

# Unlocking India's Silver Dividend

## Advancing Nutrition & Healthy Ageing for **Older Adults**

An implementation-focused framework for integrating person-centred nutrition screening, tailored diet and activity support, oral and swallowing care, caregiver capacity, referral and social protection into India's healthy-ageing response.



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## Acronyms

| Acronym  | Full Form                                                          |
|----------|--------------------------------------------------------------------|
| AAM      | Ayushman Arogya Mandir                                             |
| AB-PMJAY | Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana                   |
| ANM      | Auxiliary Nurse Midwife                                            |
| ASHA     | Accredited Social Health Activist                                  |
| AVYAY    | Atal Vayo Abhyuday Yojana                                          |
| BMI      | Body Mass Index                                                    |
| CHC      | Community Health Centre                                            |
| CHO      | Community Health Officer                                           |
| IIPS     | International Institute for Population Sciences                    |
| ICMR-NIN | Indian Council of Medical Research–National Institute of Nutrition |
| ICOPE    | Integrated Care for Older People (WHO)                             |
| LASI     | Longitudinal Ageing Study in India                                 |
| MNA-SF   | Mini Nutritional Assessment–Short Form                             |
| NCD      | Non-Communicable Disease                                           |
| NPHCE    | National Programme for Health Care of the Elderly                  |
| PHC      | Primary Health Centre                                              |
| PPHF     | People to People Health Foundation                                 |
| UNFPA    | United Nations Population Fund                                     |
| WHO      | World Health Organization                                          |

## Position in Brief

India's demographic transition is already reshaping health and social policy. The population aged 60+ was estimated at 149 million in 2022 and is projected to reach about 347 million by 2050; by 2046, older persons are expected to outnumber children aged 0-14 (UNFPA India and IIPS, 2023).

Longevity will become a silver dividend only when it is accompanied by functional ability, food, nutrition and income security, autonomy and participation. Older Indians face a double burden of undernutrition and overweight, alongside anaemia, sarcopenia, micronutrient inadequacy, oral and swallowing problems, non-communicable disease and food and nutrition insecurity. These risks are intensified by gender, poverty, disability, living arrangements and uneven access to care. Gender-responsive ageing should therefore be treated as a specific implementation principle, with deliberate attention to older women - particularly widows and women living alone - across food and income security, access to health and social-protection services, mobility, autonomy and caregiver support.

India already has the essential platforms - Ayushman Arogya Mandirs (AAMs), the National Programme for Health Care of the Elderly (NPHCE), Elder line, oral-health and rehabilitation services, Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) and social protection. What is missing is a common nutrition-and-function pathway with ownership, referral standards, follow-up and measurable outcomes.

**PPHF position.** Do not create a new stand-alone scheme. Embed a defined, accountable nutrition-and-function pathway in AAM and NPHCE services: empanel the 60+ population; screen at least annually and at high-risk transitions; provide tiered, person-centred care; connect referral and entitlements; and track function, quality and equity through a ten-year implementation roadmap.

## 1. The Urgency for Action: Unequal Ageing and Nutrition Vulnerability

Ageing is rapid and unequal. The oldest-old population is expected to grow sharply, with a disproportionate number of widowed women and people with higher care needs. More than 40% of older Indians are in the poorest wealth quintile and 18.7% report no personal income. Nutrition policy must therefore be clinical, social and gender-responsive rather than limited to food advice or body mass index.

Implementation principle - gender-responsive ageing. Given the disproportionate vulnerability of older women, particularly widows and women living alone, programme design should assess and address gendered barriers to food, income security, health services, social protection, mobility and caregiver support. Coverage, referral and outcomes should be reviewed by sex and living arrangement so that gender gaps are visible and acted upon.

Evidence and measurement should make systematic use of the Longitudinal Ageing Study in India (LASI) as a nationally comparable source for baseline and trend analysis on ageing, living arrangements, economic security, health, function and care needs, complemented by routine programme data for local accountability.

*Table 1. Selected evidence and its programme implication. Estimates come from different designs and years and should not be read as a single national dashboard.*

| Issue                         | Indicative evidence                                                                                               | Programme implication                                                                                                              |
|-------------------------------|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| <b>Demographic transition</b> | 149 million people aged 60+ in 2022; about 347 million projected by 2050.                                         | Plan against the full 60+ denominator, with additional outreach to people aged 80+, those living alone and people with disability. |
| <b>Double burden</b>          | Underweight: men 28%, women 25%; urban residence is associated with lower underweight but higher overweight risk. | Screen for both weight loss/undernutrition and obesity/NCD risk; avoid one-size feeding or restriction.                            |
| <b>Anaemia</b>                | Pooled prevalence among adults aged 60+: 68.3% (95% CI 60.7-75.9).                                                | Test and investigate according to clinical protocol; do not assume iron deficiency or use blanket supplementation.                 |

| Issue                                     | Indicative evidence                                                                                                                                         | Programme implication                                                                                                                                                                                                                                                                              |
|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Muscle and oral function</b>           | Sarcopenia 43.6%; severe sarcopenia 19.4%. Complete tooth loss 16.3% among adults aged 50+. 11% aged 60+ reported a history of falls (Biswal et al., 2026). | Combine adequate food with resistance, balance and mobility activity; include oral and swallowing care. Integrate structured group-based exercises—such as chair exercises, stair climbing, yoga-based movements and resistance-band training—as a routine component of elderly wellness services. |
| <b>Gender and economic vulnerability</b>  | Widowhood: women 54.0%, men 16.5%; living alone: 8.6% versus 2.5%. Older women have lower income and insurance coverage.                                    | Proactively identify older women living alone; protect consent; facilitate pensions, food entitlements and accessible care; monitor caregiver strain.                                                                                                                                              |
| <b>High prevalence of multi-morbidity</b> | 23.8% aged 60+ had multi-morbidities (Ahamad et al., 2025).                                                                                                 | Administer an initial screening checklist for early symptoms of disease and nutritional deficiency at PHC, CHC and tertiary hospitals, with referral to specialists where indicated.                                                                                                               |
| <b>Poor mental health</b>                 | 30% of adults aged 60+ had depression symptoms (IIPS et al., 2020).                                                                                         | Integrate routine mental-health screening and referral into primary and elderly care.                                                                                                                                                                                                              |
| <b>Support to caretakers</b>              | Compounded expenses of medical care, daily assistance and specialised housing create substantial economic strain on caregiving families.                    | Assess and provide financial benefits such as tax rebates, elderly-care leave for family, dietetic assistants and home care.                                                                                                                                                                       |

Equity must be designed into the delivery funnel. Empanelment, screening, assessment, care-plan completion, referral, entitlement linkage and outcomes should be disaggregated by sex, age band, rural or urban location, social group, wealth, disability and living arrangement. Digital access must never be a condition of care. Assessment should also capture key social determinants that shape nutrition in later life, including income and food affordability, social isolation, ability to shop and cook, access to markets, housing conditions, mobility limitations and the availability and capacity of caregivers.

### 1.1 Healthy Longevity as a Viksit Bharat @2047 Priority

India's Viksit Bharat @2047 vision — the national commitment to become a developed nation by the centenary of independence — is organised around four dimensions: economic growth, social progress, environmental sustainability and good governance. Healthy longevity belongs inside that vision as a development outcome in its own right, not as an adjunct to it. Applied to older-person nutrition and care, the four dimensions translate into the commitments set out in Table 2.

Table 2. Viksit Bharat @2047 and healthy ageing.

| Dimension                                   | Commitment for older-person nutrition and healthy ageing                                                                                                                              |
|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Economic growth and productive longevity    | Prevent avoidable disability and hospital use; sustain older adults' paid and unpaid economic contribution; and build skilled employment in nutrition, rehabilitation and caregiving. |
| Social progress and inclusion               | Reach older women, poor households, rural and tribal communities, persons with disability, and those living alone or homebound.                                                       |
| Environmental sustainability and resilience | Promote affordable local diets, safe water, heat-sensitive outreach, age-friendly environments, and continuity of food, medicine and care through climate shocks.                     |
| Good governance and accountable delivery    | Connect Ayushman Arogya Mandir (AAM), NPHCE, welfare schemes, food entitlements and insurance through common referral data; and publish district-level, equity-disaggregated results. |

An older population that stays productive, included, resilient and well-governed is a direct, measurable contribution to the 2047 vision; its absence is an equally direct, measurable drag on it.

## 2. Building an Integrated Nutrition and Care Pathway for Older Adults

India is not starting from zero. NPHCE services were reported functional in 722 districts in 2024-25, while AAMs already provide population-linked primary care for older persons, NCDs, basic oral health, mental health and palliative care. These assets can support an integrated pathway rather than a new vertical programme.

AAMs should own empanelment, screening, initial assessment and follow-up; NPHCE should provide the geriatric and referral backbone. AVYAY (Atal Vayo Abhyuday Yojana), pensions, food entitlements and community supports should be connected through facilitated referral. AB-PMJAY and the Ayushman Vay Vandana card improve hospital financial protection, but discharge must reconnect nutrition and function needs to primary care. The existing support from the Ministry of Social Justice & Empowerment to the elderly (via elderly helpline) also lacks the component of nutrition which could be utilized to promote healthy diets among the elderly. As NPHCE is a major platform for prevention and management of NCDs among older people, nutrition assessment, counselling and clinically appropriate nutrition care should be made an explicit component of NCD risk assessment, treatment plans, rehabilitation and follow-up within the programme.

Mission Saksham Anganwadi and POSHAN 2.0 do not include older adults among eligible groups. Their convergence and behaviour-change experience can inform local action, but primary case-management responsibility should not be shifted to Anganwadi Workers without mandate, staffing and finance.

Scaling up nutrition services for elderly is therefore the need of the hour. Through policy regulation, nutrition should be prioritized to ensure healthy longevity among the growing elderly population in the country.

**The policy gap.** India has platforms, but not an end-to-end pathway with common tools, defined owners, referral standards, counter-referral, entitlement follow-through and outcome accountability.

### 2.1 Essential Nutrition and Functional Care Pathway

1. **Empanel and screen.** Map all residents aged 60+ through AAM and community registers. Screen at enrolment, at least annually, after hospital discharge and when appetite, weight, mobility or function declines; use proactive outreach for high-risk groups. For planning and service-intensity purposes, data may be reported in age bands such as 60-69, 70-79 and 80+, while avoiding age alone as a gatekeeper for care. All adults aged 60+ should remain eligible for screening; comprehensive assessment and follow-up should be intensified with advancing age and, more importantly, with frailty, functional decline, multimorbidity, recent hospitalisation, living alone or other identified risk. People aged 80+ should receive proactive outreach and home-based support where needed.
2. **Assess the person, not BMI alone.** For a positive screen, assess recent weight change, appetite and diet; BMI with waist-to-hip ratio and body composition; strength or chair-rise; mobility; oral and swallowing problems; mood or cognition; medicines; living arrangements, food access and caregiver support. Include income and food affordability, social isolation, ability to obtain and prepare food, market access, housing and kitchen conditions, transport, mobility and caregiver availability/capacity as part of the social assessment.
3. **Stratify risk and co-produce a care plan.** Distinguish undernutrition and weight loss, obesity and NCD risk, sarcopenia or frailty, oral or swallowing problems, anaemia or suspected deficiency, and social risk. Record the person's goals, agreed actions, review date and escalation trigger.
4. **Deliver integrated care and referral.** Combine tailored food, safe physical activity, oral care, clinically indicated diagnostics and treatment, medication review and rehabilitation. Use designated referral points and counter-referral; trace missed visits. Make medication review a routine opportunity to identify potential drug–nutrient interactions among commonly prescribed medicines for older adults, with appropriate correction, counselling or referral incorporated into the individual care plan.
5. **Connect entitlements and caregiver support.** Facilitate access to food entitlements, pensions, insurance, assistive devices, transport and community meal options. With consent, equip family or paid caregivers without assuming unlimited unpaid care or displacing autonomy. Family caregivers should be supported with practical nutrition guidance, training for feeding and swallowing risks, access to dietetic advice, respite/home-care linkages and referral support. Policy options such as caregiver leave or targeted financial/tax support

may be assessed for feasibility and equity, but should complement - not substitute for - public responsibility for essential services.

6. **Follow outcomes and improve quality.** Reassess high-risk people within a defined interval; monitor weight stability, diet quality, strength, mobility, function, referral completion and adverse effects; use equity-disaggregated reviews to correct drop-off before scale.
7. **Development of intensive elderly care curricula.** Include geriatric care courses for doctors and allied health-care professionals to improve the quality of care for older people and build a workforce specialising in geriatric care.

## 2.2 Nutrition and Clinical Care Principles for Healthy Ageing

ICMR-NIN's Dietary Guidelines for Indians (2024), particularly Guideline 16, provide a national food-based reference. They must be adapted to body size, activity, recent weight change, appetite, disease, affordability, culture, oral function and the older person's goals; they are not universal therapeutic prescriptions.

Table 3. Compact dietary and clinical rules for older-person care in India.

| Principle                                       | Programme rule                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Reference needs, then individualise</b>      | Illustrative diets provide about 1,530-1,740 kcal and 56-62 g protein for healthy, active reference adults. Recalculate for size, activity, illness, weight change and rehabilitation goals; reassess response.                                                                                                                                                                                                                                             |
| <b>Food first; protein across meals</b>         | Promote affordable, locally available protein-rich foods such as pulses and beans, milk, curd, paneer, nuts and oilseeds, and, where culturally acceptable, eggs, fish or lean meat. Counsel older adults and caregivers to include a protein source at each meal and combine adequate protein intake with safe resistance, balance and mobility activities.                                                                                                |
| <b>Diet quality without harmful restriction</b> | Prioritise vegetables, leafy greens, seasonal fruit, whole grains and millets; use iodised salt and limit high-fat, high-salt, high-sugar and ultra-processed foods. Avoid restrictions that reduce intake or enjoyment.                                                                                                                                                                                                                                    |
| <b>Hydration, food safety and oral function</b> | Use safe water and hygienic food; check fluid restrictions, dry mouth, dental pain and dysphagia. Modify texture only after assessment and preserve nutrient density, safety and dignity.                                                                                                                                                                                                                                                                   |
| <b>Deficiency requires diagnosis</b>            | Investigate anaemia and suspected iron, vitamin B12, folate, vitamin D or other deficiency according to clinical protocol; avoid blanket supplementation. Where deficiency is confirmed or strongly suspected under clinical protocol, provide condition-appropriate supplementation (for example iron-folic acid, vitamin B12, folate or vitamin D) with dose, duration and follow-up defined by clinical guidance; avoid routine blanket supplementation. |
| <b>Adapt for risk and complex disease</b>       | Use smaller, frequent nutrient-dense meals for poor appetite or weight loss. Frailty, renal or liver disease, heart failure, diabetes and post-hospital recovery require medical and dietetic review. Integrate nutrition screening at AAMs using a validated tool such as the Mini Nutritional Assessment–Short Form (MNA-SF), supported by a brief diet-quality checklist and basic anthropometric assessment to guide individualized care.               |

Every care plan should state the nutrition problem, food and activity actions, oral or swallowing modifications, entitlement support, review date and escalation trigger.

## 3. An Economic and Equity Framework for Accountable Scale-Up

Investment in older adults' nutrition and functional health can preserve independence, delay preventable disability, reduce avoidable healthcare use and ease the financial and caregiving burden on families. These benefits strengthen the economic case for action. However, access to essential care is a right and must not be made conditional on demonstrating a positive financial return.

NITI Aayog estimated India's silver economy at approximately Rs 73,082 crore, with healthcare accounting for nearly 31% of older persons' expenditure. National Health Accounts reported that out-of-pocket expenditure represented 39.4% of total health expenditure in 2021–22. Older adults and their families also bear substantial costs for nutritious food, medicines, diagnostics, transport, assistive devices, accompanying-person time and long-term care. These indicators represent different economic concepts and should not be combined or interpreted as potential programme savings.

### 3.1 Accountability from Family to Government

Accountability should follow the older person's pathway. Families may participate by choice and with support, but government and programme leadership remain responsible for access, quality, safeguarding, referral and continuity.

Table 4. Compact accountability framework.

| Actor                                         | Core responsibility                                                                                                                                                                                                                                                                                                                                                                          | Accountability mechanism                                                                                                                                                                                                                                                                                                                                                                                         |
|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Older person and family/caregiver</b>      | Co-produce meal, activity and medication plans; notice change; seek review; respect autonomy and preferences.                                                                                                                                                                                                                                                                                | Assess caregiver capacity and burden; ensure care is not denied when family support is unavailable. All family members and caregivers provide respectful, dignified support to the best of their ability. Programme accountability should also include caregiver support: practical nutrition counselling, training, referral to home-care/respice services where available, and assessment of caregiver strain. |
| <b>Community, panchayat and civil society</b> | Identify exclusion, support peer or meal initiatives, accompany referral, connect entitlements and bring older people's experience into service design.                                                                                                                                                                                                                                      | Quarterly community review; accessible grievance channels; public action log for unresolved access or safeguarding concerns.                                                                                                                                                                                                                                                                                     |
| <b>ASHA, ANM, CHO and AAM team</b>            | Empanel, screen, stratify risk, initiate care, refer, trace missed visits and record entitlement linkage and outcomes.                                                                                                                                                                                                                                                                       | Strengthen monitoring through monthly denominator-based dashboards, supervisory case audits, and defined timelines for assessment, referral and reassessment. Add a focused module to existing ASHA/ANM training on early identification of undernutrition in older adults, including warning signs such as swallowing difficulties (dysphagia).                                                                 |
| <b>Block, district and NPHCE services</b>     | Maintain dietetic, medical, dental, diagnostic and rehabilitation referral capacity; manage supplies, counter-referral, supervision and high-risk review.                                                                                                                                                                                                                                    | Named nodal officer; quarterly convergence review; referral-completion and equity-gap analysis with dated corrective action.                                                                                                                                                                                                                                                                                     |
| <b>State and national leadership</b>          | Finance and adapt the minimum package; set standards, competencies, costing norms, safeguards and core data; assure quality and commission evaluation. Integrate nutrition standards explicitly within NPHCE/NCD care pathways and evaluate scalable supports for family caregivers, including home-care, dietetic assistance and feasible social-protection or employment-related measures. | Annual State performance and equity report; national benchmarks; independent outcome and economic evaluation; roadmap refresh.                                                                                                                                                                                                                                                                                   |

Minimum accountability dashboard: distinguish process indicators from outcome indicators. Process indicators should include empanelment and screening coverage; comprehensive assessment of positive screens within 14 days; care-plan completion; referral and counter-referral within 30 days; entitlement linkage; reassessment of high-risk cases; and grievance resolution. Outcome indicators should include nutritional status and diet quality; strength, mobility and functional ability; independence in activities of daily living; health-related quality of life; avoidable hospitalisation or readmission; and caregiver burden. The programme should be judged primarily by improvement in these outcomes rather than screening volume alone. All indicators should be disaggregated by sex, age band, disability, wealth, residence and living arrangement, and aligned where feasible with LASI measures to support national and State trend analysis.

## 4. Ten-Year Roadmap, 2026-2035

PPHF proposes a four-phase roadmap that moves deliberately from proof and costing to representative State expansion, to financed scale, to national institutionalisation — each phase gated by evidence rather than by elapsed time.

Table 5. Proposed ten-year roadmap (2026–2035), read within the Viksit Bharat @2047 backdrop set out in Table 2.

| Phase                                            | Priority action                                                                                                                                                                                                                                                                                                                                                                                                                   | Decision milestone                                                                                                                                                                                                 |
|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>2026–2027</b><br><i>Define and prove</i>      | Establish stewardship; adapt and validate screening, dietary and referral tools; map the 60+ population denominator; micro-cost the care pathway; and pilot in two to three contrasting districts with gender- and equity-disaggregated baselines. Define a core indicator set separating process from outcome measures and align baseline definitions, where feasible, with LASI to enable comparison beyond programme coverage. | A validated minimum package, workforce competencies, dataset and safeguards; a costed decision on scale-up; pilot results reported publicly.                                                                       |
| <b>2028–2030</b><br><i>Demonstrate and build</i> | Expand through representative State clusters; establish nutrition, dental and rehabilitation referral hubs; train supervisors and caregivers; and integrate core data systems with climate-continuity plans.                                                                                                                                                                                                                      | Test targets of at least 70% annual screening coverage and 80% comprehensive assessment of positive screens within 14 days, reported by equity group.                                                              |
| <b>2031–2033</b><br><i>Scale and finance</i>     | Roll out evidence-based State packages using pooled procurement, supportive supervision, performance-linked gap reduction and interoperable referral records; expand the skilled care workforce.                                                                                                                                                                                                                                  | A functional pathway in at least half of all districts, conditional on capacity and evaluation; demonstrated improvement in referral, follow-up and functional outcomes without widening equity gaps.              |
| <b>2034–2035</b><br><i>Institutionalise</i>      | Make the minimum care pathway available in every district; embed standards in routine financing and quality assurance; complete an independent outcome, economic and equity evaluation; and prepare the 2036–2047 strategy.                                                                                                                                                                                                       | Named institutional ownership and public dashboards in every district; major sex, rurality and wealth coverage gaps reduced by at least half from baseline; a refreshed national roadmap for the following decade. |

## 5. PPHF Position

India should adopt a national minimum nutrition-and-function pathway for older people, delivered through AAM and NPHCE and connected to oral health, rehabilitation, insurance and social protection. The pathway should identify risk early, individualise dietary and clinical care, support caregivers without transferring public responsibility, and measure function and equity rather than screening volume alone. Gender-responsive ageing and social determinants should be explicit implementation principles, with additional attention to older women living alone, the oldest-old, people with disability, low-income households and caregivers under strain.

This is how longer lives can become a silver dividend: not by treating older people only as economic assets or welfare recipients, but as citizens and contributors with rights to dignity, food security, health and participation. Embedding these commitments in State and district Viksit Bharat @2047 plans would make healthy longevity a measurable development outcome.

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