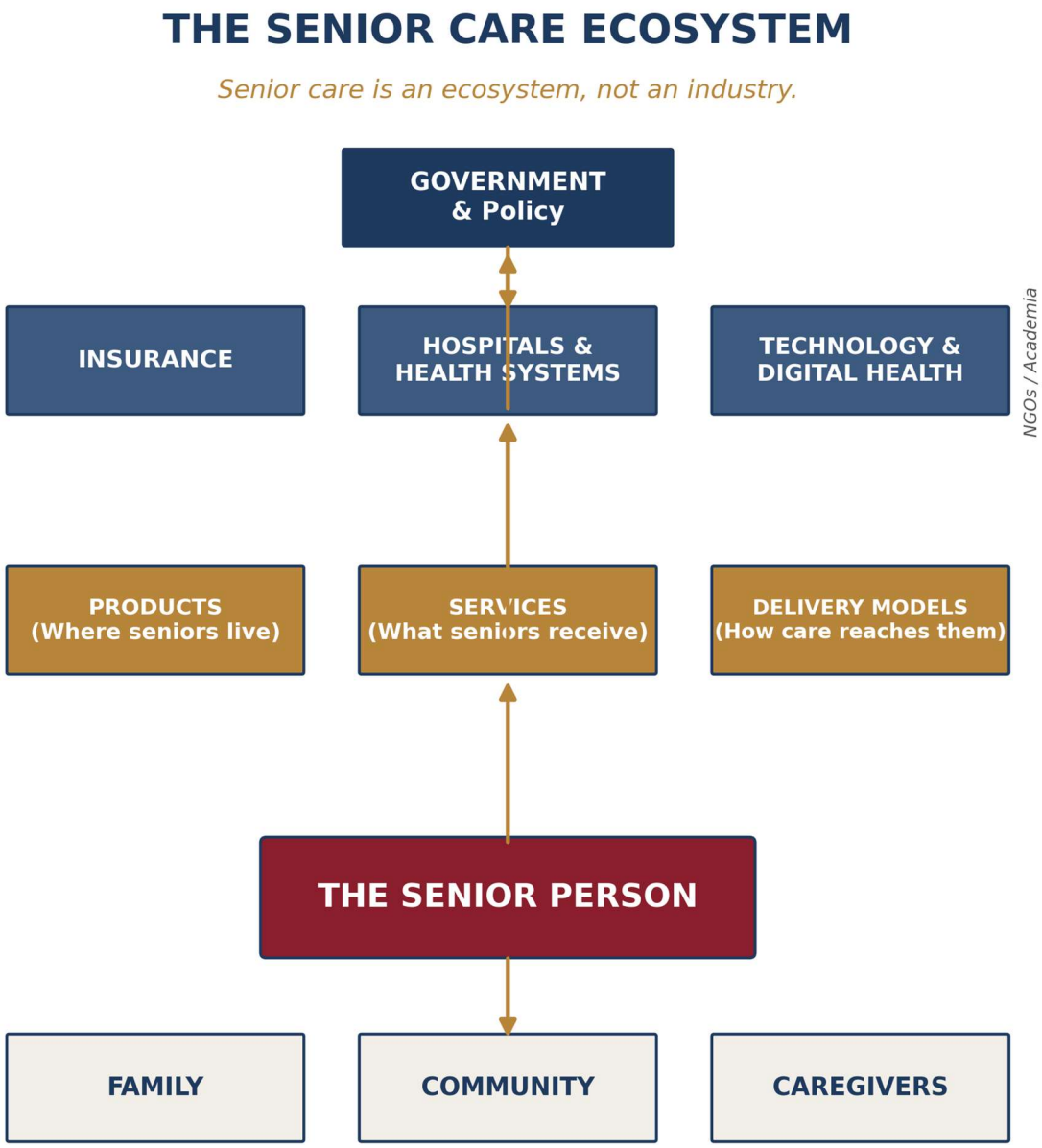

Figure 2.1 places the four layers introduced above around the senior person, family and community they exist to serve — with government, insurance, hospitals and technology forming the outer enabling ring. No single layer, read alone, explains how care actually works; only the connections between them do.

A senior's journey is dynamic, not static: Home → Hospital → Rehabilitation → Home Healthcare → Assisted Living (if required) → Memory Care (where appropriate). The objective is not to move people through institutions; it is to ensure that appropriate support is available whenever needs change.

Figure 2.2, The Ageing Journey, is referenced throughout this report — in the delivery models discussed in Chapter 5, the industry landscape in Chapter 6, and NEMA's own care pathway in Chapter 8. Not every individual passes through every stage, and movement between stages is not always one-directional; the diagram maps the possible route, not a mandatory one.

PUBLISHER'S INSIGHT

Senior care is an ecosystem, not a building. A retirement community without healthcare cannot meet changing needs. Home healthcare without rehabilitation leaves gaps after hospital discharge. Hospitals without post-acute support increase the risk of readmission. The future lies in integrating products, services and delivery models into a seamless continuum of care centred on the individual rather than the institution.

— NEMA Academy, Publisher

Chapter 3

Senior Living Products — Creating the Physical Environment for Healthy Ageing

3.1 Introduction

Every senior care journey begins with a place. Whether it is a family home, an independent living community, an assisted living residence or a specialised memory care centre, the physical environment plays a significant role in determining safety, comfort, independence and quality of life.

However, buildings alone do not provide care. They provide the environment within which care is delivered.

Understanding these products is essential for families choosing care, developers planning projects, investors evaluating opportunities and policymakers shaping future infrastructure.

3.2 Retirement Housing

Retirement housing is designed for active, independent seniors who require little or no daily assistance. Residents typically own or lease age-friendly apartments or villas within communities offering enhanced safety, maintenance services and recreational amenities.

Typical features include barrier-free design, clubhouses, walking paths, security, housekeeping, community dining, emergency response systems and recreational facilities. Advantages include an independent lifestyle, strong community engagement, reduced maintenance responsibilities and age-friendly infrastructure. Its principal limitation is that it generally does not provide continuous healthcare or personal care services; as residents' needs change, additional support often becomes necessary.

3.3 Independent Senior Living

Independent Living represents the evolution of retirement housing from a real estate product to a hospitality-driven service. Residents remain fully independent while benefiting from organised services such as dining, housekeeping, concierge support, wellness programmes and social activities. The emphasis is on lifestyle rather than healthcare, and the segment is increasingly attracting urban professionals seeking convenience, security and companionship without sacrificing independence.

3.4 Assisted Living

Assisted Living bridges the gap between independent living and nursing care. Residents receive support with Activities of Daily Living (ADLs) — medication reminders, personal care, bathing and dressing assistance, dining, housekeeping, health monitoring, recreational programmes and doctor coordination — while continuing to enjoy privacy and community life. It combines healthcare with hospitality and is operationally more complex than retirement housing because resident needs vary continuously.

3.5 Memory Care

Memory Care is one of the most specialised segments of organised senior care. Designed for individuals living with Alzheimer's disease and other dementias, these communities provide structured environments — secure settings, trained dementia caregivers, therapeutic activities, structured routines, family counselling, behavioural management and cognitive stimulation — that reduce anxiety while promoting cognitive function and emotional wellbeing.

This segment carries particular urgency in India. A 2023 nationally representative estimate based on the Longitudinal Ageing Study in India (LASI) puts dementia prevalence among those aged 60+ at 7.4%, or roughly 8.8 million people — substantially higher than earlier estimates from the 2010 Dementia India Report (3.7 million in 2010, projected to reach 5.29 million by 2020 under ARDSI's methodology). As awareness of dementia increases and diagnostic capacity improves, this segment is expected to expand significantly, though it remains significantly under-supplied relative to need.

3.6 Post-operative Recovery Centres

Hospital discharge is increasingly recognised as the beginning of recovery rather than its conclusion. Many seniors require temporary residential care following surgery or serious illness before returning home. Post-operative recovery centres bridge this gap by combining nursing, rehabilitation, physiotherapy, nutrition and medical supervision in a non-hospital homely environment — reducing hospital stay and costs, improving rehabilitation outcomes, reducing readmissions, and restoring independence more quickly. This emerging category is likely to become an important component of India's continuum of care.

3.7 Assistive Technologies and Equipment

Supporting healthy ageing extends beyond residential communities. Assistive products — hospital beds, wheelchairs, walkers, grab rails, anti-slip flooring, smart sensors, emergency call systems, fall detection devices and wearable health monitors — enable seniors to remain safe and independent both at home and in care facilities. As technology advances, these products will increasingly become integrated into everyday living environments.

3.8 Comparing Senior Living Products

Product	Independence	Hospitality Intensity	Clinical Support	Typical Duration
Retirement Housing	High	Low	Minimal	Long-term
Independent Living	High	High	Low	Long-term
Assisted Living	Moderate	High	Moderate	Long-term
Memory Care	Low	Moderate	High	Long-term
Post-operative Recovery	Variable	Moderate	High	Short-term

3.9 Market Outlook

India's organised senior living market remains significantly under-penetrated. Independent research firms give varying estimates of its current size (see Appendix A for a detailed comparison), but broadly agree that current organised supply covers only about 1.3% of estimated demand — JLL–ASLI projects this could reach roughly 2.5% by 2030 under a favourable, policy-led scenario — compared with over 6% in mature markets such as the United States and Australia. JLL–Association of Senior Living India (ASLI)'s most recent study (2025) found that more than 22,000 organised senior living units have been built nationwide to date (22,157 as of June 2025), with southern India accounting for roughly 60% of the national market — reflecting both faster regional ageing and a higher proportion of NRI (non-resident Indian) adult children.

Key drivers include increasing longevity, urbanisation, nuclear families, rising incomes, growing awareness, and expansion into Tier II and Tier III cities. Future growth is unlikely to come solely from real estate development. Instead, competitive advantage will increasingly depend upon integrating housing with healthcare, hospitality, rehabilitation and technology.

KEY TAKEAWAYS

✓ Buildings create environments — not care.

✓ Senior living consists of multiple products serving different stages of ageing.

✓ Organised supply meets only ~1.3% of estimated demand nationally, with JLL–ASLI projecting a rise to ~2.5% by 2030 under a favourable policy scenario.

✓ Future success depends upon combining infrastructure with high-quality services.

PUBLISHER'S INSIGHT

Communities create wellbeing; buildings provide the setting. Investment in senior housing should extend beyond architecture. Residents thrive when communities promote friendships, daily engagement, lifelong learning and a sense of purpose. The most successful senior living environments will be those where social connection is intentionally designed into everyday life.

— NEMA Academy, Publisher

Chapter 4

Senior Care Services — Transforming Buildings into Living Communities

4.1 Introduction

If products create the environment, services create the experience. A beautifully designed residence cannot ensure wellbeing without compassionate caregivers, effective clinical support and meaningful human interaction.

Services are the operational engine of the senior care ecosystem. Unlike physical infrastructure, services are dynamic, relationship-driven and delivered continuously throughout the ageing journey. As India's senior population grows, demand for professional services is expected to expand more rapidly than demand for residential infrastructure.

4.2 Home Healthcare

Ageing in place is increasingly recognised as the preferred choice for many seniors. Home healthcare enables professional medical and non-medical services — nursing, care attendants, physiotherapy, occupational therapy, doctor consultations, diagnostics, wound care, medication management and palliative care — to be delivered within the familiar surroundings of home.

Home healthcare is also India's fastest-growing organised care segment. Estimates of its current size vary widely across research firms — from roughly USD 9 billion to USD 16 billion in 2024/25 — reflecting differing definitions of scope, but most projections converge on annual growth of 15–20% through 2030, driven by an ageing population, rising chronic disease burden, and expanding insurance coverage for home-based treatment under initiatives such as the Ayushman Bharat Digital Mission (see Appendix A).

Its advantages include a familiar environment, family involvement, lower infection risk, reduced hospitalisation and personalised care. Its challenges include variable quality across providers, workforce shortages, limited emergency capability and fragmented coordination.

4.3 Nursing Services

Professional nursing forms the clinical foundation of organised senior care, covering medication administration, IV therapy, catheter care, PEG and Ryles tube feeding, tracheostomy care, wound management, clinical monitoring and post-surgical care. As healthcare increasingly shifts beyond hospitals, nursing will become an even more critical component of community-based care.

4.4 Care Attendants

Care attendants represent the largest workforce in India's senior care ecosystem, responsible for bathing, grooming, dressing, toileting, feeding, mobility assistance, companionship and safety supervision. Although they may not perform complex clinical procedures, they often have the greatest day-to-day influence on a senior's quality of life. Professional training, certification and career pathways are essential to strengthening this workforce.

4.5 Rehabilitation Services

Recovery extends well beyond hospital discharge. Rehabilitation — physiotherapy, occupational therapy, speech therapy, swallow therapy, gait training, fall prevention and cognitive rehabilitation — restores independence, reduces disability, improves confidence and lowers long-term healthcare costs.

4.6 Hospitality Services

Hospitality has become a defining feature of modern senior living. Residents increasingly expect services comparable to high-quality hotels — dining, housekeeping, laundry, concierge, transportation, cultural events, recreational programmes and celebration of festivals and birthdays — alongside appropriate healthcare support. These services contribute significantly to emotional wellbeing and resident satisfaction.

4.7 Mental Wellbeing Services

Mental wellbeing extends far beyond the treatment of mental illness. Healthy ageing requires social engagement, counselling, purposeful activities, memory stimulation, community participation and emotional support. Loneliness and social isolation remain among the least recognised threats to healthy ageing, requiring structured programmes that promote connection, dignity and purpose.

4.8 Technology-enabled Services

Technology is increasingly supporting the delivery of senior care, through telemedicine, electronic health records, AI-assisted care planning, remote patient monitoring, medication reminders, fall detection, family communication platforms and emergency response systems. Technology should enhance human care rather than replace it.

4.9 Family Support Services

Families remain central to eldercare in India. Organised providers increasingly support family members through regular health updates, video consultations, care planning meetings, counselling, digital health records and emergency coordination. Transparent communication strengthens trust and improves continuity of care.

4.10 Services Across the Ageing Journey

No single service can meet every need throughout later life. As health conditions evolve, seniors may require different combinations of healthcare, rehabilitation, hospitality and emotional support. The future of organised senior care therefore lies not in individual services but in coordinated service pathways that adapt to changing needs.

KEY TAKEAWAYS

✓ Services determine quality of life more than buildings alone.

✓ Care is continuous, relationship-based and multidisciplinary.

✓ Professional caregivers are the most valuable resource in the ecosystem.

✓ The future lies in integrated service delivery supported by technology and strong family engagement.

PUBLISHER'S INSIGHT

Healthcare keeps people alive. Hospitality makes life worth living. Clinical excellence is essential, but quality of life depends equally on dignity, choice, comfort, nutrition, recreation and relationships.
Organised senior care should combine healthcare with hospitality to create environments where older adults can continue to live fulfilling lives.

— NEMA Academy, Publisher

Chapter 5

Care Delivery Models — How Senior Care Reaches Older Adults

> *Products define where care is provided. Services define what is provided. Delivery models determine how those services reach the senior.*

5.1 Introduction

Healthcare is no longer confined to hospitals. Advances in medical practice, technology, logistics and workforce capabilities have fundamentally changed the way care is delivered. Today, the same service — a nursing visit, physiotherapy session or medical consultation — can be provided in multiple settings, each offering distinct advantages and limitations.

For families, understanding these delivery models is essential in choosing the most appropriate care. For operators and investors, they represent different business models with unique economics, regulatory requirements and growth opportunities. Rather than competing, these models increasingly complement one another, forming an integrated continuum of care.

5.2 Home-based Care

Home-based care enables seniors to receive medical and non-medical services without leaving their homes, supporting the growing preference for Ageing in Place. Typical services include nursing, care attendants, physiotherapy, doctor consultations, diagnostics, pharmacy delivery and remote monitoring. Advantages include a familiar environment, strong family participation, lower cost than institutional care and reduced hospital-acquired infections. Challenges include limited emergency capability, workforce availability, variable quality and fragmented service coordination.

5.3 Residential Care Communities

Residential communities combine accommodation with organised support, ranging from hospitality and social engagement to intensive nursing and dementia care — including continuous supervision, structured routines, nutrition, activities, rehabilitation, clinical coordination and social interaction. Residential care becomes particularly valuable when home-based support is no longer sufficient.

5.4 Hospital Outreach Programmes

Many hospitals are extending care beyond discharge through structured outreach programmes — home nursing, teleconsultations, physiotherapy, chronic disease management, medication monitoring and remote follow-up. Such programmes improve continuity of care while reducing unnecessary readmissions, as hospitals recognise that successful treatment depends not only on clinical intervention but also on recovery after discharge.

5.5 Nursing Agencies

Traditional nursing bureaus remain an important part of India's care ecosystem, providing nurses, care attendants, short-term staffing and replacement caregivers with flexibility, rapid deployment and lower administrative complexity. Their limitations include limited clinical governance, variable

training standards, inconsistent supervision and high caregiver turnover. Professionalisation of this segment represents one of the industry's largest opportunities.

5.6 Digital Care Platforms

Technology is transforming access to organised care. Digital platforms increasingly connect families with nurses, care attendants, physiotherapists, occupational therapists, doctors and ambulance services, offering digital discovery, background verification, online scheduling, electronic payments, ratings, documentation and family communication. Digital platforms improve transparency while reducing information asymmetry, but technology alone cannot assure quality; clinical governance and workforce training remain essential.

5.7 Comparing Care Delivery Models

Model	Best Suited For	Primary Strength	Limitation
Home-based Care	Ageing in Place	Familiarity	Limited emergency support
Residential Communities	Continuous care	Integrated services	Requires relocation
Hospital Outreach	Post-discharge recovery	Strong clinical oversight	Limited to hospital network
Nursing Agencies	Temporary staffing	Flexibility	Variable quality
Digital Platforms	Access and convenience	Transparency	Quality depends on providers

5.8 Towards Integrated Care

Historically, these delivery models operated independently. The future lies in integration. A senior recovering from hip replacement surgery, for example, may follow a pathway from hospital admission through orthopaedic surgery, a post-operative recovery centre, physiotherapy, home healthcare, remote monitoring, and back into independent living and preventive wellness. Throughout this journey, care providers should share information, coordinate treatment plans and communicate with the family. This continuity — not any single service — defines high-quality senior care.

5.9 The Economics of Care Delivery

Model	Capital Intensity	Operational Complexity	Scalability
Home Healthcare	Low	High	High
Residential Care	High	High	Moderate
Digital Platforms	Moderate	Moderate	Very High
Hospital Outreach	Moderate	Moderate	Moderate

Understanding these economics is essential for entrepreneurs and investors seeking sustainable business models.

The comparison above reflects NEMA Academy's qualitative assessment of each model's economics rather than a third-party study.

KEY TAKEAWAYS

- ✓ Care can now be delivered through multiple complementary models.
- ✓ Families increasingly require seamless transitions between these models.
- ✓ Technology enables coordination but does not replace human care.
- ✓ Integrated delivery systems are likely to define the future of senior care.

PUBLISHER'S INSIGHT

Care should move with the person, not stop at the institution. Every transition — from home to hospital, hospital to rehabilitation, rehabilitation back home or into assisted living — creates the potential for fragmented care. Effective systems ensure that information, care plans and communication follow the individual across these transitions.

— NEMA Academy, Publisher

Chapter 6

The Indian Senior Care Industry Landscape — Mapping an Emerging Ecosystem

6.1 Introduction

India's organised senior care sector is often discussed as though it were a single industry. In reality, it comprises multiple interconnected sectors that together support the ageing journey. Some organisations develop retirement communities; others provide home healthcare; some specialise in dementia care; others build technology platforms, train caregivers or manufacture assistive devices.

No single organisation currently dominates the entire ecosystem. Instead, the industry is evolving through specialised providers that increasingly collaborate rather than compete directly. Understanding this landscape enables families, policymakers, entrepreneurs and investors to appreciate where opportunities and gaps exist.

6.2 The Senior Care Value Chain

India's organised senior care ecosystem can be viewed as a value chain of four interconnected layers: Living Solutions (retirement housing, independent living, assisted living, memory care, post-operative recovery); Care Services (home healthcare, nursing, physiotherapy, rehabilitation, hospitality, nutrition, mental wellbeing); Care Delivery (home care, residential communities, hospital outreach, nursing agencies, digital platforms); and the Enabling Ecosystem (hospitals, insurance companies, government, technology providers, medical equipment companies, NGOs, academic and training institutions).

6.3 Market Size: What the Data Actually Shows

Unlike many mature sectors, India's senior care industry does not yet have a single, agreed-upon market size. Independent research firms use different methodologies and scope definitions, producing a wide range of estimates. Rather than present one number as definitive, this report shows the range, which is itself informative about how early-stage and rapidly evolving this sector is.

Segment	Estimates (base year)	Estimates (2030+)	Source
Senior Housing / Living	USD 2–3.6 bn (2024/25)	USD 3.2–14.1 bn by 2030–31	Grand View Research; Mordor Intelligence; Colliers
Senior Living Housing (JLL–ASLI)	USD 1.8–2 bn (2025)	USD 8 bn by 2030, ~4x current size	JLL / Association of Senior Living India, 2025 ("Elevating the Golden Years 2.0")
Home Healthcare	USD 9–16 bn (2024/25)	USD 15–75 bn by 2030–34	Grand View Research; IMARC; Mordor; TechSci; SPER

Several figures recur across sources and are worth highlighting: current organised senior living supply meets an estimated 1.3% of potential demand — a figure JLL–ASLI projects could rise to roughly 2.5% by 2030 under a favourable, policy-led scenario, not a present-day alternative estimate — compared with over 6% in the United States and Australia; more than 22,000 organised senior living units have been built in India to date (JLL–ASLI counted 22,157 as of June 2025); and southern India accounts for roughly 60% of the national senior living market, reflecting both an earlier demographic transition and a higher share of NRI-supported households.

6.4 Segment Analysis

Retirement Housing remains real estate-driven, capital intensive, and built around sale, lease and maintenance revenue, with long development cycles.

Independent Living focuses on lifestyle, hospitality and community rather than clinical care, driven by urban professionals seeking safety and convenience.

Assisted Living is one of the fastest-growing organised care segments, combining healthcare and hospitality with monthly recurring revenue and high operational intensity.

Memory Care requires secure infrastructure, clinical expertise, trained caregivers and family education, and remains significantly under-supplied in India relative to an estimated 8.8 million people living with dementia.

Home Healthcare is one of the largest service opportunities, driven by Ageing in Place, hospital-at-home models, chronic disease management and technology adoption.

Digital Health Platforms are an emerging category focused on care coordination, workforce discovery, scheduling, payments, monitoring and data integration.

This segmentation also exposes a structural tension running through much of the sector. Almost every large real estate developer active in senior housing today says it wants to add a "senior care" arm alongside its residential projects — and, on paper, the demographic case is obvious. In practice, the two businesses run on different economics.

Real estate development is built around large, front-loaded capital gains: sell or lease units, recognise the return, move to the next project. Service delivery — assisted living, memory care, home healthcare — is a low-margin, high-opex, staffing-intensive business built on thin monthly recurring revenue and years of operational discipline before it turns a profit. An organisation whose core competency and incentive structure is optimised for high-margin real estate development does not straightforwardly acquire the patience, staffing discipline or clinical governance that low-margin service delivery demands simply by adding a care division. The risk this creates for families is concrete: a beautifully built community with an under-resourced, under-trained or high-turnover care layer, because the capital and management attention that built the building was never designed to sustain the service. This is not an argument against developers entering care — several have built credible operations — but it is a reason for families, investors and regulators to evaluate the care arm of any developer-led project on its own operational and staffing evidence, rather than assuming that construction quality implies care quality.

6.5 Industry Challenges

- Low public awareness
- Workforce shortages
- Fragmented regulation
- Real estate developers adding care as a division without matching operational capability (see 6.4)
- Limited insurance coverage
- Affordability constraints
- Lack of standardised quality benchmarks
- Social stigma associated with organised care

These constraints also represent opportunities for innovation and policy reform.

6.6 Who Is Building the Ecosystem: Key Industry Players

India's senior care industry does not yet have a single trade census, but the Association of Senior Living India (ASLI) — the sector's principal self-regulatory body, founded in 2011 — maintains the closest thing to a national membership directory. As of 2026, ASLI's published member directory lists founding members, board members, and more than 60 primary and associate member organisations spanning housing, home healthcare, memory care, technology and ancillary services. The selection below, organised by the four-layer framework introduced in Chapter 2, is drawn directly from that public directory; membership is voluntary and self-selected, so this is illustrative of who is active and organised in the space — not an exhaustive market census or a ranking of quality.

Diversified Real Estate Developers (senior living as one product line)

Consistent with the distinction drawn in 6.4, this group is publicly described as general real estate developers for whom senior living is one product line within a broader residential or commercial portfolio: Ashiana Housing, Paranjape Schemes (Athashri brand), Max group, Columbia Pacific, Manassum, Prestige Estates Projects, Arun Excello Group, Pioneer, and recently DLF. Their scale and balance sheets are assets for construction; whether that translates into comparable strength in day-to-day care delivery is a separate question this report does not attempt to answer for any individual company.

Dedicated Senior Living Operators

This group's core business, as publicly described, is operating senior living rather than general real estate development: Columbia Pacific Communities — described in ASLI's own materials as India's largest senior living operator by residential units under management, with close to 1,600 units across nine communities in south India — Antara Senior Living, Primus Lifespaces, Oasis Senior Living, Aurum Senior & Assisted Living, and NEMA Eldercare, which operates independent senior co-living communities alongside the other services described below. This is not a claim that operator status guarantees better care, only that these organisations' stated core business is care delivery rather than construction.

Other Housing Members

Saket Group, Bahri Estates (Anandam), Eden Retirement Living, Vardaan Senior Living, Golden Planet, 2nd Innings Retirement Resort, and PP Reddy Retirement Homes are also listed by ASLI

under senior housing. This report has not independently confirmed whether each operates primarily as a developer or a dedicated operator, and lists them separately rather than guessing.

Assisted Living & Memory Care Specialists

Athulya Senior Living (Chennai), Epoch Eldercare, NEMA Eldercare, Antara, Kites, Sukino, Kshetra Assisted Living (Hyderabad),Hope ek Asha, Aurum, and Priaashraya Assisted Living are among the members focused on assisted living and memory care. NEMA, examined as a case study in Chapter 8, is notable for appearing across several segments in this directory rather than one — consistent with its own account of running an integrated, multi-service model rather than a single-line business.

Home Healthcare & Clinical Services

Portea Medical, Health Care at Home (HCAH), AmeriHealth Home Health Care, Care Continuum (Kolkata), Yodda Elder Care and NEMA Eldercare's home healthcare line represent the home healthcare segment discussed in Chapter 4.

Antara, SuVitas and Genesis Rehab Services (an Indian partnership with a US rehabilitation operator founded in 1985) focus specifically on post-acute and rehabilitation care, the segment described in Chapter 3.6; NEMA's post-operative recovery service, discussed in Chapter 8, sits in the same category.

Eldercare Platforms, Technology & Ancillary Services

Emoha Eldercare, SeniorWorld, Unmukt (The Senior Hub), Khyaal, WisdomCircle, GenS Life, NEMA club, and NEMA's own caregiver platform NEMA Care Hub, and caregiver-education NEMA academy represent the digital care-coordination, community and workforce-training platforms described in Chapter 5.6. Assistive-technology members include BeAble Health (rehabilitation devices), Flexmo/FlexMotiv (mobility aids) and True Assist Tech, alongside remote-monitoring providers such as Dozee. Specialised and nonprofit providers include Travancore Foundation (a Kerala-based charitable trust) and Hope Ek A.S.H.A. (dementia-focused caregiver support, founded 2003), while Karevoyage and Seniority address senior-focused travel and retail respectively.

Two things stand out from this list. First, it confirms the segmentation this report uses in Chapters 2–6: developers, care specialists, home healthcare providers and technology platforms are largely distinct organisations rather than one another's competitors — NEMA Eldercare is the clearest exception, appearing across five of the categories above — co-living, assisted living/memory care, home healthcare, post-acute/rehabilitation and digital platforms — which is itself the point of the ecosystem argument made in Chapter 8. Second, the list is short relative to India's population of ageing seniors — fewer than 100 organised, association-affiliated providers for a market UNFPA projects will exceed 300 million people by 2050 — which is itself evidence for this report's argument that organised supply remains a small fraction of potential demand.

Source: Association of Senior Living India (ASLI), Member Directory, asli.org.in/member-directory, accessed 2026. Company descriptions are summarised from ASLI's published member profiles and are not independently audited by this report.

6.7 A Regional Lens: Why Geography Matters

India's ageing transition is not a single national story — it is several regional stories moving at very different speeds, and the senior care industry has followed accordingly.

Kerala is, by a wide margin, the fastest-ageing large population in India. Official Sample Registration System data for 2021 puts 14.4% of Kerala's population at age 60 or above — the highest of any Indian state, against a national average of roughly 9% — and some estimates using different survey methods put the figure closer to 16–17%. A 2026 Reserve Bank of India study on state finances classifies Kerala, alongside Tamil Nadu (12.9%), as an “ageing state” and projects Kerala's elderly share will reach 22.8% by 2036, the highest of any state. This is the product of decades of low fertility, high literacy, strong healthcare access, and — distinctively — sustained outward migration of working-age Keralites to the Gulf, Europe and North America, which has both funded and hollowed out family-based elder care in the state.

This helps explain why South India, and Kerala in particular, has become the epicentre of India's organised senior living industry — and why, as the directory above shows, a disproportionate share of ASLI's assisted living and memory care members (Athulya, Covai Care, Kshetra, Travancore Foundation) are headquartered in Chennai, Coimbatore, Hyderabad and Kerala itself. JLL–ASLI's most recent study (2025) found southern India commands roughly 60% of the national senior living market, reflecting both an earlier demographic transition and a higher proportion of NRI adult children willing to pay for organised care from abroad.

The National Capital Region (NCR) and other northern and western metros represent the opposite pattern: a younger overall population, but a fast-growing base of urban, dual-income, nuclear-family households with rising disposable incomes. Industry analysts note developers are increasingly expanding into northern and western metros beyond the traditional southern strongholds, encouraged by state-level incentives and reverse-mortgage policy support that let older homeowners unlock equity to pay for senior living. The result is a two-speed market: the South selling largely to an already-ageing, NRI-supported population, and the North and West building ahead of a demographic wave that has not yet fully arrived.

This is evident from the fact that Northern industry players' growth has been slow, despite providing much higher quality of space and care. Market dynamics have forced them to move south --- for example, Antara opening centres in Hyderabad and Bangalore, and Epoch planning carehomes in the south.

For operators and investors, this regional divergence matters as much as the national growth rate: a strategy calibrated to Kerala's already-ageing, remittance-funded market will not translate directly to Delhi NCR's younger, aspirational, dual-income buyer base.

6.8 Opportunities for Growth

- Integrated care ecosystems
- Affordable assisted living
- Expansion into Tier II and Tier III cities

- AI-enabled healthcare
- Remote monitoring
- Dementia services
- Rehabilitation
- Caregiver training
- Preventive health
- Senior-focused financial products

6.9 Industry Outlook

India's senior care industry is transitioning from isolated businesses to interconnected ecosystems. The future leaders are unlikely to be organisations offering a single product or service; they will be those capable of integrating housing, healthcare, technology, hospitality, workforce development and community engagement into a seamless experience. As this transformation unfolds, collaboration between private enterprise, healthcare institutions, governments and civil society will become increasingly important.

This also creates an opportunity for investors to consolidate the market around a genuine continuum of care.

KEY TAKEAWAYS

✓ Organised senior care is an ecosystem, not a single industry.

✓ ASLI's member directory lists fewer than 100 organised providers nationally — itself a sign of how under-penetrated the sector remains.

✓ Market-size estimates vary widely across research firms; treat any single figure with appropriate caution.

✓ Organised supply meets only ~1.3% of estimated demand, projected to reach ~2.5% by 2030 under a favourable policy scenario.

✓ Integration, technology and collaboration will define the industry's next phase of growth.

PUBLISHER'S INSIGHT

India does not need one dominant provider. It needs a connected ecosystem. The sector will be strengthened by collaboration among hospitals, home healthcare providers, assisted living communities, insurers, technology companies, educational institutions and government. Partnerships — not isolated excellence — will determine long-term success.

— NEMA Academy, Publisher

Chapter 7

The Future of Senior Care — Building India's Next Healthcare Ecosystem

> *The future of senior care will not be determined by where seniors live. It will be determined by how seamlessly society supports them throughout the ageing journey.*

7.1 Introduction

Every major demographic transition reshapes industries. The industrial revolution transformed manufacturing. The digital revolution transformed communication. The ageing revolution will transform healthcare, housing, technology, financial services and community life.

India is entering this transformation later than many developed countries, but with significant advantages. It can learn from international experience while leveraging its strengths in healthcare, digital infrastructure, entrepreneurship and technology. The future of senior care will not be characterised by larger retirement communities or more hospital beds alone; it will be defined by integrated ecosystems that combine clinical excellence, hospitality, digital health and human relationships.

7.2 Ageing in Place

Across the world, research consistently shows that most older adults prefer to remain in their own homes for as long as possible. This preference, known as Ageing in Place, is reshaping service delivery.

Enabling seniors to remain at home requires much more than occasional nursing visits. It requires an ecosystem comprising home healthcare, telemedicine, remote monitoring, home modifications, care attendants, emergency response, family communication and community engagement. Residential care will continue to play an essential role, but increasingly as part of a broader continuum rather than as the default solution.

7.3 From Institutions to Ecosystems

Historically, senior care evolved as separate industries: hospitals treated illness, retirement communities provided housing, homecare agencies delivered services, and technology companies built digital tools. These sectors often operated independently. The next decade will favour organisations that integrate these components into seamless care pathways. The future belongs not to isolated service providers but to ecosystem builders. Technology will play an important role in enabling this shift, as discussed in the following section.

7.4 Artificial Intelligence and Digital Health

Artificial Intelligence has the potential to transform every stage of the senior care journey — clinical support through early risk detection, predictive deterioration alerts, medication optimisation and care planning; operational excellence through workforce scheduling, occupancy forecasting, resource allocation and documentation; and resident experience through personalised activities, cognitive stimulation, voice assistants and family engagement.

AI should augment caregivers, not replace them. Compassion remains fundamentally human.

7.5 Professionalising India's Care Workforce

India's greatest constraint is unlikely to be infrastructure alone. It will increasingly be the availability, quality and retention of trained caregivers. The country requires a comprehensive workforce strategy including national competency standards, accredited training and certification, career pathways, continuing education, better working conditions, social protection, digital workforce systems, international mobility and professional recognition. The caregiver must evolve from being viewed as domestic help to being recognised as a skilled care professional. NITI Aayog's August 2026 report, “Reimagining Care: Strategies for Empowering Caregivers in Viksit Bharat@2047,” gives this workforce question national policy significance, calling for a more organised, professional and future-ready caregiving ecosystem, including stronger standards, training, career pathways and institutional support.

Behind these policy statistics sits a more specific, and more troubling, operational problem that senior care operators describe consistently but that is rarely quantified in public data: training is not the bottleneck, retention is. Candidates trained under National Skill Development Corporation (NSDC)-aligned caregiving courses frequently leave the profession within months of certification, not for lack of skill but because the role offers little social standing, no visible career ladder beyond entry-level bedside work, and pay that does not reflect the physical and emotional demands of the job. Operators report that this attrition also follows a gendered pattern: young women are more likely to remain in caregiving roles for a period — often until marriage — or to use them as a stepping stone into nursing through distance-education upgrading, while young men more often leave caregiving altogether in favour of gig-economy work such as delivery and ride-hailing, which offers comparable or better pay with more flexibility and, in their assessment, more dignity. Because India does not yet track caregiver retention, exit destinations or gender-disaggregated attrition at a national level, this pattern currently rests on operator experience rather than published statistics — itself evidence for Priority 9 in Chapter 9, which calls for workforce data as a national research priority. Without a genuine career pathway — supervisory roles, specialisation in dementia or rehabilitation care, recognised progression into nursing or allied health — training capacity alone will not solve the shortage described earlier in this chapter; it will continue to produce certified caregivers who do not stay caregivers.

7.6 The 2026 Policy Shift: Caregiving as a National Workforce Issue

Source: NITI Aayog, “Reimagining Care: Strategies for Empowering Caregivers in Viksit Bharat@2047,” August 2026.

The policy conversation is moving from the provision of care to the organisation of the care workforce itself. In August 2026, NITI Aayog released “Reimagining Care: Strategies for Empowering Caregivers in Viksit Bharat@2047.” The report treats caregiving as a skilled and dignified occupation and calls for a more organised, professional and future-ready care system. Among its recommendations are stronger national standards and institutional mechanisms, accredited training, career progression, social protection, digital systems for the caregiving ecosystem, and pathways to international employment. This is significant for senior care because the availability of trained, reliable caregivers is a constraint across homecare, assisted living, dementia care and post-acute recovery. It also shifts

the policy lens: caregiver development is not a supporting activity around senior care; it is part of the infrastructure of the care economy.

7.7 Dementia — India's Emerging Public Health Challenge

Longer life expectancy will inevitably increase the prevalence of dementia. A 2023 nationally representative study using LASI data estimated 8.8 million Indians aged 60+ live with dementia (7.4% prevalence), with meaningfully higher rates among women, rural residents and those with less education — and significant variation across states. This is a considerably higher estimate than earlier ARDSI figures from the 2010s (3.7 million in 2010), reflecting improved measurement rather than a sudden increase in disease burden. Yet awareness remains limited.

Future priorities include public education, early diagnosis, memory clinics, family counselling, community support, dementia-friendly communities, research and workforce training. Countries that prepare today will manage tomorrow's burden more effectively.

7.8 The Silver Economy

The Silver Economy extends beyond healthcare to include housing, financial planning, insurance, tourism, nutrition, mobility, technology, education, employment and wellness. Rather than viewing older adults as dependents, society must increasingly recognise them as active consumers, contributors and citizens.

7.9 Five Predictions for 2035

1. Integrated ecosystems will outperform standalone operators.
2. Home healthcare will become one of the largest organised healthcare segments.
3. Technology-enabled monitoring will become routine.
4. Dementia care will emerge as a specialised healthcare discipline.
5. The senior care workforce will become one of India's largest employment generators.

Chapter Summary

The future of senior care will be defined not by individual facilities but by connected ecosystems that integrate healthcare, housing, technology and community. India has an opportunity to build one of the world's most innovative models of healthy ageing. The decisions taken over the next decade will determine whether the country merely responds to demographic change or actively shapes it.

PUBLISHER'S INSIGHT

Artificial intelligence should amplify compassion, not replace it. Digital tools can support clinical decisions, improve coordination and enhance safety. Yet empathy, reassurance and human presence remain irreplaceable. Technology should free caregivers to spend more meaningful time with those they support.

— NEMA Academy, Publisher

Chapter 8

NEMA: A Case Study in Building an Integrated Senior Care Ecosystem

Editorial Note: This chapter is not an advertisement. It examines how one organisation interpreted the industry's evolution described in earlier chapters and attempted to respond to it. Readers should feel free to critique the model as well as learn from it; the case study reports NEMA's own account of its approach and does not constitute independent verification of outcomes.

8.1 Why This Case Study?

Throughout this report, we have argued that India's senior care industry is evolving from isolated services towards integrated ecosystems. This chapter examines one practical example of that approach. Rather than evaluating commercial performance, the objective is to illustrate how multiple services can be organised around the changing needs of older adults.

NEMA is not the only organisation attempting this. But independent evidence of the pattern is limited, which is part of why this chapter exists. One data point external to NEMA's own account: the Association of Senior Living India's (ASLI) public member directory — summarised in Chapter 6.6 and reproduced in full in Appendix A.4 — lists NEMA Eldercare across five distinct market segments (co-living, assisted living/memory care, home healthcare, post-acute/rehabilitation and digital platforms), more than any other member organisation reviewed for this report. That breadth is consistent with, though it does not by itself prove, the integrated model NEMA describes below.

8.2 The Problem NEMA Set Out to Solve

Conversations with seniors, families and healthcare professionals informing NEMA's approach revealed recurring challenges: loneliness and social isolation, difficulty navigating fragmented services, limited organised homecare, shortage of trained caregivers, inadequate post-hospital recovery options, increasing prevalence of dementia, and poor coordination between providers. These observations suggested that families required continuity rather than isolated services.

8.3 The Ecosystem Approach

Instead of focusing on a single business line, NEMA developed complementary services supporting different stages of ageing. The objective was not vertical integration for its own sake, but continuity of care. As of 2026, NEMA's operating platform includes independent senior co-living, established assisted living and memory care, home healthcare, caregiver education and an emerging technology marketplace; it is also extending its clinical platform into post-operative recovery. NEMA 38 is scheduled to launch in October 2026, while CareHub is being developed as a technology-enabled caregiver marketplace. As part of this build-out, NEMA CareHub is also developing a Digital National Register of care attendants --- a verified database intended to help senior care organisations, agencies and families identify and hire background-checked staff, and to give the wider industry a shared reference point for workforce credentialing as it professionalises. As with CareHub itself, this register remains under development rather than an operating capability.

(These stages matter: the report should distinguish operating businesses from initiatives that are newly launched or still being developed.)

Figure 8.1, drawn from NEMA's own description of its operating model, shows each service as a spoke connecting back to the senior and family at the centre — the same hub-and-spoke logic this report applies to the industry as a whole in Figure 2.1. As with all figures in this chapter, it reflects NEMA's self-reported structure rather than independently audited data.

8.4 NEMA Academy and Workforce Development

NEMA's workforce response is an emerging capability rather than a mature national training system, and the report should distinguish the two. NEMA has identified trained, reliable caregiving staff as a critical scaling constraint and launched an in-house NEMA Academy with a standardised caregiver curriculum before staff reach residents, alongside nursing-college partnerships and dedicated staff accommodation. NEMA has also developed structured caregiver-training material covering areas such as personal hygiene, activities of daily living, infection prevention, professional boundaries, escalation and the limits of the caregiver role. This is closely aligned with the direction of the 2026 NITI Aayog caregiving report. However, NEMA should not yet be presented as having solved the national caregiver shortage, nor as operating a nationally accredited certification system; those are future or system-level objectives. The significance of the Academy at this stage is that NEMA is

attempting to build workforce capability as part of its care infrastructure, rather than treating caregivers as an external staffing input.

NEMA's own account of retention illustrates the wider pattern discussed in Chapter 7.5: certification has not been the constraint, staying in the role has. NEMA reports that NSDC-trained caregivers who complete its curriculum leave the profession quickly more often than they stay, and that the pattern differs by gender — young women more often remain until marriage or move into nursing through distance-education programmes, while young men more often exit caregiving for gig-economy work. NEMA states it is trying to address this through supervisory and specialisation roles, staff accommodation and nursing-college partnerships intended to give caregiving a visible career path rather than a single entry-level role, though it acknowledges this has not solved the underlying retention problem.

8.5 Mapping the Continuum of Care

NEMA describes a typical continuum as: Independent Living → Home Healthcare → Hospitalisation → Post-operative Recovery → Return Home → Assisted Living (if required) → Memory Care. Not every individual follows this sequence; the purpose is to ensure that appropriate support is available whenever needs change.

8.6 Lessons Learned

Building an integrated ecosystem has highlighted several broader lessons, according to NEMA's own account: families value continuity over complexity; trust is built through consistent communication; hospitality and healthcare are complementary; technology enables coordination but does not replace relationships; and workforce quality determines long-term success. These lessons may be relevant beyond a single organisation, though they reflect one operator's experience rather than an independently audited study.

8.7 Current Limitations

Like the wider industry, NEMA reports continuing to face challenges including workforce availability, scaling while maintaining quality, public awareness, affordability, regulatory evolution and technology integration. Recognising these limitations is essential for continuous improvement, and readers evaluating any senior care provider — including NEMA — should seek independently verified data on outcomes, staffing ratios and pricing before making care decisions.

8.8 Looking Ahead

The ageing journey is dynamic. Needs change, families change, healthcare evolves, and technology advances. Consequently, senior care organisations must continue adapting. The future will reward organisations capable of integrating housing, healthcare, hospitality, workforce development and technology into a coherent, person-centred ecosystem.

NEMA's own priorities for the next phase — deepening the caregiver Academy, scaling CareHub and extending post-operative recovery capacity — track closely with the workforce, technology and

continuum-of-care priorities this report sets out at a national level in Chapter 9; whether that alignment holds up as both scale is, in the end, a question for evidence rather than assertion.

Chapter Summary

The NEMA experience illustrates one possible approach to organising senior care around the individual rather than around isolated services. Whether this model proves optimal will depend on continued innovation, evidence, collaboration and adaptation. Its value lies less in claiming to provide all the answers than in demonstrating one practical framework for integrating diverse services into a more seamless ageing journey.

PUBLISHER'S INSIGHT

Every care model should be judged by one question: does it improve the ageing journey? Integrated care is not an end in itself. Its value lies in helping older adults experience safer transitions, stronger family involvement, greater independence and better quality of life. Success should be measured by outcomes for residents rather than by the number of services offered.

— NEMA Academy, Publisher

Chapter 9

A National Roadmap for India's Senior Care Ecosystem (2026–2035)

> *India cannot prepare for an ageing society by building more care homes alone. It must build an integrated ecosystem that enables every older adult to live with dignity, independence and purpose.*

"Senior care is an ecosystem, not an industry."

Every priority in this chapter is an attempt to build institutional support for that single idea. A roadmap built around isolated schemes — more beds here, a helpline there — will not close India's care gap. A roadmap built around ecosystem thinking might.

9.1 Why India Needs a National Roadmap

India stands at a critical demographic crossroads. The coming decade will witness a substantial increase in the number of older adults, accompanied by rising life expectancy, a growing burden of chronic disease, increasing prevalence of dementia, shrinking family size and rapid urbanisation.

Without coordinated planning, the country risks increasing pressure on hospitals, rising healthcare expenditure, greater caregiver shortages, social isolation among seniors, inadequate long-term care capacity, and unequal access between urban and rural India. Conversely, timely action presents an opportunity to build one of the world's most inclusive and innovative senior care ecosystems.

India already has a policy foundation to build on: the National Policy on Older Persons (1999), the Maintenance and Welfare of Parents and Senior Citizens Act (2007), the National Programme for the Health Care of the Elderly (NPHCE, launched 2010–11 by the Ministry of Health and Family Welfare), Ayushman Bharat Health and Wellness Centres (2018), and the National Action Plan for Senior Citizens (2020, Ministry of Social Justice and Empowerment). NPHCE has established Regional Geriatric Centres in 19 medical colleges across 18 states and two National Centres for Ageing (at AIIMS, New Delhi, and Madras Medical College, Chennai), alongside the Longitudinal Ageing Study in India (LASI), the country's principal evidence base on ageing. More recently, NITI Aayog's 2026 caregiving report has widened the policy lens toward the organisation, professionalisation and protection of the caregiving workforce. The priorities below build on — rather than replace — this evolving framework.

9.2 Vision for 2035

Every older adult in India should have access to safe, affordable, person-centred care that promotes health, independence, dignity and meaningful social participation, regardless of income or place of residence.

This vision rests on five guiding principles:

1. Ageing with Dignity — Respecting autonomy and individual choice.
2. Continuity of Care — Seamless transitions across care settings.
3. Community Before Institution — Supporting ageing in place wherever possible.
4. Quality and Safety — Standardised care with measurable outcomes.
5. Collaboration — Government, private sector, civil society and families working together.

9.3 National Priorities

Priority 1 — Build an Integrated Continuum of Care

Care should no longer exist in silos. Every district should progressively develop pathways linking primary healthcare, hospitals, home healthcare, rehabilitation, assisted living, memory care and palliative care. The goal is coordinated care rather than isolated services.

Priority 2 — Build a National Caregiving Workforce System

India needs a structured caregiving workforce strategy. Consistent with the direction of NITI Aayog's 2026 caregiving report, this should include a national policy framework, an appropriate national institutional mechanism for standard-setting and oversight, accredited training and certification, career pathways, continuing education, better working conditions and social protection, digital systems for workforce discovery and accountability, and ethical pathways to international employment. Caregiving should be recognised as a skilled and respected profession.

Priority 3 — Expand Home and Community-Based Care

Ageing in place should become the default policy objective, through home nursing, community rehabilitation, telemedicine, day-care centres, respite care, volunteer networks and family caregiver education.

Priority 4 — Develop Dementia as a National Health Priority

With an estimated 8.8 million Indians already living with dementia, priorities include national awareness campaigns, memory assessment clinics, dementia-friendly public spaces, specialist training, family support programmes, research funding and community-based memory support services.

Priority 5 — Improve Financing and Insurance

Long-term care remains unaffordable for many families. Potential reforms include long-term care insurance products, tax incentives, employer-supported eldercare benefits, public-private funding models, and expanded health insurance coverage for rehabilitation and home healthcare.

Priority 6 — Promote Technology and Innovation

Technology should support — not replace — human care, through electronic health records, AI-assisted care planning, remote monitoring, fall detection, medication adherence tools, digital caregiver training and integrated care coordination platforms.

Priority 7 — Create Age-Friendly Cities

Urban planning should incorporate universal accessibility, barrier-free public buildings, walkable neighbourhoods, safe transportation, accessible parks, community centres and senior-friendly housing standards.

Priority 8 — Establish National Quality Standards

India should progressively develop common standards covering infrastructure, staffing, infection control, resident safety, clinical governance, emergency preparedness, resident rights, family engagement and outcome measurement.

Priority 9 — Encourage Research and Data

Policy should be guided by evidence: annual national senior care reports, workforce data, occupancy trends, dementia prevalence studies, economic impact assessments, quality benchmarking and public reporting of key indicators.

Priority 10 — Build Public Awareness

Changing perceptions is as important as building infrastructure. National campaigns should promote healthy ageing, dementia awareness, financial planning, caregiver wellbeing, active lifestyles, social inclusion and positive images of ageing.

Priority 11 — Protect an Infant Industry Through Calibrated Regulation

India's organised senior care industry is still in its infancy, and how it is regulated over the next decade will shape whether it can scale to meet the demand set out earlier in this report. Because senior care sits at the intersection of healthcare, social care, hospitality and residential real estate, it risks being regulated as though it were each of these sectors at once --- building-usage and land-use norms designed for purely residential or purely clinical facilities, GST treatment that does not reflect its character as a social-sector service, and multiple, overlapping healthcare Acts and licensing regimes, none of which were designed with an integrated continuum-of-care model in mind. Applied cumulatively and without calibration, this regulatory burden risks constraining an industry India will need at scale within the next decade. Government should treat senior care as a distinct, emerging sector meriting a calibrated approach during this build-out phase --- including a review of building-usage classifications for senior living, rationalised GST treatment for age-care services, and a single coordinating framework that reconciles the different healthcare and social-care Acts currently governing the sector.

9.4 Stakeholder Action Matrix

Stakeholder	Key Responsibilities
Government	Policy, regulation, financing, public awareness
Healthcare Providers	Integrated clinical pathways, rehabilitation, training
Senior Care Operators	Quality care, innovation, transparency
Insurance Industry	Affordable long-term care products
Technology Companies	Digital solutions and AI-enabled care
Educational Institutions	Workforce development and research
NGOs	Community outreach and caregiver support
Families	Shared decision-making and emotional support

9.5 A Phased Roadmap (2026–2035)

Phase I (2026–2028): Build the Foundation

- Develop common quality standards.
- Begin implementation of a national caregiving policy and institutional framework, including the proposed national-level mechanism for standards and oversight.
- Expand caregiver training and develop retention mechanisms.
- Improve public awareness.
- Pilot integrated care models.
- Strengthen home healthcare.

Phase II (2029–2031): Scale the Ecosystem

- Expand assisted living and rehabilitation.
- Increase insurance participation.
- Integrate digital health records.
- Develop dementia services.
- Strengthen district-level care networks.

Phase III (2032–2035): Achieve Integrated Care

- Nationwide continuum of care.
- Mature workforce ecosystem.
- Technology-enabled coordination.
- Comprehensive quality benchmarking.
- Strong public-private partnerships.

9.6 Measuring Progress

A national scorecard should monitor: percentage of districts with integrated senior care pathways; number of certified caregivers; home healthcare utilisation; dementia diagnosis rates; hospital readmission rates among seniors; long-term care insurance coverage; resident and family

satisfaction; and quality accreditation rates. Transparent reporting will encourage accountability and continuous improvement.

Chapter Summary

India's demographic transition requires more than additional facilities — it requires a coordinated national strategy. By investing in workforce development, community-based care, technology, quality standards and age-friendly environments, India can create a senior care ecosystem that supports healthy ageing while strengthening healthcare and the economy.

PUBLISHER'S INSIGHT

India's demographic transition requires a societal response, not merely a healthcare response. Healthy ageing depends on coordinated action across healthcare, housing, finance, education, urban planning, technology and community organisations. A national roadmap must therefore extend beyond medical care to build an environment in which older adults can continue to contribute, participate and thrive.

— NEMA Academy, Publisher

Chapter 10

Conclusion — Towards an Age-Friendly India

India's ageing population represents one of the defining transformations of the twenty-first century. While it presents undeniable challenges, it also offers an opportunity to rethink how society supports later life.

This report has argued that senior care is not a single industry but an interconnected ecosystem comprising housing, healthcare, community services, technology, workforce development and public policy. The future lies not in isolated institutions but in integrated systems that accompany individuals throughout the ageing journey.

Families will remain the cornerstone of eldercare in India. However, changing social structures mean that families increasingly require organised support rather than replacement. Public institutions, private enterprises, healthcare providers, educational institutions and civil society all have important roles to play. No single organisation can build this ecosystem alone. Progress will depend on collaboration, innovation and a shared commitment to quality, dignity and inclusion.

"Senior care is an ecosystem, not an industry."

The Five Pillars of Healthy Ageing

This report proposes one original framework, developed by NEMA Academy and used throughout this publication, for thinking about what healthy ageing requires — intended to recur in national and industry conversations beyond this report:

Health — Preventive, acute and long-term care.
Home — Safe, accessible and age-friendly living environments.
Human Connection — Family, friendships, community and purpose.
Hospitality — Comfort, dignity, nutrition and meaningful experiences.
Hope — Lifelong learning, independence and optimism.

These Five Pillars are not a marketing device. They are offered as a memorable, testable framework: any senior care policy, investment or service can be evaluated by asking which of these five pillars it strengthens, and which it neglects.

The India Senior Care Report is intended not as the final word on the sector, but as a contribution to an ongoing national conversation. As the ecosystem evolves, new models, technologies and policies will emerge. Future editions of this report will document those developments, highlight progress, identify emerging challenges and encourage informed dialogue among stakeholders.

Ultimately, the success of India's senior care ecosystem will not be measured by the number of facilities built or services offered. It will be measured by whether older adults across the country are able to live longer, healthier, safer and more meaningful lives.

Appendix A

India Senior Care Statistics 2026 — A Data Compendium

This appendix collects the key demographic, health, market and policy statistics referenced throughout this report, together with their original sources. Where estimates vary meaningfully across sources — common in an early-stage, loosely defined sector — the range is shown rather than a single figure.

A.1 Demographics

Indicator	Value	Source
Population aged 60+, 2022	149 million (10.5% of population)	UNFPA / IIPS, India Ageing Report 2023
Population aged 60+, 2024 (est.)	153–157 million	UNFPA, 2025; JLL-ASLI, 2024
Population aged 60+, 2050 (projected)	347 million (20.8% of population)	UNFPA / IIPS, India Ageing Report 2023
Growth in population aged 80+, 2022–2050	~279%	UNFPA / IIPS, India Ageing Report 2023
Elderly population overtakes children (0–14)	Projected 2046	UNFPA / IIPS, India Ageing Report 2023
India's global share of world population aged 60+ by 2050	~15–17%	UNFPA / IIPS, 2023; Colliers, 2024
Life expectancy at birth	42.9 yrs (1960) → 70.4 yrs (2020)	Registrar General of India, SRS-based Life Tables 2014–18
Additional life expectancy at age 60	18.3 yrs (men); 19.0 yrs (women)	India Ageing Report 2023 (LASI-based)
Sex ratio among elderly, central India	973/1,000 (2011) → 1,053/1,000 (2021)	India Ageing Report 2023, Census of India
Elderly in poorest wealth quintile	~40%	UNFPA India, 2025
Elderly with no personal income	~20%	UNFPA India, 2025
Index of ageing (elderly per 100 children under 15)	23.4 (2001) → ~53 (2026, projected)	ISEC / BKPAI Working Paper, using Census-based projections

A.2 Dementia and Cognitive Health

Indicator	Value	Source
Dementia prevalence among 60+ (national estimate, LASI-based)	7.4% (~8.8 million people)	Lee et al., Alzheimer's & Dementia, 2023 (LASI data, IIPS/Harvard)
Earlier ARDSI estimate, 2010	~3.7 million people	Dementia India Report 2010, ARDSI
Earlier ARDSI projection, 2020	~5.29 million people	Dementia in India 2020, ARDSI Cochin Chapter
Alternative expert-consensus (Delphi) estimate	2.8% prevalence (~3.9 million people)	Delphi process study, PMC, India-specific expert panel
Annual household cost of dementia care (2019)	₹29,000–96,000 (rural); ₹66,000–300,000 (urban)	Dementia in India 2020, ARDSI

Note on divergent dementia estimates: prevalence estimates vary by an order of magnitude across studies (2.8%–7.4%) due to differing sample designs, diagnostic criteria and geographic coverage. This report treats the 2023 LASI-based national estimate (7.4%, ~8.8 million) as the most methodologically robust current figure, since it is drawn from a nationally representative survey with clinical consensus validation, but reports the alternative estimates for transparency.

A.3 Market Size Estimates

Segment / Firm	Base Year Estimate	Forecast	CAGR	Source
Senior Housing — Grand View Research	n/a	USD 3.23 bn by 2030	7.78% (2024–30)	Grand View Research, 2024
Senior Living — Mordor Intelligence	USD 3.55 bn (2025)	USD 14.14 bn by 2031	25.92% (2026–31)	Mordor Intelligence, 2026
Senior Living — Colliers	USD 2–3 bn (2024)	USD ~12 bn by 2030	>30%	Colliers India, May 2024
Senior Living Housing — JLL / ASLI	USD 1.8–2 bn (2025)	USD 8 bn (₹68,000+ cr) by 2030	n/a (~4x vs. current)	JLL – Association of Senior Living India, 2025 ("Elevating the Golden Years 2.0")
Home Healthcare — Grand View Research	USD 8.8 bn (2022)	USD 36.1 bn by 2030	19.29% (2023–30)	Grand View Research, 2023
Home Healthcare — IMARC Group	USD 16.30 bn (2025)	USD 74.57 bn by 2034	15.83% (2026–34)	IMARC Group, 2026

Home Healthcare — Mordor Intelligence	USD 11.90 bn (2025)	USD 27.38 bn by 2030	18.13% (2025–30)	Mordor Intelligence, 2025
Home Healthcare — TechSci Research	USD 9.07 bn (2024)	USD 15.51 bn by 2030	9.35% (2025–30)	TechSci Research, 2025
Home Healthcare — SPER Market Research	n/a	USD 52.47 bn by 2032	19.49%	SPER Market Research

Additional benchmarks: organised senior living supply meets an estimated 1.3% of potential demand nationally as of 2025 — JLL–ASLI projects this could reach roughly 2.5% by 2030 under a favourable, policy-led scenario, not a current alternative estimate — versus over 6% in the United States and Australia (JLL–ASLI, 2025; Colliers, 2024). More than 22,000 organised senior living units (22,157 as of June 2025) have been developed in India to date, with southern India commanding roughly 60% of the national market (JLL–ASLI, 2025). Target households for senior living are projected to grow from 1.7 million (2025) to 2.3 million (2030) (JLL–ASLI, 2025).

A.4 Key Industry Players (ASLI Member Directory)

The table below summarises organisations listed in the Association of Senior Living India's public member directory as of 2026, mapped to the four-layer ecosystem framework used throughout this report (see Chapter 6.6 for full discussion). ASLI membership is voluntary and self-selected; this is a reference list of organised, association-affiliated providers, not an exhaustive market census or quality ranking.

Segment	Selected Organisations	Region / Notes
Dedicated Senior Living Operators	Columbia Pacific Communities, Antara Senior Living, Primus Lifespaces, Oasis Senior Living, Aurum Senior & Assisted Living, NEMA Eldercare (Amen co-living)	Columbia Pacific: ~1,600 units, 9 communities, south India (largest by units, per ASLI)
Diversified Real Estate Developers	Ashiana Housing, Paranjape Schemes (Athashri), Prestige Estates Projects, Arun Excello Group	Senior living is one product line within a wider residential/commercial portfolio
Other Housing Members	Saket Group, Bahri Estates (Anandam), Eden Retirement Living, Vardaan Senior Living, Golden Planet, 2nd Innings Retirement Resort, PP Reddy Retirement Homes, The Panchvati Residences	Developer vs. operator status not independently confirmed by this report
Assisted Living / Memory Care	Athulya Senior Living, Covai Care / Manasum Buildtech, Kshetra Assisted Living, Artha Assisted Living, Vedaanta Senior Living, Priaashraya, NEMA Eldercare	Concentrated in Chennai, Coimbatore (since 2004), Hyderabad, Kerala

Home Healthcare	Portea Medical, Health Care at Home (HCAH), AmeriHealth Home Health Care, Care Continuum, Yodda Elder Care, NEMA Eldercare	Care Continuum founded 2014, Kolkata-focused
Post-Acute / Rehabilitation	SuVitas, Genesis Rehab Services, NEMA Eldercare (post-op recovery)	Genesis: India partnership with a US operator founded 1985
Digital Platforms & Community	Emoha Eldercare, SeniorWorld, Unmukt (The Senior Hub), Khyaal, WisdomCircle, GenS Life, NEMA Carehub	Care coordination, discovery, community engagement and caregiver training
Assistive Technology	Clockheath, BeAble Health, Flexmo / FlexMotiv, True Assist Tech, Dozee,	Rehabilitation devices, mobility aids, remote monitoring
Nonprofit / Specialised	Travancore Foundation, Hope Ek A.S.H.A.	Kerala charitable trust; dementia caregiver support (est. 2003)

NEMA Eldercare appears in five rows above rather than one — co-living, assisted living/memory care, home healthcare, post-acute/rehabilitation and caregiver platform/Academy — reflecting the multi-service model described in its own account in Chapter 8, rather than a data error. Among ASLI's member organisations, this breadth of coverage across the ecosystem appears to be unusual, though this report has not independently verified whether any other member spans a comparable number of segments.

Source: Association of Senior Living India (ASLI), Member Directory, asli.org.in/member-directory, accessed 2026.

A.5 Policy and Institutional Framework

Policy / Institution	Year	Detail
National Policy on Older Persons (NPOP)	1999	First national policy framework recognising state responsibility for elderly welfare
Maintenance and Welfare of Parents and Senior Citizens Act	2007	Section 20 mandates state provision for treatment of chronic, terminal and degenerative diseases in the elderly
National Programme for the Health Care of the Elderly (NPHCE)	2010–11	Ministry of Health and Family Welfare; established Regional Geriatric Centres in 19 medical colleges (18 states) and 2 National Centres for Ageing (AIIMS Delhi; Madras Medical College)
Longitudinal Ageing Study in India (LASI)	Ongoing (since ~2017)	Nationally representative survey led by IIPS Mumbai; principal evidence base for India's ageing research
Ayushman Bharat Health & Wellness Centres	2018	Extended comprehensive primary health care to include elderly care services

National Action Plan for Senior Citizens	2020	Ministry of Social Justice and Empowerment; cross-ministry plan covering financial security, health care and dignity

A.6 A Note on Data Quality

India's senior care sector suffers from a shortage of independent, peer-reviewed data relative to its scale and urgency. Much of the market-sizing data in this appendix originates from commercial research firms whose methodologies are not always fully disclosed; demographic and dementia data are stronger, drawing on government surveys (Census, SRS Life Tables) and the LASI survey, which involved clinical validation. Readers using this report for investment, policy or clinical decisions should consult primary sources directly (linked in Appendix C) rather than relying on this compendium alone.

Workforce data is a particular gap. No public, national dataset currently tracks caregiver retention, attrition, exit destinations or gender-disaggregated outcomes for NSDC-aligned caregiving courses. The attrition and gendered-exit pattern discussed in Chapter 7.5 is therefore reported as operator experience, not as a published statistic, and should be treated accordingly until national workforce data — called for as Priority 9 in Chapter 9 — becomes available.

Appendix B

Glossary of Senior Care Terms

Activities of Daily Living (ADLs)
Basic self-care tasks — bathing, dressing, toileting, transferring, continence and feeding — used to assess a person's level of functional independence.

Instrumental Activities of Daily Living (IADLs)
More complex tasks needed for independent living, such as managing finances, medication, transportation, shopping and housekeeping.

Ageing in Place
The preference and practice of older adults remaining in their own home and community for as long as possible, supported by appropriate services rather than institutional relocation.

Assisted Living
A residential care model providing support with ADLs alongside housing and hospitality, for residents who need some but not continuous nursing supervision.

Continuum of Care
An integrated system of care settings and services designed to guide and track a person over time through a comprehensive range of health, rehabilitation and support services.

Dementia
A syndrome, usually chronic or progressive, involving disturbance of multiple higher cortical functions including memory, thinking, orientation and comprehension; Alzheimer's disease is its most common cause.

Geriatric Care
Medical care focused on the health needs of older adults, typically provided by specialists trained in the physiological and psychological aspects of ageing.

Home Healthcare
Medical and non-medical services — nursing, therapy, personal care — delivered to a patient in their own home rather than in a hospital or care facility.

Independent Living
Housing designed for self-sufficient older adults who require no regular personal or medical care, but who benefit from community, security and hospitality services.

Long-Term Care (LTC)
A range of services designed to meet a person's health or personal care needs over an extended period, typically due to a chronic illness or disability.

Memory Care
A specialised, secure form of residential care designed for individuals living with dementia or other cognitive impairments, involving trained staff and structured routines.

Old-Age / Elderly Dependency Ratio

The ratio of the population aged 60 or 65 and above to the working-age population, used to measure the economic burden of an ageing population on the workforce.

Palliative Care

Specialised medical care focused on providing relief from the symptoms and stress of serious illness, aimed at improving quality of life for the patient and family, distinct from end-of-life (hospice) care though sometimes overlapping.

Rehabilitation

Services — physiotherapy, occupational therapy, speech therapy — aimed at restoring function and independence after illness, injury or surgery.

Respite Care

Short-term, temporary care provided to give primary family caregivers a break from their caregiving responsibilities.

Retirement Housing

Age-restricted or age-friendly residential communities for active, independent seniors, typically offering enhanced safety and amenities but minimal clinical support.

Silver Economy

The full range of economic activity — products, services and employment — generated by and for the population of older adults.

Appendix C

Methodology and References

C.1 Methodology

This report combines three types of source material: (1) government and multilateral demographic and policy data, including the UNFPA/IIPS India Ageing Report 2023, Census of India, SRS-based Life Tables, NITI Aayog policy and caregiving publications, and national policy documents; (2) peer-reviewed academic research, notably the 2023 Longitudinal Ageing Study in India (LASI)-based dementia prevalence study published in Alzheimer's & Dementia; and (3) commercial market-research reports on senior living and home healthcare market size, sourced from firms including Grand View Research, Mordor Intelligence, Colliers, JLL, IMARC Group, TechSci Research and SPER Market Research.

Where commercial market-sizing estimates diverge significantly — which they do throughout this sector, given differing scope definitions and proprietary methodologies — this report presents the range of published figures rather than selecting a single number, and flags this explicitly in the relevant chapters and in Appendix A. Chapter 8's case study material reflects NEMA Academy's own account of its operations and has not been independently audited; it is presented as illustrative rather than as verified performance data.

This report does not present original primary research, survey data or proprietary datasets. It is a synthesis and analytical framework built on publicly available secondary sources, current as of mid-2026. Readers requiring investment-grade or clinical-grade data should consult the primary sources listed below directly.

C.2 Limitations

- Market-size figures for senior living and home healthcare vary widely across commercial research providers and should be treated as indicative ranges, not precise figures.
- Dementia prevalence estimates depend heavily on study design; this report favours the most recent nationally representative estimate but notes meaningful variation in the literature.
- State- and district-level data are limited; most figures cited are national aggregates and may mask significant regional variation (for example, faster ageing in southern states).
- This report was prepared with the assistance of an AI language model (Claude, Anthropic) for research synthesis, drafting and editing; all cited facts were checked against the named sources at the time of writing, but sources, market estimates and policy details can change and should be independently reverified before use in investment, clinical or policy decisions.

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