

Demographic Transition, Evolving Families and the Future of the Care Ecosystem in Rural India

Better families, stronger institutions, and a care ecosystem for human flourishing

India will grow old before it grows rich; it will grow old in its villages first. It will unfold among its women, and within families now half the size they were generations ago and once shared the burden of care. The systems we built for yesterday's diseases cannot sustain tomorrow's care needs. This paper argues that the answer lies not in more of the medicines, but in building **Neighbourhoods of Care**.

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Preface

A generation ago the question before rural India was whether a child would live to see her fifth birthday, and whether her mother would survive the delivery. That question has largely been answered, and it was answered by people, by ASHAs, Anganwadi workers and ANMs who carried a public system to the doorstep of every household.

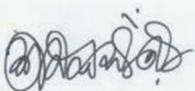
The question before us now is different in kind. It is not whether people will live, but how they will live healthy through the thirty years that the success has added to their lives. That is a question about households, living conditions and relationships; about time spent, and above all about the women whose unpaid hours, and the support extended by families and kinship, have always been invisible to the systems.

The direction of travel is visible in the data: more people now live with illness rather than die from it, and by 2050 nearly one in five Indians will be over sixty. A health system that has learned how to keep people alive is not yet prepared to keep them well.

The paper builds on three megatrends of this transition, drives deep into two areas of concern; system and social and four influencing areas: technology, financing, time spending and the care burden on women, and climate change. It reads the system through the eyes of the women who navigate it every day, and builds on the institutions rural India already has. It is an invitation to the reader: to treat the household as the unit of health, families and caregivers as part of the care system, the neighbourhood as the unit of delivery, and the woman who holds both together as the person the system must support.

This document was assembled in conversation with community leaders, frontline health workers, local governments and civil society organizations. We are grateful to Shri Sandeep Ghose for the encouragement that prompted it; to Shri Anish Kumar and Shri Anirban Ghose of TRI for their insights along the way; and to TRI's Senior Leadership Team and the practitioners of its Community Action Lab, who brought ground realities into the discussion. We thank Shri Neeraj Jain (PATH; Member, Board of Directors, TRI), Ms Kachina Chawla (Lighthouse Health Solutions), Prof. N. K. Arora (INCLEN Trust International) and Shri Prabhat Sinha (Takeda), who unveil this paper and carry its argument forward in discussion. And a special thanks to Ms Sita Kumari, for her support and efforts in conducting the research, assembling the data and checking the drafts.

We remain humbled by the courage and agency rural women continue to demonstrate, and owe a particular debt to the ASHAs, Anganwadi workers, ANMs and SHG members who described their days to us; any errors are our own. We hope it serves policymakers, practitioners, researchers and development partners working to strengthen rural health systems and secure a healthier, more equitable future for India's women.



Shyamal Santra

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HOW TO READ THIS PAPER

Every exhibit states its claim in its title. Read the exhibit titles alone and you have the argument.

Where a figure is a projection it is marked *forecast*; where an exhibit is illustrative rather than measured, it says so on its face.

Demographic transition, evolving families and the future of the care ecosystem in rural India

Our public health system has learned how to keep people alive. It has not yet to keep them well.

India will grow old before it becomes rich, and it will grow old in its villages first. By 2050 one in five Indians will be above 60, roughly 347 million people, seven in ten of them living in rural India. The person who will need care is most likely a widow in her late seventies, struggling for a pension, whose children work in a city far from home.

She is the outcome of India's great public-health achievements. Over five decades, sustained investment in vaccination, safe delivery and sanitation, carried by a frontline of millions of ASHAs, Anganwadi workers and ANMs, has saved lives on an extraordinary scale. Infant mortality has fallen from 129 per 1,000 live births in 1971 to 25. Maternal mortality has fallen by 86 percent since 1990, nearly twice the global pace. Life expectancy has crossed seventy.

But the burden has shifted from dying too early to living unwell. The share of disease burden made up of time lived in ill health, rather than life lost, rose from 17.5 percent in 1990 to 32.8 percent in 2016, and it is still rising. Only 11 percent of older people meet a strict test of ageing well.

The achievements are not evenly distributed. A woman in Uttar Pradesh is almost six times more likely to die in pregnancy than one in Kerala, and the gaps in life expectancy and infant mortality are just as wide. Kerala's ageing index stands at 97 older adults per 100 children; Uttar Pradesh is at 34. The largest absolute increase in older adults will come in Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan and Jharkhand.

The need for care will emerge precisely in the geographies where health systems are least prepared.

Meanwhile family, the foundational institution that has supported, financed and delivered care, is changing fast. In 2001 there were 8.4 working-age adults for every older person; by 2026 there will be 5.2. At the same time, the number of people aged 80 and above for every hundred people in their fifties will rise from five to fourteen. Many more years of dependency, and far more intensive care needs.

Average household size has fallen from 5.3 in 2001 to 4.9, as families have fewer children and more of those children live away from home and three decades of data show that nearly 94 percent of care for older people is still provided inside the home. The obligation has not moved. Only the number of hands has.

Rising care needs and shrinking family capacity meet on one pair of shoulders. Women spend 305 minutes a day on unpaid care work, while men's contribution has fallen to 56 minutes. In rural India, 84 percent of women's work is unpaid. Climate change is now adding to that load: a single heatwave day adds around 90 minutes of unpaid work, and floods add 10 to 18 hours of unpaid work in a week. As families shrink and care needs grow, women carry an ever-heavier share of India's care economy.

Seven forces are shaping India's care ecosystem; demographic, epidemiological, systemic, sociological, technological, economic and environmental. Together a clinical, facility-based, medical-centric response is not the route to the destination.

India transformed survival by building one of the world's largest community health systems. The twenty-first century will judge it not by how many lives it saved, but by how well those longer lives were lived.

And the time is not distant. The cohort that will be old in 2047 is today's forty-five-year-old small farmer and self-help-group member. The SHG didi strengthening her community today is tomorrow's care recipient.

It is time to weave the systems rural India already has into a neighbourhood of care.

The argument in brief

In Rural India Two things are happening together. One is remarkable and one is troubling.

The remarkable part. A child born in an Indian village today will, in all likelihood, survive; her mother will almost certainly survive the birth. This was not the case a generation ago. Infant mortality has fallen from 129 per 1,000 live births in 1971 to 25 today; maternal mortality by 86 percent since 1990, nearly twice the pace of the rest of the world. Life expectancy has crossed seventy. Among the great public-health achievements of the century.

The troubling part. The same forces that made that progress possible are quietly overloading the institution that has always carried the care need. Longer lives mean more years lived with illness, weakness and dependency: India's burden has shifted from dying too early to living unwell. And the family that finances, organises and delivers almost all care in this country is shrinking as the demography turns. In 2001 there were 8.4 working-age adults for every older person; by 2026 there will be 5.2.

The evidence does not show families abandoning their responsibilities, co-residence has held. What has changed is arithmetic. A household that once relied on five adult children may now rely on two, and those two must support parents living ten or fifteen years longer. The institution has endured; its capacity has been compressed.

Between rising need and shrinking hands, the gap falls on one person, and we know who she is. She spends nearly five hours a day on housework and caregiving; the men around her under forty minutes on the same housework and caregiving. By 2050 the person most likely to need care in an Indian village will be a widow in her late seventies, seven in ten of the oldest women have lost their husbands. She probably cannot read. She has no land, no savings, no pension. Her children live in a city far away.

This paper identifies seven forces acting on care; demographic, epidemiological, systemic, sociological, technological, economic and environmental. They lead to one conclusion. A linear, facility-based, medical-centric response may not be able to taking care of diversified need of emerging population. What is required is a care ecosystem woven from the institutions rural India already has: panchayats, women's collectives, frontline workers, Anganwadi centres and primary-care platforms, connected by a shared care mandate and anchored in the community itself. We call it the **Neighbourhood of Care**.

India's burden has shifted from dying too early to living unwell.

SEVEN FORCES

1. Demographic
2. Epidemiological
3. Systemic
4. Sociological
5. Technological
6. Economic
7. Environmental

THE PROPOSITION

Rural India does not need to build a care infrastructure. It needs to connect those already has.

What happens if India answers the emerging needs in same way

Each conventional intervention may succeed in isolation but fails when it encounters the others. This is the defining signature of a wicked problem: every symptom is linked to another cause, so, isolated actions are absorbed, displaced or even become counterproductive the wider system.

Build a Hospital	The older widow still cannot make twenty visits a year and no facility replaces the daughter who migrated.
Digitise care	The record is thinnest exactly where vulnerability is greatest. Older adults hold barely 12 percent of health IDs.
Transfer cash	It arrives in an account she may not control, and it cannot purchase a caregiver's presence.
Train more doctors	They will concentrate where doctors already practise. One rural CHC in twenty-two has its full specialist team.

Therefore, Scaling a linear, medical-centric model is not a slower route that India required. It is a faster route to a destination India has already substantially reached.

The direction

Almost every building block of a future care system already exists within walking distance of the households that need it: a constitutionally mandated Gram Panchayat; the world's largest network of organised rural women in self-help groups and their federations; an ASHA for nearly every thousand people; an Anganwadi in almost every habitation; and the Ayushman Arogya Mandir, with population empanelment, NCD screening from age thirty and a design norm of care within thirty minutes.

What is missing is a shared care mandate that connects them. Care today falls across many programmes and belongs to none.

EVERYONE'S PROGRAMME, NO ONE'S MANDATE

Anganwadi

Under-sixes, pregnant women

ASHA

Maternal and child incentives

Self-help groups

Savings and livelihoods

Gram Panchayat

Infrastructure and schemes

No actor is solely responsible for the widow with failing sight, the stroke survivor, or the mother of a child with cerebral palsy.

The crisis is not that families care less. It is that smaller families are being asked to provide more care for longer.

The argument in numbers

Fourteen indicators across four domains:

DEMOGRAPHY AND FAMILY	Indians aged 60 or older	1 in 10 (2021)	1 in 5
	Older persons living in villages	—	7 in 10
	Working-age adults per older person	8.4 (2001)	5.2
	Ageing index, older adults per 100 children	~20 (2001)	53
HEALTH BURDEN	Years lived with disability, share of burden	17.5% (1990)	32.8%
	Deaths from noncommunicable disease	—	~66%
	Older adults meeting a strict test of ageing well	—	11%
	Deaths occurring in an institution	—	40.2%
SYSTEM AND MONEY	Health costs paid out of pocket	62% (2014-15)	~40%
	People pushed below the poverty line by illness, a year	—	60m
	Public health spending, share of GDP	target 2.5%	1.3-1.5%
	Rural CHCs with a full specialist team	—	1 in 22
WOMEN'S TIME AND CLIMATE	Unpaid work, minutes a day – women against men	305 : 67 (2019)	305 : 56
	Unpaid care work as a share of GDP	—	7.5-15%
	Jobs from investing 2% of GDP in the care economy	—	11m
	Hours added to a woman's week by one flood	—	10-18

Sources: Census of India; UNFPA-IIPS *India Ageing Report 2023*; Subaiya & Bansod (2011); LASI Wave 1; India State-Level Disease Burden Initiative, *The Lancet* (2017); Menon et al. (2019); SRS 2024; NFHS-5 and NFHS-6; Rural Health Statistics 2023-24; NSO Time Use Survey 2019 and 2024; Fifteenth Finance Commission. Second column is the latest available value or the 2026/2050 projection as noted.

Definitions and data

Care

The continuous, everyday work of sustaining human life and capability: nurturing children, supporting the ill and disabled, accompanying the old. Not only medical treatment.

The care ecosystem

The full set of actors who provide care; family, community, state and market: the “care diamond” of the development literature.

Disability-adjusted life years (DALYs)

Years lost to premature death combined with years lived with disability. The balance between the two tells you whether a society's problem is dying early or living ill.

Potential support ratio

Working-age adults per person aged 60 or over. The **parent support ratio** counts people aged 80+ per 100 people in their fifties, the children most likely to be caring for them.

Ageing index

Older adults per 100 children aged 0–14.

The Neighbourhood of Care (NoC)

A community-anchored care system in which the household and the care-dependent person place at the centre, and existing local institutions; the Gram Panchayat, women's self-help groups and their federations, the ASHA-ANM-Anganwadi frontline, and the Ayushman Arogya Mandir, operate under a shared, explicit care mandate.

The evidence base

The evidence is Indian and deliberately publicly available data: the National Family Health Surveys (NFHS-3 through the latest round); the Longitudinal Ageing Study in India (LASI Wave 1, 2017–18), the first nationally representative study of ageing; the Time Use Surveys of 2019 and 2024; National Sample Survey and Household Consumption Expenditure Survey rounds; the Sample Registration System; the Census; the India State-Level Disease Burden Initiative; and the Million Death Study supplemented by peer-reviewed studies cited in the notes.

Where projections are shown they are marked as forecasts. Where an exhibit is illustrative rather than measured, it says so on its face.

A CAUTION THAT SHAPES TARGETING

Self-reported morbidity in rural India systematically understates true disease burden. Older rural adults report *better* health than urban ones, an advantage that disappears when health is measured clinically. Lower reported illness is not better health; it is a diagnosis deficit.

The geography of this argument: rural India, disproportionately tribal

When we say “rural India,” we mean the villages where roughly two-thirds of the country still lives, and where the demographic and epidemiological transitions will meet the institutional interface. Empirically the paper is anchored in the four states where Transform Rural India works: Jharkhand, Chhattisgarh, Madhya Pradesh and Uttar Pradesh.

Three characteristics justify the anchor. **Rurality:** around three-quarters of each state's population lives in villages, against 69 percent nationally. **Tribal concentration:** Scheduled Tribes are 31 percent of Chhattisgarh and 26 percent of Jharkhand, against roughly 9

percent nationally, while Madhya Pradesh holds the largest tribal population of any state in absolute terms.

And a baseline health-system deficit: against a norm of one Primary Health Centre per 30,000 rural people, a PHC serves about 43,000 in Madhya Pradesh and about 95,000 in Jharkhand — three times the intended load, and nine times Kerala's. Add scale: Uttar Pradesh alone will add more people aged 60 and above over the coming quarter-century than the total population of most countries. What holds for rural India in aggregate holds true, later and harder, in these four states. A care model that works here has passed its hardest test.

WHY THESE FOUR STATES

THEY ARE THE HARD CASE

More rural, more tribal and less served than the country as a whole. A care model proven here is portable upward; one proven on the national average is not.

THEY CARRY THE GROWTH

The largest absolute increase in older adults over the coming quarter-century will come in these states, alongside Bihar and Rajasthan.

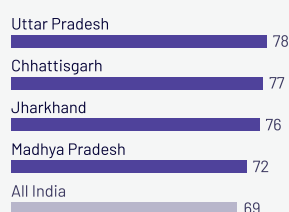
THEY DIFFER FROM EACH OTHER

Chhattisgarh meets the primary-care norm and still records weak outcomes; Jharkhand misses it threefold. Together they separate the facility question from the capability question.

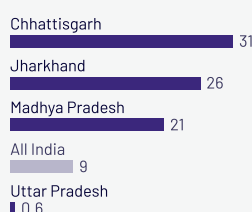
EXHIBIT 1 · RURAL AND TRIBAL SHARE OF POPULATION, %; RURAL POPULATION PER PRIMARY HEALTH CENTRE, THOUSANDS

Four states carry this paper's argument: more rural, more tribal, less served.

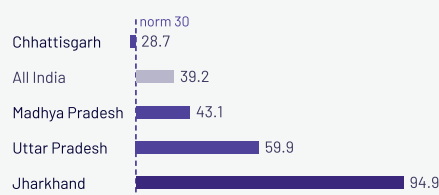
RURAL SHARE



SCHEDULED TRIBES



PEOPLE PER PHC, THOUSANDS — AGAINST THE NORM OF 30



Rural and tribal shares from Census of India 2011. PHC load from Rural Health Statistics and Venkateswaran (2022); the Indian Public Health Standards norm is one PHC per 30,000 rural people, and per 20,000 in designated tribal areas.

The transitions

India is ageing faster than any large country has aged before, and it is ageing fastest where it is least prepared. The disease burden has already crossed from dying early to living ill. And the first health transition, the one India is celebrated for, is not finished everywhere.

1 Growing old before growing rich

2 Surviving is not thriving

3 The unfinished first transition

India is growing old before it grows rich and it is ageing fastest where it is least prepared

Alongside economic growth and urbanisation, demographic change is the megatrend shaping India's future and India is growing older at an unprecedented pace. In 1961, one in eighteen Indians was aged 60 or above. By 2021 it was one in ten. By 2050 it is expected to be one in five: about 347 million people, an older population larger than the total population of every country except two. India's median age, which was near 20 for most of the twentieth century, is projected to reach 31 by the end of this decade.

Europe took a century and grew rich first. India has a few decades, and is still middle-income.

What makes India's transition distinctive is not the number of older people but the speed. Western Europe took more than a century to make this change, and grew rich before it grew old. India is making it in a few decades, at a fraction of the per-capita income European societies enjoyed at the same demographic moment. Where the social security nets pension coverage remains limited, and formal long-term care is barely developed.

THREE WAYS THIS TRANSITION DIFFERS FROM THE ONES BEFORE IT

SPEED

Western Europe had a century to build pensions, geriatric medicine and long-term care around an ageing population. India has roughly three decades, and is starting from a much thinner base of formal provision.

INCOME

Ageing societies elsewhere were rich by the time the transition arrived. India reaches the same demographic point at a fraction of the per-capita income, which limits what can be bought rather than built.

PLACE

The national figure conceals two different countries. The states ageing fastest are not the states adding the most older people, and the second group is where the health system is weakest.

The share age of people 60 and above understates the change, as it describes only the top of the age structure. The whole shape is moving. For most of the twentieth century India's age distribution was a broad-based pyramid: each cohort smaller than the one below it, children the largest group, older adults a narrow tip. Fertility decline has removed that base. By 2050 the distribution is closer to a column cohorts of similar size from childhood into the sixties, with a substantial population above seventy for the first time. India's median age nearly doubles across the century shown, from 21.0 years in 1950 to 39.3 in 2050.

A care system designed for the pyramid will be asked to serve a column.

WHAT THE SHAPE CHANGE ASKS OF A CARE SYSTEM

FROM A TIP TO A TIER

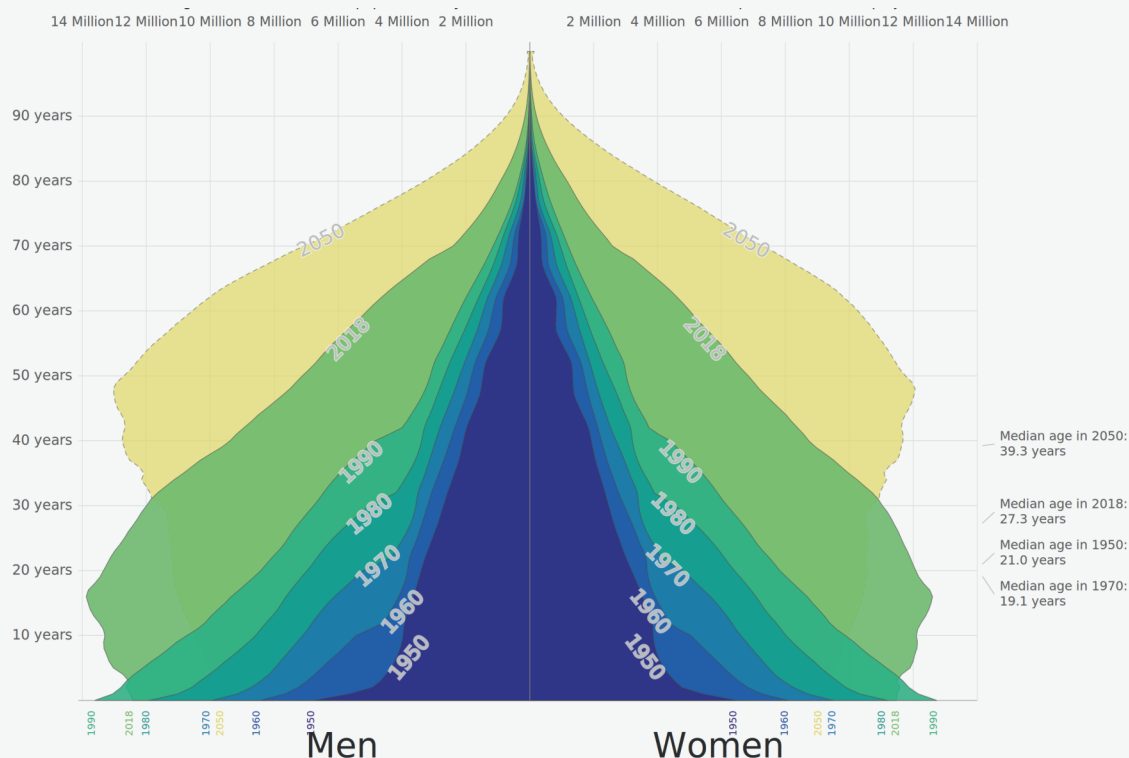
When older adults were the narrow tip of a pyramid, care for them could be treated as an exception the family absorbed. A column makes them a standing tier of demand that has to be planned for, staffed and financed like any other.

THE MIDDLE THINS FIRST

The cohorts that carry both children and parents stop growing before the older cohorts stop arriving. Household capacity peaks a generation before need does.

EXHIBIT 2 · AGE DISTRIBUTION OF INDIA'S POPULATION BY SEX, SINGLE-YEAR AGES, 1950-2018 AND PROJECTED TO 2050

The pyramid is becoming a column: the base stops widening and the top fills in.



Each band is the age distribution in the year labelled; the 2050 band is the medium-variant projection and is drawn with a dashed edge. Chart form after "The Demography of the World Population", Max Roser, Our World in Data (CC BY). Source: United Nations, Department of Economic and Social Affairs, Population Division — *World Population Prospects 2024*, medium variant, single-year ages, 1 July.

Demographers use two ratios to read the future of caregiving. The **potential support ratio**, working-age adults per older person has fallen from 8.4 in 2001 to a projected 5.2 by 2026, and will keep falling. The **parent support ratio**: people aged 80 and above per 100 people in their fifties, the children most likely to be caring for them is expected to rise sharply from 5 to around 14 over the same period.

One ratio is halving. The other is nearly tripling. They describe the same household.

Read together, the message is unambiguous: demand for care is rising quickly while the number of family members available to provide it is steadily shrinking. This is one of the defining social challenges India will face in the coming decades.

READING THE TWO RATIOS TOGETHER

FEWER HANDS

The potential support ratio counts who could care. Falling from 8.4 to 5.2 in a quarter-century means the same obligation spread across four in ten fewer working-age adults.

LONGER DUTY

The parent support ratio counts how intensive that care becomes. Rising from 5 to 14 means far more households will be supporting someone over eighty, the years when dependency is highest.

WHY BOTH MATTER

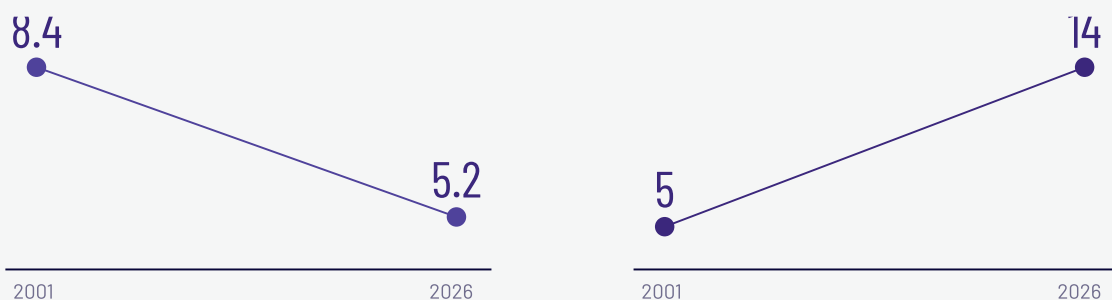
Either trend alone would be manageable. Together they compress supply and expand demand in the same decades, which is what makes this a system problem rather than a family one.

EXHIBIT 3 · POTENTIAL SUPPORT RATIO AND PARENT SUPPORT RATIO, INDIA, 2001 AND 2026

The arithmetic of family care is collapsing on both ends.

Working-age adults per person aged 60+

People aged 80+ per 100 people in their fifties

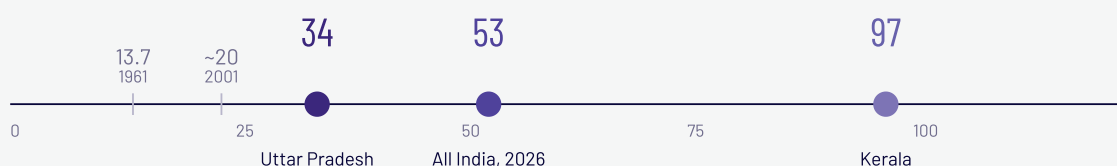


2026 values are projections. Source: Subaiya & Bansod (2011), from Registrar General of India projections.

The shift shows in the **ageing index**; older adults per 100 children. It rose from 13.7 in 1961 to about 20 in 2001, and is projected to reach 53 by 2026. But it is not happening uniformly. Kerala's index is heading for 97, an age structure like a developed country's. Uttar Pradesh sits at 34. The southern states, with Punjab, Himachal Pradesh, Maharashtra and West Bengal, are ageing much faster; the central and eastern belt is younger, poorer and for now slower.

EXHIBIT 4 · AGEING INDEX – OLDER ADULTS AGED 60+ PER 100 CHILDREN AGED 0-14

India's states are ageing in different centuries.



National figures for 1961 and 2001 shown as reference marks; state values are 2026 projections.
Source: Subaiya & Bansod (2011); Registrar General of India.

Three features of the transition

It is rural

Nearly three-quarters of India's older population has always lived in villages, and around seven in ten still do. Yet rural ageing has remained, as Alam put it in 2007, a "dormant issue" in Indian policy.

One reason is out-migration. As younger family members leave for work, older parents are left behind with fewer people to support them and studies find these left-behind adults carry higher levels of chronic illness.

Growing old in rural India does not mean retiring. LASI finds 35.4 percent of rural older adults still working, against 19.6 percent in cities. For most this is not choice but necessity, often despite poor health.

It is female

Women live longer across every social and economic group, but often spend those years in far harder circumstances. The sex ratio among older adults is projected to move from 94 women per 100 men in 1991 to 105 by 2026 and among those aged 80 and above, to 136.

Living longer is not living better. Around 71 percent of women aged 80 and above are widows, against 29 percent of men. In 2001, only 13 percent of rural women aged 60 and above were literate, against 45.5 percent of older men.

The feminisation of ageing is the most predictable feature of India's demographic future.

It is unequal

The largest absolute increase in the older population will come in Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan and Jharkhand, the same states where health systems are weaker, public resources thinner, and pension or income security scarcest.

The greatest need for care will arise in the places least prepared to provide it.

And it is not distant. The cohort that will be old in 2047 is today's forty-five-to-sixty-year-old small farmer, agricultural labourer and self-help-group member. The SHG *did* strengthening her community today is tomorrow's care recipient.

THE CARE RECIPIENT OF 2047 IS ALREADY IN THE DATA

She is an elderly widow,
living alone or with an
ageing spouse, with limited
literacy, little financial
security, and children
working far from home.

She is not the exception. She is the future. A
care system that is not built around her realities
is a care system built for a country that no
longer exists.

71%

of women aged 80+ are widows, against 29% of men

13%

of rural women aged 60+ were literate in 2001,
against 45.5% of men

136

women per 100 men among those aged 80+,
projected 2026

One more demographic fact shapes everything
that follows: growing older does not mean ageing
well. LASI finds only about 27 percent of Indians
aged 65 and above meet a broad definition of
successful ageing. On a stricter measure of
physical and functional ability the figure falls to
11 percent, about one in nine.

And 28.4 percent of adults aged 80 and above are
underweight, the cumulative record of a lifetime
of deprivation. Health in later life is shaped long
before later life. Therefore, care should be
treated as a life-course investment: beginning in
childhood, continuing through adulthood, and
supporting healthy ageing at the end.

AGEING WELL IS RARE

27%

of Indians aged 65+ meet a
broad definition of
successful ageing

11%

meet a strict test based on
physical and functional
ability, one in nine

28.4%

of adults aged 80+ are
underweight

Source: LASI Wave 1 (2017–18); Pengpid & Peltzer (2021).

Surviving is not thriving: the burden has shifted from dying early to living ill

The decline in mortality is India's greatest public-health achievement. Over five decades the country has dramatically reduced deaths among mothers and children. The crude birth rate fell from 36.9 per 1,000 in 1971 to 18.4 in 2023. Infant mortality fell from 129 per 1,000 live births to 25; under-five mortality has fallen nearly 80 percent since 1990. Maternal mortality dropped from 412 per 100,000 live births in the late 1990s to 103 in 2017–19, a fall of about 75 percent, and to 88 in the latest bulletin (2020–22). Measured from its 1990 level, India's maternal mortality has fallen 86 percent, against a global average of 48 percent. India is among the world's seven “exemplar” countries for maternal and newborn survival.

It came from sustained public investment in proven, low-cost interventions delivered at scale, at the life stages where the risk of death was highest. Any antenatal care rose from 57 to 94 percent of pregnancies (four or more visits remain far lower, at 61.4 percent in rural India); institutional deliveries nearly doubled from 43 to 90 percent. Since the National Rural Health Mission in 2005, nearly one million ASHAs, roughly one per thousand rural residents, have connected households to services, immunisation, oral rehydration, iron-folic acid supplementation.

And the gains became more equitable: the slope index of inequality for institutional deliveries fell from 64 percentage points to 17. The lesson is clear. When political commitment, public financing, effective governance and a strong frontline workforce come together, India's rural health system can deliver transformation at scale.

The system learned to prevent early death. It has not yet learned to sustain late-life health.

WHAT INDIA BUILT, 1971–2023

Infant mortality, per 1,000

129 → 25

Maternal mortality since 1990

–86%

Institutional deliveries

43 → 90%

ASHAs in the field

~1m

India has added twenty-one years of life since 1970-75 – but four states still trail the leader by six to eleven years

Life expectancy at birth rose from just under fifty in the early 1970s to 70.6 today. The national line conceals a persistent spread: Kerala reached seventy before the century turned, while Chhattisgarh has yet to reach sixty-five.

The four states are at the bottom of the distribution, between six and eleven years behind Kerala. Those are the years in which chronic illness, disability and dependency accumulate, and they are the years a care system has to serve.

THREE THINGS THE SPREAD TELLS US

THE GAP IS NOT CLOSING

Every state gained, so the lines rise together. The difference between the top and the bottom is roughly what it was thirty years ago, convergence has not happened.

LATE STARTERS, STEEP CLIMBS

Chhattisgarh and Jharkhand enter the series only in the 2000s and climb faster than the national line.

YEARS OF NEED, NOT YEARS OF HEALTH

A six-to-eleven-year shortfall is also a shortfall in healthy years. The states furthest behind are the ones whose added years will arrive with the most illness attached.

EXHIBIT 5 · EXPECTATION OF LIFE AT BIRTH, YEARS, BOTH SEXES, RURAL AND URBAN COMBINED

India has added 21 years of life expectancy since 1970-75, but four states still trail the leader by six to eleven years.



Brackets show the shortfall in years against Kerala, the best-performing state. Light lines indicate the spread of the seventeen other states and union territories; drawn schematically, not from the plotted appendix values. Five-year moving averages plotted at period mid-year; the Chhattisgarh and Jharkhand series begin at their first published period, and Jammu & Kashmir has no published series for the 1980s and 1990s. Source: SRS-based Abridged Life Tables 2020-24, Office of the Registrar General & Census Commissioner, India (May 2026), state-wise trend appendix.

But the success has a shape

Almost all of India's health gains came from preventing deaths in pregnancy, childbirth, infancy and childhood. Progress in survival *after* age fifty has been far slower, and longevity is unequally distributed, the spread is nearly fifteen years wide.

Around 2003, India's health profile changed historically. It drew little attention at the time, but this was the year noncommunicable diseases and injuries overtook infectious, maternal, child and nutritional conditions as the leading source of ill

health measured in DALYs. By 2023, NCDs accounted for roughly two-thirds of all deaths (63–66 percent), driven by poor diets, high blood pressure, elevated blood sugar and rising body mass index.

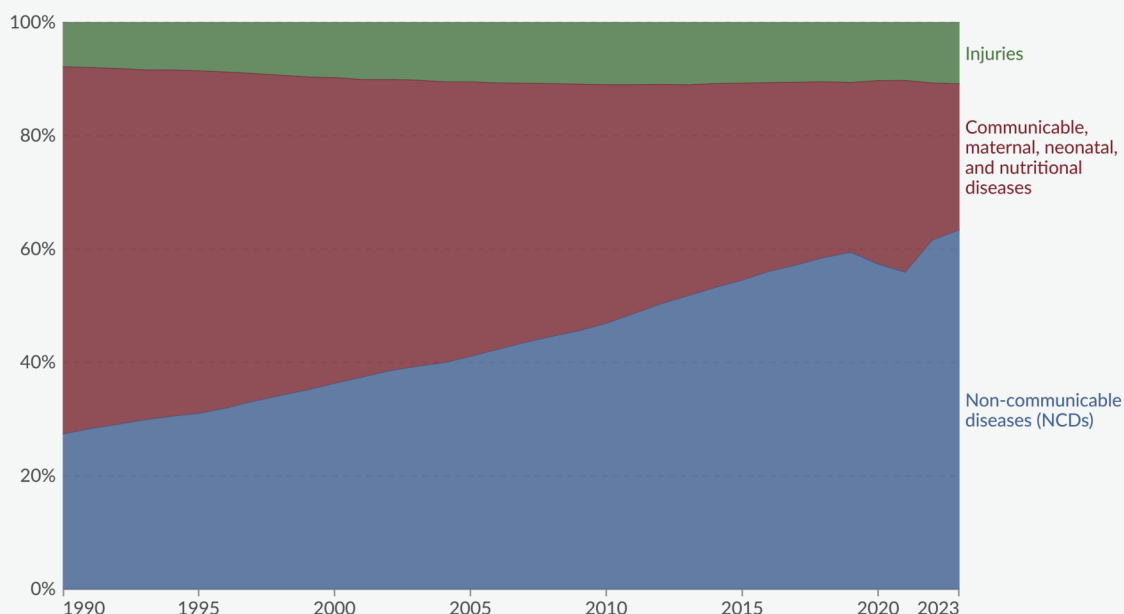
India has largely won the battle against many infectious diseases. It now faces a different one: chronic illness requiring lifelong prevention, continuous treatment and long-term care, from a primary health centre whose workforce, financing and design were built for yesterday's challenge.

PLATE 1 · TOTAL DISEASE BURDEN BY CAUSE, INDIA, 1990–2023

A quarter to two-thirds: the composition of India's burden turned over in one generation.

Total disease burden by cause, India

Total disease burden measured as Disability-Adjusted Life Years (DALYs) per year. DALYs measure the total burden of disease – both from years of life lost due to premature death and years lived with a disability. One DALY equals one lost year of healthy life.



Data source: IHME, Global Burden of Disease (2025)

OurWorldinData.org/burden-of-disease | CC BY

Total disease burden measured in Disability-Adjusted Life Years; one DALY is one lost year of healthy life. Data source: IHME, Global Burden of Disease (2025); chart reproduced under CC BY.

An even bigger change is taking place in the *nature* of the burden. More people are living with illness and disability for many years rather than dying from it. The share of burden measured as years lived with disability rose from 17.5 percent in 1990 to 32.8 percent in 2016, and continues to climb.

Many of the conditions driving this trend do not usually cause death. They reduce quality of life and generate long-term care need: nutritional deficiencies, mental health disorders, vision and hearing impairment, musculoskeletal conditions. Together they account for nearly two-thirds of all years lived with disability in India. Depression alone affects around 10 million Indians aged 30 to 59.

Unlike infectious disease or medical emergency, these conditions do not resolve with one-time treatment. They require continuous care, regular follow-up, rehabilitation, emotional support and help with everyday living. India's growing health challenge is no longer only about saving lives; it is about helping people live well with chronic illness and disability — and that care cannot be delivered by hospitals. It must be available close to where people live.

A third of India's disease burden is now time lived unwell, not time lost.

TWO-THIRDS OF ALL YEARS LIVED WITH DISABILITY

- Nutritional deficiencies
- Mental health disorders
- Vision and hearing impairment
- Musculoskeletal conditions

WHY YEARS LIVED WITH DISABILITY CHANGE THE DESIGN BRIEF

THEY DO NOT PRESENT AS EMERGENCIES

Poor vision, hearing loss, joint pain and low mood rarely trigger a hospital visit. They accumulate quietly, and a system organised around episodes never sees them.

THEY COMPOUND EACH OTHER

Impaired hearing isolates; isolation deepens depression; depression reduces adherence to treatment for the chronic condition underneath. Each is individually minor and collectively disabling.

EXHIBIT 6 · COMPOSITION OF INDIA'S DISEASE BURDEN, 1990 AND 2016, % OF DALYS

The burden is moving from dying early to living ill.



Source: Menon et al., *The Lancet Global Health*(2019); National Burden Estimates.

Three qualifications make this transition challenging for rural India

FIRST — IT RUNS AT DIFFERENT SPEEDS

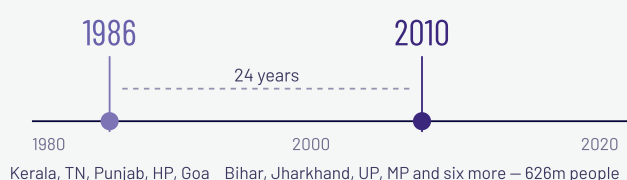
India is, in *The Lancet's* phrase, “nations within a nation.” Kerala, Tamil Nadu, Punjab, Himachal Pradesh and Goa crossed the point where NCDs overtook infectious disease as early as 1986. Bihar, Jharkhand, Uttar Pradesh, Madhya Pradesh, Odisha, Chhattisgarh, Rajasthan, Assam and Meghalaya, together home to around 626 million people reached the same stage only around 2010.

SECOND — THE OLD BURDEN HAS NOT LEFT

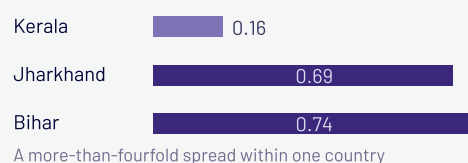
In many states the transition is not a replacement but an overlap. Child and maternal malnutrition remained India's largest single risk factor in 2016, just as in 1990, contributing about a sixth of total burden. Bihar carries the highest malnutrition burden; Jharkhand the highest burden from unsafe water and sanitation. Meanwhile NCDs in these states have grown by nearly two-thirds since 1990.

EXHIBIT 7 · YEAR THE NONCOMMUNICABLE-DISEASE CROSSOVER OCCURRED, AND THE 2016 EPIDEMIOLOGICAL TRANSITION RATIO

The same crossover, twenty-four years apart.



TRANSITION RATIO, 2016 — LOWER IS FURTHER THROUGH



Source: India State-Level Disease Burden Initiative, *The Lancet* (2017).

THIRD — BOTH BURDENS LIVE IN ONE HOUSE

Child stunting is slowly declining while overweight and obesity rise among rural women and children. Undernutrition and overnutrition now coexist under the same roof. Across the life course the pattern is starker still: the stunted child of the 1990s became the anaemic adolescent of the 2000s and is now the adult with early-onset diabetes and hypertension.

As age advances, many develop more than one condition at once. Multimorbidity among older rural adults means more medicines, more journeys, greater physical limitation and increasing dependence on family members for everyday care. It is the same household, carrying both centuries of disease at the same time.

Where it all settles: the end of life

Around one in eight Indians aged 60 and above requires supportive or palliative care, and older rural people are nearly three-quarters more likely to need it than urban ones. According to the Sample Registration System, almost one in every two deaths in India occurs without any medical attention at the time of death simply without a hospital bed, but without care.

Kerala, through its panchayat-led community palliative care model, has shown another approach is possible.

And a warning about how need is found

Some analyses of LASI suggest older rural people report *better* health than city dwellers. The advantage disappears when health is measured clinically rather than by self-report. Many rural adults simply do not know they have hypertension or diabetes.

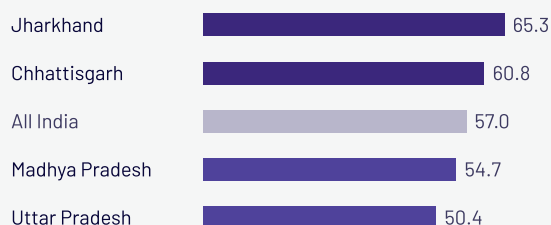
Lower self-reported morbidity in rural India is not evidence of better health. It is a diagnosis deficit which is why population-based screening from age thirty, now expanding through Ayushman Arogya Mandirs, is a core building block of the future rural care system rather than an optional addition.

Between 1992 and 2019, India proved that affordable, evidence-based interventions delivered at scale with political commitment can transform the chances of survival. The challenge of the next twenty-five years is to transform the experience of living, helping people live not just longer, but healthier, more independent and more dignified lives.

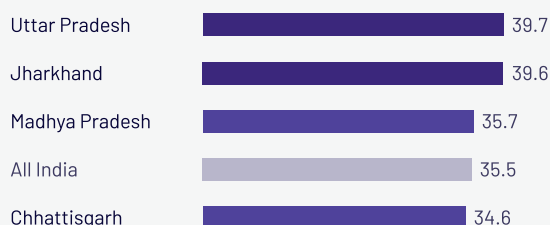
EXHIBIT 8 · ANAEMIA AMONG WOMEN AGED 15–49 AND STUNTING AMONG CHILDREN UNDER FIVE, %, 2019–21

In the four states, the old burden and the new burden share a house.

WOMEN WHO ARE ANAEMIC



CHILDREN UNDER FIVE WHO ARE STUNTED



All-India shown in grey. Madhya Pradesh also records the country's highest infant mortality rate; diabetes, hypertension and obesity are climbing through the same villages and often the same households. Source: NFHS-5 (2019–21), IIPS/MoHFW.

On the journey to universal health coverage, India met its first targets but not everywhere. The next must be designed for continuous care, and aimed where the first is still unfinished

India is committed to Universal Health Coverage: The National Health Policy 2017 adopted it as a guiding principle, Ayushman Bharat followed in 2018, and SDG target 3.8 commits the country to essential services without financial hardship. The WHO-World Bank service coverage index placed India at 55 out of 100 in 2017, below the average for low- and middle-income countries.

Viewed through the three dimensions of the UHC cube- who is reached, what is delivered, who pays- a consistent pattern emerges. The system performs best where yesterday's challenges were concentrated, and thins progressively where today's burden of chronic disease, disability and ageing demands continuous care is increasing.

The first transition remains unfinished

Nationally, maternal mortality fell from 130 per 100,000 live births in 2014-16 to 88, and infant mortality from 129 per 1,000 in 1971 to 25. But the average conceals persistent geographic inequality. The Empowered Action Group states and Assam still record a maternal mortality ratio of 116, nearly three times the southern states' 41 and a woman in Uttar Pradesh is almost six times more likely to die of pregnancy-related causes than her counterpart in Kerala.

The same geography governs child survival: Chhattisgarh records the highest infant mortality (36, rising to 39 in rural areas) and, with Madhya Pradesh, the highest neonatal mortality (26); Kerala reports 6 and 4. Preventable deaths have concentrated in a few states, in rural and tribal districts where capacity is weak.

The epidemiology that remains points to a different health-system challenge. Nearly three-quarters of infant deaths now occur in the neonatal period, when survival depends on skilled birth attendance, newborn care, timely referral and emergency transport rather than community outreach.

Continuity is the weak link. Institutional delivery is nearly universal, yet only 61.4 percent of rural women receive four antenatal visits, 88.7 percent in rural Kerala against 36.4 in rural Bihar. High institutional delivery has not uniformly lowered maternal mortality, because the continuum of care remains incomplete.

A woman in Uttar Pradesh is almost six times more likely to die in pregnancy than one in Kerala.

MATERNAL DEATHS PER 100,000

Uttar Pradesh	154
Madhya Pradesh	135
Chhattisgarh	124
SDG target	<70
Kerala	24

The variation reflects capability. Life expectancy is a cumulative outcome shaped by decades of survival, socioeconomic conditions and repeated encounters with the system, so state disparities narrow over time. Maternal and neonatal mortality and emergency obstetric care are, by contrast, acutely sensitive to system performance at a single moment: skilled providers, functional facilities, supplies, referral and clinical management all available at once. Where they fail, mortality rises sharply.

Eight states rank below the national median on *both* child survival and survival beyond sixty and the presence of Gujarat and Haryana among them matters: weak outcomes cannot be attributed to poverty alone.

CHHATTISGARH: A DECADE THAT DID NOT MOVE

64.8 → 64.7

Life expectancy, 2010–14 to 2020–24 – the only large state not to gain a year

–18.3%

Fall in infant mortality, against a national decline of 37.4%

Progress in both early-life and later-life survival has stalled in the same state at the same time.

The next phase of universal coverage has a dual objective: finish the survival agenda where it is unfinished, while redesigning the system for continuous, integrated care across the life course.

Each of the four states has cut mortality But Measured against the country, almost every one has fallen further behind

Reported the usual way as whole as a decline from its own starting point each of the four states is a success story. Indexing the same series to the national average removes the national tailwind and leaves what is attributable to the state. On that basis **eleven of twelve state-indicator pairs have moved the wrong way, and none has improved faster than India as a whole.** The two states that began near parity, Jharkhand and Chhattisgarh, have given up the most ground.

Falling rates and widening gaps are the same decade, read two ways.

EXHIBIT 9 · STATE MORTALITY RATE AS A MULTIPLE OF THE ALL-INDIA RATE, BASELINE ROUND AGAINST LATEST ROUND

Not one of the twelve state-indicator pairs has improved faster than India.

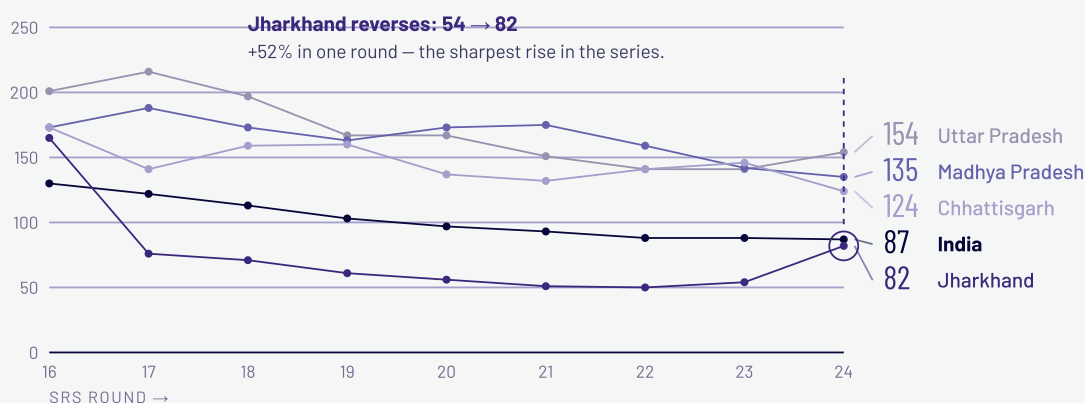


Hollow marker = baseline round, solid = latest round. Uttar Pradesh's maternal ratio is the one pair that has not deteriorated: it has held at 1.77× the national average for seven rounds. Holding a ratio steady is not convergence. Maternal mortality is indexed from round 17, the first round in which all four states are reported separately; infant and under-five mortality from round 12. Source: computed from Sample Registration System bulletins and statistical reports, Office of the Registrar General of India.

It has a shape, and in the latest round it has a location. India's maternal mortality ratio has flattened at 87–88 for three consecutive rounds. Two of the four states moved up in the same round, and one of them moved a long way: Jharkhand, the strongest performer of the four for a decade, rose from 54 to 82 – a 52 per cent increase in a single round, and the largest reversal anywhere in the series.

EXHIBIT 10 · MATERNAL MORTALITY RATIO, DEATHS PER 100,000 LIVE BIRTHS, INDIA AND THE FOUR STATES, SRS ROUNDS 16–24

A decade of gain given back in a single round.



Rounds are labelled as in the source series; rounds 14–15 are not published for this indicator. Earlier rounds are omitted because maternal mortality was then reported for joint state groupings – Madhya Pradesh with Chhattisgarh, Jharkhand with Bihar, so any decline quoted across that break overstates progress. Source: Sample Registration System special bulletins on maternal mortality, Office of the Registrar General of India.

THREE FINDINGS

Jharkhand's advantage has been spent

It entered the series below the national average on all three indicators. It is now above it on infant and under-five mortality and level on maternal mortality.

Chhattisgarh has plateaued

Infant mortality held at 38 for three consecutive rounds and under-five mortality at 41 for four. Its ratio to the national average has worsened more than any other state's on both child indicators.

Three states are converging on a floor

Chhattisgarh, Madhya Pradesh and Uttar Pradesh now sit within two points of one another on under-five mortality, having started eighteen apart, a common ceiling on what the current delivery model reaches.

One of the world's largest primary-care networks, and one of its thinnest at the point of complexity

Rural India is served by more than 2.12 lakh public primary-care facilities, one of the world's largest publicly financed networks, and the reason institutional deliveries exceed 95 percent. Yet scale has not become adequacy. Against Indian Public Health Standards, shortfalls persist at every level and grow with complexity. The network is strongest where it delivers high-volume, standardised services and progressively thinner where specialised care, emergency referral and advanced clinical capability are required.

One PHC is meant to serve 30,000 rural residents; in practice it serves 43,074 in Madhya Pradesh and 94,945 in Jharkhand, against 10,400 in Kerala. At higher levels the imbalance widens: in Bihar one rural CHC serves 363,548 people, making the first referral point for an obstetric emergency, a stroke or a critically ill newborn responsible for the population of a small city.

But the greater constraint is **continuity**. A long journey is manageable once, and schemes such as Janani Suraksha Yojana were designed around that assumption. Chronic disease changes the equation: an older adult with two conditions may need twenty or more visits a year, and transport costs and lost wages accumulate. Facility availability increasingly overstates effective access for the conditions that now dominate India's burden.

A journey affordable once becomes unaffordable when repeated twenty times a year.

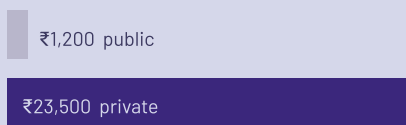
RURAL NETWORK, MARCH 2024

Sub-Centres	167,230
Primary Health Centres	25,785
Community Health Centres	5,639
In tribal areas	31,987

THE CENTRAL PARADOX

Excluding childbirth, 57.9 percent of rural hospitalisations occur in private facilities, in rural Uttar Pradesh 71.4 percent; despite a median out-of-pocket cost of ₹23,500 against ₹1,200 in the public sector. Patients are not bypassing the public system because it is dearer or farther away, but because they perceive greater clinical capability elsewhere. The gap is beyond physical access. It is capability, continuity and trust.

Median out-of-pocket cost per rural hospitalisation



57.9% of rural hospitalisations are private

A Primary Health Centre is meant to serve 30,000 rural people. In Jharkhand it serves 94,945, more than three times the norm

Three of the four states do not meet the PHC norm and all four the exceed recommended population per facility at CHC level, where the referral tier matters most. Uttar Pradesh and Madhya Pradesh each place roughly 190,000 rural people behind a single Community Health Centre, against a norm of 120,000. Chhattisgarh is the one state at or below the PHC norm which makes it the useful counter-case, not the reassuring one.

HOW TO READ THE LOAD FIGURES

THE NORM IS A FLOOR

One PHC per 30,000 rural people assumes a full staff roster and a working referral tier above it. A state at the norm with unfilled posts is not at the norm in practice.

THE CHC TIER IS WHERE IT BINDS

A crowded PHC lengthens a queue. A crowded CHC removes the only place an emergency caesarean or an acute stroke can be handled at all.

CHHATTISGARH IS THE COUNTER-CASE

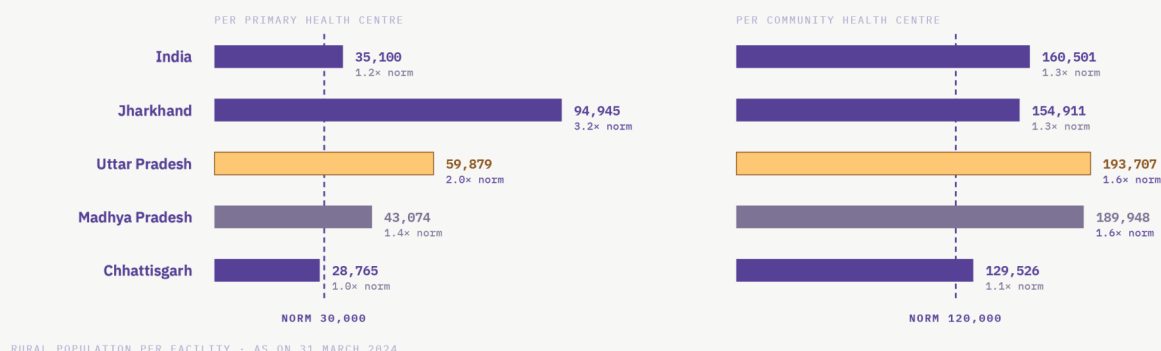
It meets the primary-tier norm on paper and still records the weakest outcomes among the four, which is the clearest evidence that facility counts are not the solution.

PLATE 2 · TABLE 117 · WHO IS REACHED

A facility exists. The population it must carry is two to three times the standard it was built to.

How many rural people each facility serves

Against the Indian Public Health Standards norms of one PHC per 30,000 and one CHC per 120,000 rural people.



From *Health Dynamics of India (Infrastructure & Human Resources) 2023-24*, data as on 31 March 2024. Source: Table 117, Average Rural Population Covered by SC, PHC and CHC.

Availability measures access. Readiness decides whether care actually happens

Of 25,785 rural Primary Health Centres, only 46 percent provide 24-hour services, more than half are unavailable when labour begins at night. Sixty-two percent have a functional labour room; only 22 percent have an operation theatre. Among 5,639 rural Community Health Centres, most have a laboratory and a labour room, yet only 73 percent have a Newborn Care Corner, 68 percent a functional operation theatre, and fewer than half a functional X-ray machine.

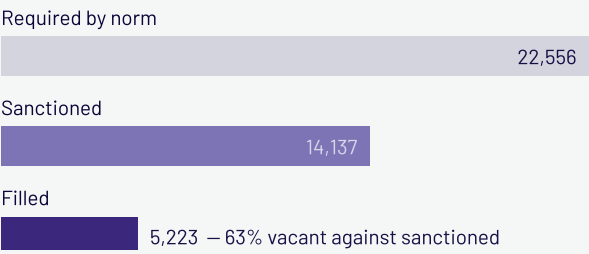
These are not infrastructure statistics. They are measures of emergency readiness. The facilities responsible for preventing maternal and neonatal deaths are precisely those lacking the labour rooms, newborn care, theatres and specialist support on which survival depends.

The basic amenities are also missing. Only 77,794 of 167,230 rural Sub-Centres 46.5 percent; have a separate toilet: 61.0 percent in Uttar Pradesh, 55.3 in Chhattisgarh, 45.1 in Jharkhand and 26.5 in Bihar. For women seeking care these are clinical necessities, not amenities. Without water, sanitation and staff accommodation, antenatal care becomes undignified, repeat visits decline, and facilities cannot function reliably at night.

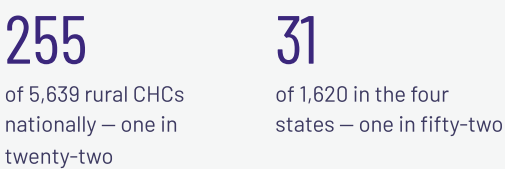
Infrastructure determines whether a health centre is merely present or genuinely usable.

EXHIBIT 11 · SPECIALIST POSTS AT RURAL COMMUNITY HEALTH CENTRES, MARCH 2024, AND CHCS WITH A COMPLETE TEAM

One rural CHC in twenty-two has its full specialist team – and one in fifty-two in the four states.



CHCS WITH SURGEON, PHYSICIAN, OBSTETRICIAN-GYNAECOLOGIST AND PAEDIATRICIAN



Without both an obstetrician and a paediatrician, a First Referral Unit becomes a referral *destination* rather than a referral service.

Source: Rural Health Statistics 2023–24, MoHFW.

Nationally 18 per cent of Sub-Centres short, 28 per cent of PHCs, 34 per cent of CHCs. Uttar Pradesh and Madhya Pradesh follow the same ladder. Jharkhand breaks it in an instructive way, its worst tier is the PHC, where it is short of more than two-thirds of what it needs, which is exactly why one Jharkhand PHC ends up serving 94,945 people.

TWO DIFFERENT FAILURES

A SHORTFALL OF BUILDINGS

The left-hand gradient is a planning gap: fewer facilities than the population requires. It widens as the tier rises, so the referral end of the system is the thinnest.

A SHORTFALL OF PEOPLE

The right-hand figures are a staffing gap. Between 74 and 95 per cent of specialist posts sit vacant, which means new construction alone changes nothing.

JHARKHAND INVERTS THE LADDER

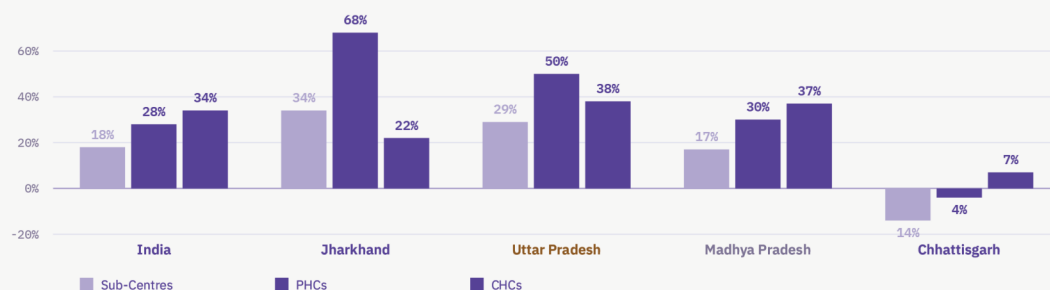
Its worst tier is the PHC rather than the CHC and that inversion is precisely why one Jharkhand PHC carries 94,945 people.

PLATE 3 · TABLE 4 · SHORTFALL BY TIER

The shortfall deepens as the tier gets more complex — and Chhattisgarh shows that a primary-tier surplus is no guarantee

Shortfall against requirement, by tier

Facilities short of the number the rural population requires, per cent. Bars below the line mark a surplus.



Chhattisgarh has 5,056 Sub-Centres against a requirement of 4,429 and 770 PHCs against 738 — a surplus at both primary tiers, and still a shortfall at CHC level.

Source: Table 4, Shortfall in Health Facilities as per Mid-Year Population 2024, Rural Areas. Note: The all-India figure sums state shortfalls and ignores surpluses elsewhere, the report's own convention.

A caesarean needs a surgeon and an anaesthetist at the same time, so single-specialty counts overstate real capability. Only 6 CHCs in Jharkhand, 3 in Chhattisgarh, 2 in Madhya Pradesh and 20 in Uttar Pradesh hold a full team, every one of them below the national 4.5 per cent.

WHY EMERGENCY CARE NEEDS THE WHOLE TEAM

SPECIALTIES DO NOT SUBSTITUTE

A surgeon without an anaesthetist cannot operate. Counting posts one specialty at a time makes a centre look half-capable when it is not capable at all.

THE THRESHOLD IS BINARY

For an emergency caesarean or an acute abdomen there is no partial service. Either the team is in post that night or the patient travels further, later, in worse condition.

TWO CENTRES IN A WHOLE STATE

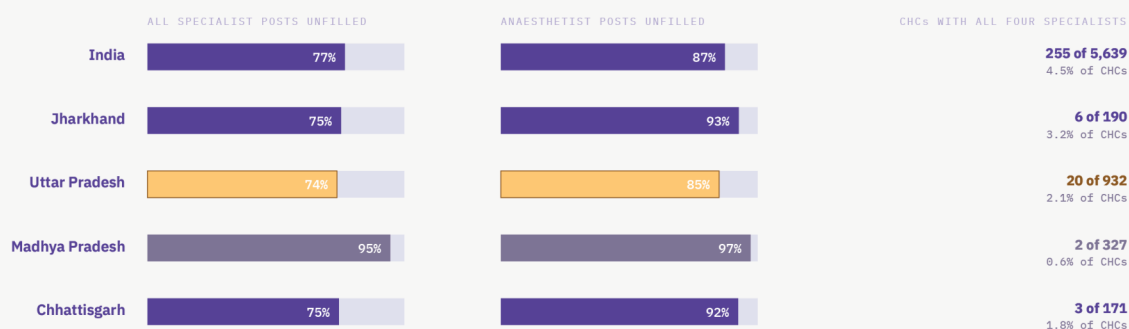
Two of Madhya Pradesh's 327 rural CHCs hold all four specialists. That is the real width of the emergency net across a rural population of tens of millions.

PLATE 4 · TABLES 68, 69, 70 · SPECIALIST CAPABILITY

At the tier where emergency capability should begin, two of Madhya Pradesh's 327 rural CHCs had all four specialists in post

Specialist capability at rural Community Health Centres

One post of each specialty is required per CHC. Bars show the share of required posts that is unfilled.



2 of Madhya Pradesh's 327 rural CHCs had all four specialists in post

The state has 71 specialists against 1,308 required, and 9 anaesthetists across the whole rural network. Every one of the four states sits below the national figure of 4.5 per cent of CHCs with a full specialist team.

Source: Table 68 (total specialists), Table 70 (anaesthetists) and Table 69 (CHCs having all four specialists), rural areas. Requirement is one post of each specialty per functioning CHC.

The contrast between birth and death is the sharpest line in it: in 2024, 95.4 percent of births received medical attention, while 45.5 percent of deaths received none at all and only 40.2 percent occurred in an institution. In rural Bihar, Jharkhand and Chhattisgarh around two-thirds of deaths occurred unattended, against 28.2 percent in rural Kerala.

Nor is home-based professional care filling the gap 5.8 percent of deaths in Jharkhand, against 26.5 in West Bengal.

The National Programme for Health Care of the Elderly extends, at best, to the sub-centre level. India's health system remains well equipped for the life stages where mortality was historically concentrated, but is insufficiently prepared for the later stages of life where the burden of disease has increasingly shifted.

It is not a failed system. It is a completed one built for a transition that is now largely over.

TRIBAL INDIA IS A DISTINCT PLANNING GEOGRAPHY, NOT A REMOTER RURAL ONE

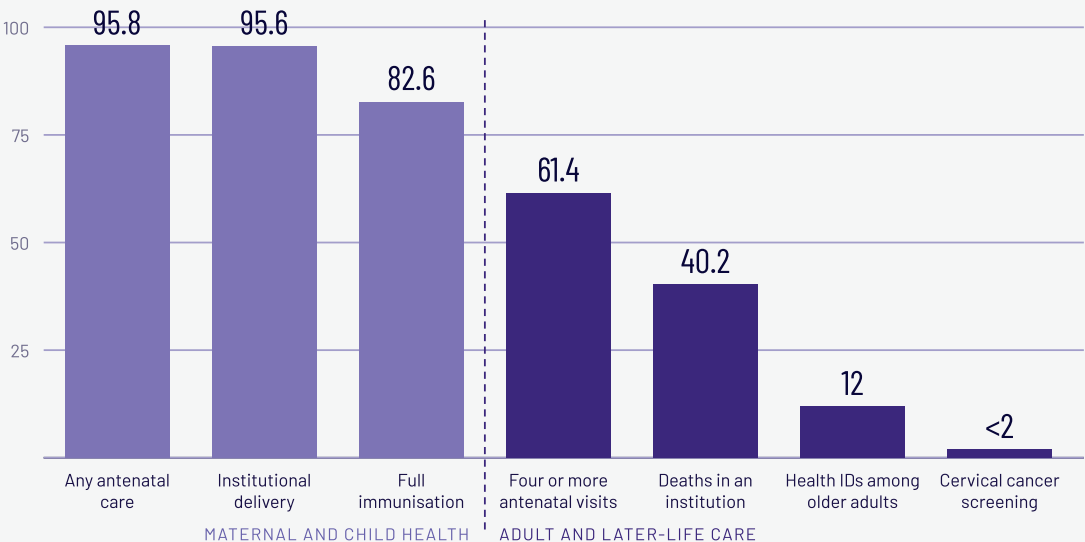
Planning norms are more generous – one PHC per 20,000 people rather than 30,000 – but readiness is worse. In Chhattisgarh, 383 of 412 tribal PHCs have a labour room; only 26 have a functional operation theatre. In Odisha, 6 of 457 do. Facilities exist; the personnel and equipment needed to save lives do not.

SPECIALIST POSTS FILLED IN TRIBAL CHCS

Jharkhand	107 of 444
Chhattisgarh	64 of 353
Madhya Pradesh	20 of 428

EXHIBIT 12 · COVERAGE OF SELECTED SERVICES ACROSS THE LIFE COURSE, %, LATEST AVAILABLE

Coverage drops sharply beyond early childhood.



Sources: NFHS-6 (2023–24); NSS 80th Round; SRS Statistical Report 2024; ABDM assessments (2024–25); national programme data.

Financial protection is built around the hospital episode. The burden has moved to the chronic year

Out-of-pocket expenses accounted for around 62 percent of India's health expenditure in 2014–15, falling to roughly 40 percent by 2021–22 but still among the highest shares in the world. The Fifteenth Finance Commission estimates that health spending pushes around 60 million people below the poverty line each year. Krishna's cross-country fieldwork found illness to be the single most common pathway into poverty, leaving households "one illness away" from destitution.

The composition reveals the design gap. Medicines account for 47 percent of household health spending, largely for outpatient and chronic care while PM-JAY, India's flagship protection scheme, primarily covers hospitalisation. Protection is aligned to acute episodes even as the burden has shifted decisively to long-duration conditions.

The financing architecture mirrors the imbalance. Public health expenditure has stayed at 1.3–1.5 percent of GDP for two decades against a policy target of 2.5. Government financing was 27.1 percent of current health expenditure in 2014–15, ranking India 134th of 186 countries; it has since risen to roughly 48 percent. Preventive care accounted for just 6.7 percent of current health expenditure in 2014–15. It briefly rose to around 13 percent during the pandemic (2020–21), but fell back to 8.88 percent by 2022–23. Allocated funds are not always spent where they are needed: states drew down only about 58–59 percent of the National Health Mission funds available to them in 2017–19, and underspending persists at the programme level, in 2022–23 states used only about a third of the anaemia-control budget approved under the Mission.

With 90 percent of India's workforce employed in the informal economy and fewer than 10 percent covered by contributory insurance, payroll-financed social insurance cannot provide the foundation for universal coverage. For India, tax-financed universalism is therefore not simply preferable but fiscally unavoidable.

THE MISMATCH, IN FOUR NUMBERS

~40%

of health spending is out of pocket, down from 62% in 2014–15

47%

of that goes on medicines, mostly outpatient and chronic

8.9%

goes to prevention in 2022–23; peaked near 13% in the pandemic

9%

of public hospital spending reaches the poorest fifth; 40% reaches the richest

PM-JAY received ₹6,400 crore in 2021–22 against the Commission's estimated requirement of ₹28,000–74,000 crore; states drew down about 58–59% of available National Health Mission funds in 2017–19. Sources: NHA estimates; Fifteenth Finance Commission; NSS 75th Round; NHM expenditure statements.

India does not lack schemes; it lacks continuity. Facilities exist, entitlements exist and insurance exists but each reaches its limit where chronic illness and long-term care begin.

The missing layer is continuous, community-based engagement between households and the health system: prevention, outreach, follow-up and accountability. That is the primary health care envisioned at Alma-Ata and reaffirmed at Astana.

Where health is made

Even with universal access to clinical care, the health of rural India would still be decided elsewhere: in the hour a woman spends collecting water, in the smoke from the cooking fire, in the mud floor on which a bedridden person must be cared for and in whether she controls a bank account or a phone she can answer herself.

Health is where a person lives, decides how well and how long; the next frontier is the conditions of daily life

This matters more now than a generation ago. When mortality was concentrated in infancy, childbirth and infectious disease, ill health was episodic and the clinic was the point of intervention. As lives lengthen, the burden shifts to conditions that unfold over years. Health is no longer produced only during encounters with a facility. It is lived continuously within the household.

The home is no longer merely where people live. It is increasingly where care is delivered.

A smoky kitchen, unsafe water or an unclean floor carries a very different cumulative risk across more particularly for a life extending to eighty-five than across one ending at sixty.

Better health is produced through the distribution of opportunity, resources and living conditions. Healthcare can prevent, diagnose and treat illness; it cannot compensate for unhealthy living conditions sustained over decades. The WHO's *World Report on Social Determinants of Health Equity* (2025) finds that progress in reducing health inequalities has been slower than expected and in many countries has reversed.

The amenity ledger

Water

Safe drinking water is no longer India's principal challenge; *reliable* access is. NFHS-6 reports 96.5 percent of Indians in households with an improved source, but in rural Jharkhand coverage fell from 86.6 percent to 81.3, and nearly half of rural households still collect water outside the home. Every hour fetching water is an hour not spent on care and it limits the hygiene that chronic illness requires.

Sanitation

India achieved one of the world's fastest sanitation transitions: open defecation fell from 70 percent in 1993 to 19 percent in 2021. The remainder is overwhelmingly rural; one in four rural households still does not use a toilet.

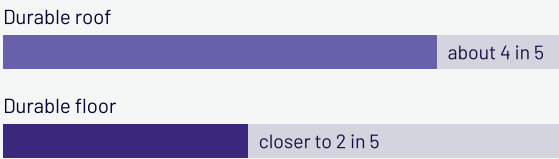
Energy

Households primarily using LPG rose from under one in five in 2000 to three in five today, but a third still depend on firewood, mostly rural. Household air pollution is a recognised risk factor for stroke, ischaemic heart disease, COPD and lung cancer, the same diseases now driving India's mortality.

Housing

The share of durable rural houses has risen from about one in ten to nearly one in two. But a house is a set of components, each with different implications for health and separating them makes the remaining deficit visible.

India has roofed its houses – but not floored them.



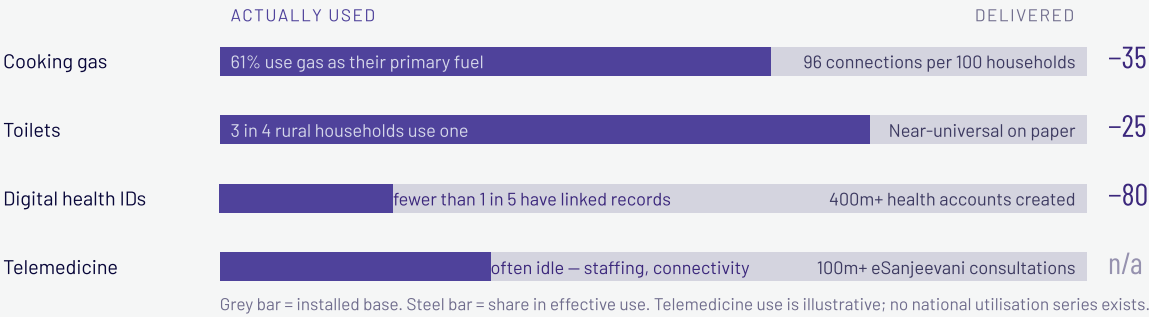
For the future of care, the floor may matter more than the roof. A mud floor raises infection risk for a crawling child, demands repeated maintenance that falls largely on women, and makes hygiene difficult during illness. For an older person living with frailty, a stroke survivor or a person with disability, it decides whether safe, dignified care can be given at home at all.

Shares are approximate; the source notes estimates vary with the definition of housing durability. Source: NFHS-5 (2019-21) “Housing Conditions” (2025).

EVERY DEPRIVATION HAS THE SAME ADDRESS

More than half of the poorest quintile cook with firewood. Around half of all households without a toilet are in the poorest quintile. More than nine in ten of the poorest rural households live with low-quality floors. In the poorest rural quintile only 1 percent own a television, refrigerator and washing machine, against more than 70 percent in the richest urban quintile; a seventy-fold difference in the domestic technologies that reduce the time and physical effort of everyday care. It is the same household behind each statistic, and the same woman absorbing the work.

India has become expert at measuring installation. Health improves only with use.



Sources: NFHS-5 and NFHS-6; PPAC LPG connection data to 2024; ABDM assessments (2024-25); Mishra, Yadav & Joe (2024).

Living conditions in rural India

Light and water are settled. The kitchen is not.

Across three decades of the National Family Health Survey, rural electricity has gone from 39% of households to 97.8% and improved drinking water now reaches 95.4%. Sanitation has been transformed, from 17.6% to 64%. But fewer than half of rural households have clean cooking fuel or an improved dwelling — and cooking fuel is the one gap with urban India that has widened.

ELECTRICITY

97.8%

from 39.0% in 1992–93

IMPROVED DRINKING WATER

95.4%

from 85.0% in 2005–06

IMPROVED SANITATION

64.0%

from 17.6% in 2005–06

IMPROVED HOUSING

48.0%

from 19.0% in 1998–99

CLEAN COOKING FUEL

43.2%

from 5.8% in 1998–99

RURAL HOUSEHOLDS, LATEST ROUND REPORTED

Three decades of progress, indicator by indicator

Per cent of households. Bold line is rural, grey line urban. Shared timeline across all five panels.

Electricity

97.8

rural · urban 99.5%



N1

N6

Improved drinking water

95.4

rural · urban 99.1%



N3

N6

Improved sanitation

64.0

rural · urban 81.0%



N3

N5

Improved housing

48.0

rural · urban 84.9%



N2

N5

Clean cooking fuel

43.2

rural · urban 89.7%



N2

N5

N1 1992–93 · N2 1998–99 · N3 2005–06 · N4 2015–16 · N5 2019–21 · N6 2023–24

The gap with urban India: then and now

Percentage points by which urban coverage exceeds rural, first comparable round against the latest.

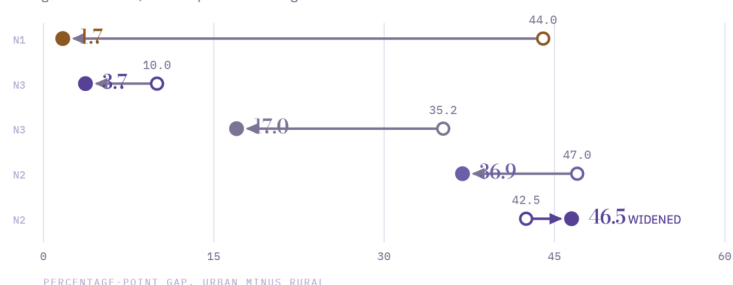
Electricity

Improved drinking water

Improved sanitation

Improved housing

Clean cooking fuel



PERCENTAGE-POINT GAP, URBAN MINUS RURAL

What is left

Share of rural households still without each service, latest round reported.

Clean cooking fuel



56.8% (NFHS-5)

Improved housing



52.0% (NFHS-5)

Improved sanitation



36.0% (NFHS-5)

Improved drinking water



4.6% (NFHS-6)

Electricity



2.2% (NFHS-6)

PER CENT OF RURAL HOUSEHOLDS WITHOUT · FULL BAR = 100%

Source: National Family Health Survey rounds 1 to 6 (1992–93 to 2023–24), India fact sheets.

Drinking water and sanitation are shown from NFHS-3 only. The first two rounds used narrower definitions – a 60-point jump in rural water between NFHS-2 and NFHS-3 is a change of definition, not of coverage.

Sanitation, housing and cooking fuel were not reported on this basis in NFHS-6. Administrative sources report higher coverage on different definitions – Jal Jeevan Mission 82.1% rural tap connections, Swachh Bharat Mission 95% rural sanitation, both 2026.

Cash, connection and a phone of one's own

Access to healthcare is becoming digital, WHO identifies digitalisation as a major determinant of health equity precisely because unequal access to technology reproduces existing social inequality. India illustrates both the promise and the gap.

Platforms have expanded rapidly but ownership has not. Rural women's personal mobile ownership is 40.6 percent in Madhya Pradesh and 41.5 percent in Chhattisgarh. Nationally, 150 million people over fifteen had not used a phone in the previous three months although nine in ten lived in a household that owned one. More than seven in ten of them were women, many relying on a shared device.

The distinction is critical. Digital health IDs, one-time-password authentication, teleconsultation and health messaging all assume the intended user controls a personal phone. For many rural women that assumption does not hold. It is not the connectivity but the control matters most. who owns the phone, who can answer it, and who decides its use. These have become determinants of access to healthcare, and they remain largely invisible in health disclosure and policy.

WHOSE PHONE IS IT

40.6%

of rural women in Madhya Pradesh own a personal mobile phone

150m

Indians over fifteen had not used a phone in three months

7 in 10

of them were women

EMPOWERMENT IS A DETERMINANT

India has expanded access to services and infrastructure, but control over the resources that shape health remains uneven. Fewer than one in five households include a woman who owns the house or land she helps sustain; 14.5 percent in Jharkhand. Fewer than one in three women earn cash income. A phone cannot enable a teleconsultation if she cannot answer it. A health facility cannot provide timely care if she cannot decide to seek it. Assets create opportunities; agency converts them into health.

63%

of married women cannot make independent decisions about their own healthcare

14.5%

of households in Jharkhand include a woman who owns house or land

Rural India came online through the handset, not the household

Between NFHS-4 and NFHS-6 rural women's phone ownership rose from 37% to 69% and the rural gender gap on phones nearly halved. The gap with urban India narrowed on every measure but one: the household internet connection, which has not moved in a decade. More rural people have now used the internet than live in a connected household.

RURAL WOMEN OWN A PHONE

68.5%

from 37.3% in NFHS-4

POINT GENDER GAP ON PHONES

22.7

from 41.0 points

RURAL HOUSEHOLDS ONLINE

46.8%

3.1× the NFHS-4 level

POINT RURAL-URBAN GAP

27.7

on household internet — unchanged

RURAL HOUSEHOLDS AND ADULTS · NFHS-6, 2023-24

Rural against urban, indicator by indicator

Per cent. Bold line is rural, grey line urban. Internet use was not reported in NFHS-4.

Women own a phone

68.5

rural · urban 83.2%



N4 2015-16 · N5 2019-21 · N6 2023-24

Women have been online

48.4

rural · urban 72.4%



Men own a phone

91.2

rural · urban 94.6%



Men have been online

67.7

rural · urban 82.5%



Households with internet

46.8

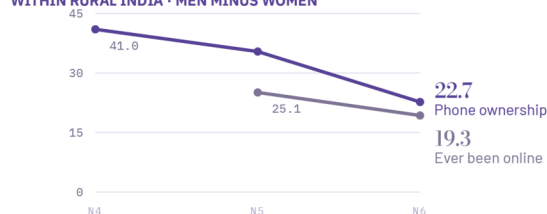
rural · urban 74.5%



Two gaps, moving at different speeds

Left: the gap between rural men and rural women. Right: the gap between urban and rural.

WITHIN RURAL INDIA · MEN MINUS WOMEN



URBAN MINUS RURAL · FIRST ROUND TO NFHS-6

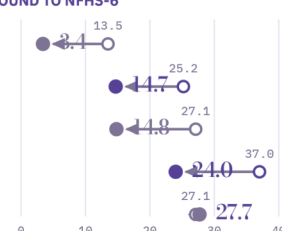
Men own a phone

Women own a phone

Men have been online

Women have been online

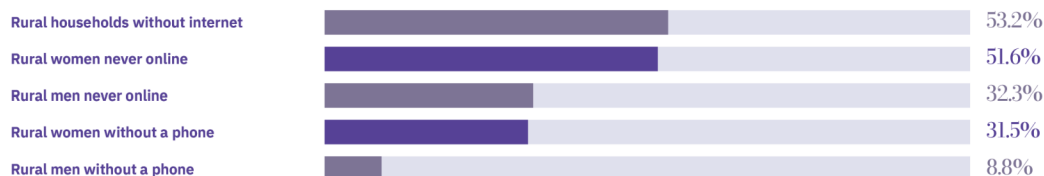
Households with internet



The household connection is the only gap that has not closed — 27.1 points in NFHS-4, 27.7 today.

Who is still outside

Share of rural adults or households without access, NFHS-6.



PER CENT WITHOUT · FULL BAR = 100%

Source: National Family Health Survey, rural India. NFHS-4 (2015-16), NFHS-5 (2019-21), NFHS-6 (2023-24, released May 2026). Phone ownership is a phone the respondent uses herself or himself. Internet figures are "ever used", women 15-49 and men 15-49/54. Individual internet use was not collected as a fact-sheet indicator in NFHS-4, so those two panels begin at NFHS-5.

Change the unit of intervention

These determinants do not accumulate within the same household and are managed largely by the same woman, and are experienced in the same village. Jal Jeevan Mission sees the tap; Swachh Bharat the toilet; PM Ujjwala the LPG connection; PMAY the house; and the Ayushman Arogya Mandir the patient whose health has been shaped by all of them.

Only at the local level do these realities become visible together. And that is precisely where India has quietly built one of the world's largest networks of community institutions.

Now the opportunity is to let those institutions work as a single care ecosystem rather than as parallel programmes.

Electricity reached 97.8 percent of rural households. When India recognises a household amenity as national infrastructure and finances it accordingly, progress is rapid. As care shifts from hospitals to households, water, sanitation, clean fuel and a durable floor are no longer welfare. They are care infrastructure.

FIVE MINISTRIES, ONE HOUSEHOLD

Jal Jeevan
sees the tap

Swachh Bharat
sees the toilet

PM Ujjwala
sees the
connection

PMAY
sees the house

Arogya Mandir
sees the patient
shaped by all of
them

Only at the local level do these realities become visible together.

WHAT CHANGES WHEN REDESIGN THE PROGRAM

DETERMINANTS STOP BEING SEPARATE

Water, sanitation, fuel, housing and clinical care arrive in one dwelling and are managed by one person. Treating them as five programmes means nobody sees the whole.

THE VILLAGE ALREADY HAS THE PLATFORM

The panchayat, the self-help group, the Anganwadi centre and the frontline worker are all present. What is missing is a shared mandate, not new infrastructure.

The family is the fundamental institution of human flourishing and demographic change is compressing its capacity

The family is the oldest and most enduring institution of care. In India, care is financed, organised and delivered primarily by families: they nurture infants, recognise illness, manage medicines and stay beside relatives at the end of life. Hospitals intervene at critical moments; the continuous work happens within households. It is largely unpaid, rarely measured and almost invisible in public budgets, despite being the country's largest care system.

Comparative welfare scholars describe this as *implicit familialism*. The Maintenance and Welfare of Parents and Senior Citizens Act, 2007 places a legal duty on children to support ageing parents; the National Programme for Health Care of the Elderly reaches the primary-care level. The same Act envisages an old-age home in every district, fewer than 500 were operational by 2024. Beyond that, policy assumes every older person has a family that is present, capable and willing to extend care support.

That assumption is becoming fragile because demographic change is reshaping their capacity. The dominant narrative is the disappearing joint family. In reality is different: families still shoulder the overwhelming burden, but with fewer caregivers, over longer periods, against rising chronic illness and dependency.

The institution of care has endured. Its capacity has been compressed.

EXHIBIT 15 · AVERAGE HOUSEHOLD SIZE AND THE SHARE OF HOUSEHOLDS WITH SIX OR MORE MEMBERS, INDIA, 2001 AND 2011

Households are shrinking because fertility fell not because families stopped living together.

AVERAGE HOUSEHOLD SIZE

5.3 → 4.9

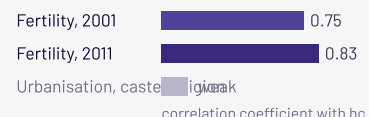
persons, 2001 to 2011

HOUSEHOLDS WITH SIX OR MORE

38.3% → 31.5%

of all households

WHAT EXPLAINS HOUSEHOLD SIZE



Nayak & Behera (2014) found household size driven overwhelmingly by fertility rather than urbanisation, caste or religion. Source: Census of India; SRS/NFHS fertility series.

The transition is also uneven. In 2011 the average household still contained 5.33 persons in Jharkhand against 3.9 in Tamil Nadu. The southern states have already been through the compression that much of northern and central India is only beginning to experience. That gap is a narrowing valuable policy window: time to build community-based care before household capacity contracts further.

The structure of Indian families has proved more resilient than commonly assumed. Analysing census, NFHS and IHDS data, Breton (2019) found no wholesale shift from joint to nuclear living between 1983 and 2009. Nuclear households actually *declined* between 2004–05 and 2015–16, while stem households, older parents living with one married son remained stable or increased. Co-residence remains the dominant arrangement for old age. The demographic architecture has changed but the institution remains same.

Breton's analysis also locates where the compression is most acute. Older people with pensions or rental income are around 25 percentage points more likely to live independently it means economic independence makes separate living possible, and for poorer households co-residence functions as social protection. Since 2004, nuclear living has expanded fastest among poorer, less-educated rural households. The emerging care gap is concentrated among landless labourers and marginal farmers: the households least able to purchase care, hire assistance or forgo wages to provide it.

Care also depends on people being present. Migration raises incomes through remittances, but removes the members who provide everyday care. Money can pay for medicines; it cannot accompany an older person to a facility, recognise the early signs of depression or ensure the evening tablets are taken. As migration separates families, responsibility falls on those who remain most often women, and particularly older women.

A household that once relied on five adult children may now rely on two – for parents living fifteen years longer.

AVERAGE HOUSEHOLD SIZE, 2011

Jharkhand	5.33
Uttar Pradesh	5.26
Madhya Pradesh	4.99
All India	4.90
Chhattisgarh	4.60

The joint family is quietly becoming more expensive – and more of a luxury.

THE CAREGIVER, UNMEASURED

2 in 3

caregivers support an older relative every day

20 hrs

a week, on average

3 in 10

report physical strain; one in three financial strain

1 in 10

knows of any paid age-care service nearby

Source: HelpAge India (2024). The caregiver remains largely invisible in public policy – untrained, unpaid and unsupported.

Across the life course, the needs of young children, persons with disabilities, chronically ill adults and older people converge within the same household, competing for the time of one or two caregivers. Care needs are continuous and household-shaped whereas the Policy remains episodic and programme-shaped. That mismatch defines India's emerging care challenge.

Between the family and the formal health system, rural India's has three decade success building something no other developing country possesses at this scale: is the large nature of community institutions. As industrialised societies responded to shrinking families by transferring care to the state or the market, India has a third possibility, organising care through the neighbourhood self help groups.

THE LATENT INFRASTRUCTURE

Gram Panchayats

statutory welfare responsibilities in every village

Self-help groups

and their village and cluster federations, now ageing into the cohorts

13 lakh Anganwadis

staffed by local women, physically lived in villages

One million ASHAs

with Village Health, Sanitation and Nutrition Committees alongside

The question is whether this infrastructure can take a care mandate forward. Today it is fragmented. Anganwadis serve under-sixes and pregnant women; ASHAs are incentivised for maternal and child health and nutrition interventions; SHGs to do savings and livelihoods; panchayats do infrastructure. A National Training Needs Assessment of Panchayati Raj Institutions across six states found elected members with limited knowledge of referral and health-committee functions and never mentioned long-term care at all.

Everyone's programme; no one's mandate.

EXHIBIT 16 · RURAL OLDER PERSONS LIVING ALONE, SHARE OF RESPONDENTS; TEN-STATE RURAL SAMPLE

Where familial care fails: roughly one rural older person in eight now lives alone.



Each square is one in eight older persons.
The steel square has no one at home.

These are rarely families that have abandoned their responsibilities. More often they are families with too few members available because of low fertility, widowhood, migration or economic necessity.

They are also the group for whom no institution accepts continuous responsibility.

Source: HelpAge India (2026), *Climate Resilient Ageing*. Rural sample across ten states; 13 percent of respondents live alone.

The opportunity hides inside the deficit

Sarkar (2016) argued a decade ago that the Anganwadi, familiar, trusted, village-embedded, and with space freeing up as child enrolment declines could serve older adults. An ICMR-supported pilot in Puducherry found an Anganwadi-based day-care model accessible to nearly every older resident except the severely immobile. The Lancet Citizens' Commission on Reimagining India's Health System has argues that universal coverage must extend to prevention, mental health and long-term care, with community participation at its core.

Rural India does not need to build a care infrastructure. It needs to connect, equip and mandate the one it already has while the families that infrastructure must support are still able to carry the load.

THE FINDING OF PART II

The crisis is not that families care less. It is that smaller families are being asked to provide more care for longer.

WHAT HAS NOT CHANGED

Co-residence. The preference for living together has held across three decades of data, and stem households have held or grown. Families have not withdrawn.

WHAT HAS CHANGED

The arithmetic. Fewer children, longer dependency, and migration removing the members who provide presence rather than money.

WHAT FOLLOWS

A care gap concentrated among the households least able to buy their way out of it – and a set of village institutions with everything except a mandate.

The new pressures

Four forces are now acting on a care system already compressed. Technology amplifies whatever system it enters. The state can transfer money to an individual but has no instrument that finances care. The whole structure rests on women's unpaid time and climate change is consuming that time fastest in the households with least of it to spare.

6 Technology rewrites how care is sought

7 The state's hand is changing

8 A woman's time is the currency

9 Climate opens a new front

Technology is rewriting how care is sought & Delivered

In little more than a decade India has built the world's largest digital public infrastructure: 1.37 billion Aadhaar identities, more than 470 million Jan Dhan accounts, the JAM architecture enabling direct transfers, over 400 million Ayushman Bharat Health Accounts, more than 100 million teleconsultations through eSanjeevani, and AI systems that detect tuberculosis from chest X-rays and screen for diabetic retinopathy where no radiologist has ever practised. The question is can the digital state help fill the widening gap between the care rural India needs and the care it receives?

Digital technologies can expand the *reach* of care but they do not automatically expand its *equity*. They have transformed the state's capacity to identify people, move resources and extend clinical expertise at scale. But unless deliberately designed around the realities of rural households, they tend to reproduce and sometimes deepen the inequalities of class, caste, gender and geography they are meant to overcome.

Technology amplifies the system into which it is introduced.

EXHIBIT 17 · REACH OF INDIA'S DIGITAL HEALTH INFRASTRUCTURE AGAINST DEPTH OF USE

Breadth without depth: the digital layer is thinnest exactly where the need is greatest.

THE REACH		THE DEPTH	
Aadhaar identities	1.37bn	Health IDs with linked records	<1 in 5
Jan Dhan accounts	470m	Share of IDs held by older adults	12%
Health accounts created	400m+	Rural women in India with a personal phone	63.6%
eSanjeevani consultations	100m+	Lowest adoption states	Bihar, UP

linked records

400m+ health IDs created

The all-India linked-record figure is an upper bound on "under a fifth." Sources: ABDM assessments (2024–25); Mishra, Yadav & Joe (2024); NFHS-6.

Three things to be considered

Cash

Direct Benefit Transfer spans more than 1,100 schemes and reached an estimated 85 percent of rural households during the pandemic but the best-studied health transfer, the PMMVY maternity benefit shows the limits.

In reality Aadhaar-bank name mismatches, particularly for women whose names change after marriage, delayed enrolment. Instalments arrived months late. A quarter of the cash met immediate household needs. One in five women reported that a husband or mother-in-law controlled the money.

Therefore, the last mile is not the transfer. It is the household.

Algorithms

Systematic reviews report 81–97 percent diagnostic accuracy across tuberculosis, malaria, kidney disease and diabetes. But most of that evidence comes from tertiary hospitals or Global North populations; evaluation under rural Indian conditions remains limited.

More importantly, the binding constraints are not algorithmic. They are unreliable electricity, poor connectivity, fragmented records and low digital literacy.

The consensus is AI is replacing people but *augmented* intelligence supporting them in the hands of ASHAs, Community Health Officers and nurses, working offline and in local languages.

Records

More than 400 million health IDs exist, but linked records cover fewer than one in five people, with the lowest adoption in Bihar and Uttar Pradesh, and among the older adults who need continuous care most.

eSanjeevani has crossed 100 million consultations, yet studies from remote areas find telemedicine facilities lying idle in absence of staff, power, connectivity and awareness.

Digital health succeeds when it strengthens existing services and frontline workers rather attempts to replace them.

THE UNCOMFORTABLE FINDING

A fixed-effects analysis of two waves of the India Human Development Survey, covering around 12,000 rural households, found that the spread of mobile phones was associated with *reduced* healthcare access among households that had not adopted them, the greatest disadvantage falling on the poor. The divide mirrors existing inequality rather than overcoming it.

A digital-first health system should not be presumed equitable because it is available. It must be judged by whether it reaches those most at risk of exclusion.

Five design principles

Cash transfers must account for who controls household resources.

AI should augment frontline workers, not replace them.

Telemedicine must be designed around reliable staffing, power and connectivity.

Digital records should strengthen continuity of care.

Digital inclusion is itself a public-health and equity intervention.

In the era of DBT and AI, the future of rural care depends less on the sophistication of the technology than on the wisdom of its design.

The state's hand is changing: how India finances care is being quietly rewired

For most of independent India's history, public welfare reached households as goods and services. Over the past decade an increasing share has begun to flow directly as cash to individuals.

More than 1,100 schemes now operate through the Direct Benefit Transfer platform. The National Food Security Act covers around two-thirds of the population; PM-JAY covers hospitalisation for the poorest 40 percent; pensions and income support increasingly move through digital payments. Official estimates put DBT savings at around one percent of GDP. This solves three long-standing problems of welfare delivery and leaves untouched the one that technology alone cannot solve: the organisation of care itself.

The transfer state can find a widow and pay her. It cannot yet sit with her.

FIRST — TARGETING WORKS

The state can now identify a specific widow, a pregnant woman or a tribal household and transfer support directly the pandemic expansion of food security showed the speed of that architecture.

Doorstep banking in rural Karnataka raised savings most among poorer households but stayed viable only where welfare payments generated enough volume.

SECOND — BUT AROUND THE WRONG UNIT

PM-JAY insures the hospital episode. The greatest burden increasingly comes from managing chronic conditions over years rather than days, with medicines nearly 47 percent of out-of-pocket spending.

Health financing must move from insuring hospital stays to supporting *care journeys*: medicines, diagnostics, follow-up, and long-term care itself.

THIRD — CARE IS OUTSIDE THE ARCHITECTURE

The transfer state recognises food, hospitalisation, maternity and, to a limited extent, old age. It provides almost no protection for the continuous support ageing, disability and chronic illness require.

The central old-age pension remains ₹200–500 a month, unchanged for over a decade, far below the cost of medicines or caregiving.

Until “care” is a budget line, it will remain an extraction from women's time.

South Korea finances long-term care through social insurance; Uruguay recognises care as a social right. India's answer will differ. What is missing is not fiscal capacity but a recognised *object* of finance.

More schemes, smaller payments the rail is now built for frequency, not size

Schemes routed through the Public Financial Management System rose from 56 to more than 1,100 between 2014–15 and 2024–25, moving ₹20.23 lakh crore across 1,212 crore transactions. The average transfer has fallen from a peak of ₹5,438 in 2017–18 to ₹1,228, and credit failures are down from 1.85 to 1.24 percent. For a care system, this matters less as a fiscal fact than as an operating one: the state can now reach a rural household reliably, often and cheaply — but only with small sums.

₹20.23

LAKH CRORE PAID SINCE 2014

Across eleven financial years

1,212

CRORE TRANSACTIONS SINCE 2014

Averaging ₹1,669 each

1,146

SCHEMES ON PFMS AT PEAK

In 2023–24, from 56 in 2014–15

1.24%

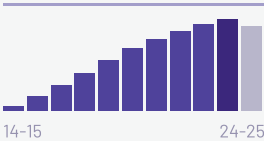
CREDIT FAILURE RATE

Down from 1.85 percent

EXHIBIT 18 · DIRECT BENEFIT TRANSFER THROUGH PFMS, FINANCIAL YEARS 2014–15 TO 2024–25

Four curves, four different shapes.

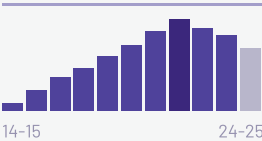
SCHEMES ON PFMS



1,056

latest · peak 1,146

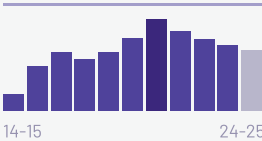
TRANSACTIONS, CRORE



182

latest · peak 266

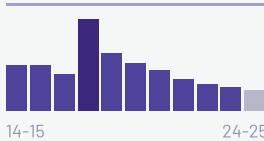
PAID, ₹ LAKH CRORE



2.23

latest · peak 3.34

AVERAGE TRANSFER, ₹



1,228

latest · peak 5,438

Grey bar marks the partial year, to 30 November 2024. Peak transfer size was 2017–18 and peak transaction volume 2022–23; intermediate years are indicative of the published shape. Source: DBT Mission and Public Financial Management System, Government of India.

THE SIX LARGEST SCHEMES ARE NOT LARGE IN THE SAME WAY

SCHEME	TRANSACTIONS, CRORE	AMOUNT PAID	PER TRANSFER
PAHAL — LPG subsidy	91.78 cr	₹13,433 cr	₹146
MGNREGA	29.74 cr	₹47,094 cr	₹1,584
PM-KISAN	20.92 cr	₹41,844 cr	₹2,000
National Social Assistance (NSAP)	10.03 cr	₹11,617 cr	₹1,158
PM Awas Yojana — Rural	0.45 cr	₹16,622 cr	₹36,937
PM-Surya-Ghar	0.04 cr	₹3,103 cr	₹77,586

FY 2024–25 to August 2024. A transfer of ₹146 and one of ₹77,586 run on the same rail; the design question is which of them a care entitlement resembles.

A new care economy is being born and a woman's time is both its currency and its constraint

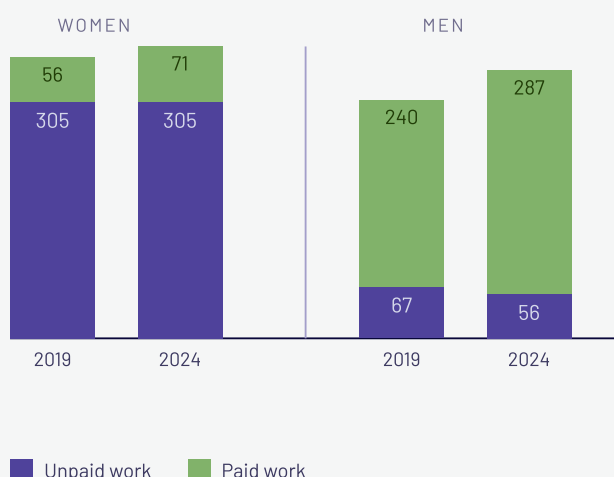
India's care economy is taking shape in reality, from projection. From in crèche enterprises and home-care subscriptions, in geriatric skilling programmes and corporate parenthood policies, and in a national roadmap built around care infrastructure, financing, workforce, quality assurance and leave. What is less often acknowledged is the foundation. Every paid care service entering the market builds on an existing and largely invisible system of unpaid care within households.

Five years, no redistribution. Paid work was added. Nothing was taken away.

According to the second Time Use Survey reveals that between 2019 and 2024, women's unpaid work stayed unchanged at 305 minutes a day, while men's fell by 11 and every one of those minutes reappeared as paid work. Men's total work burden stayed constant; women's rose by six, entirely because paid work was layered onto an unchanged unpaid load. The unpaid-work gap widened from 238 to 249 minutes a day. The care economy is expanding because women are combining paid employment with the same volume of unpaid caregiving.

EXHIBIT 19 · TIME USE SURVEY 2019 TO 2024 · MINUTES PER DAY, PER PERSON, AGE 6+

Five years on, no redistribution: women's unpaid load held at 305 minutes while paid work was layered on top.



UNPAID-CARE GAP, WOMEN – MEN

249 min

Up 11 on 2019. It widened because men did less, not because women did more.

WOMEN'S UNPAID WORK

5.4×

Men's, up from 4.6× in 2019.

TOTAL WORKLOAD ROSE FOR BOTH

+15 · +36

Minutes a day. Women 361→376; men 307→343, driven by paid hours.

Per person per day, all-India, age 6 and above. Paid = employment; unpaid = domestic services, caregiving, own-use production and volunteering (ICATUS divisions 2–5). 2019 all-India figures are population-weighted from rural and urban estimates. Source: NSO Time Use Survey 2019 and 2024 (Fact Sheet, Table 7), MoSPI.

The constraint is sharpest in rural India. Rural women spend 377 minutes a day in productive work against 300 for rural men a gap of 77 minutes, more than three times the urban gap of 24. The more unpaid workload is concentrated where formal care services are least available. Paid employment does not replace unpaid care; it is layered on top of it.

What occupies the unpaid time also matters. Food preparation alone accounts for 159 of the 236 minutes women spend daily on unpaid domestic work about two-thirds while cooking, cleaning and laundry together account for 95 percent. And even that understates the burden: collecting water and fuel is classified separately, as production for own final use rather than as care.

The caregiving that is rising is childcare, not eldercare

Between 2019 and 2024 women's daily caregiving rose from 37 to 47 minutes, with women accounting for around 83 percent of the increase. Participation in the care of dependent adults remains just 0.5 percent of the population. India's demographic transition has advanced far faster than its care transition which makes this a window for building institutions, workforce and financing, a moment for catching up after the system is overwhelmed.

DATA FLAG — JHARKHAND

Rural women in Jharkhand carry **358 minutes** of unpaid work a day: 249 minutes of domestic services, 54 of caregiving, and 55 of own-use production, the last figure two and a half times the all-India female average of 21 minutes, and a direct measure of the state's water and fuel burden.

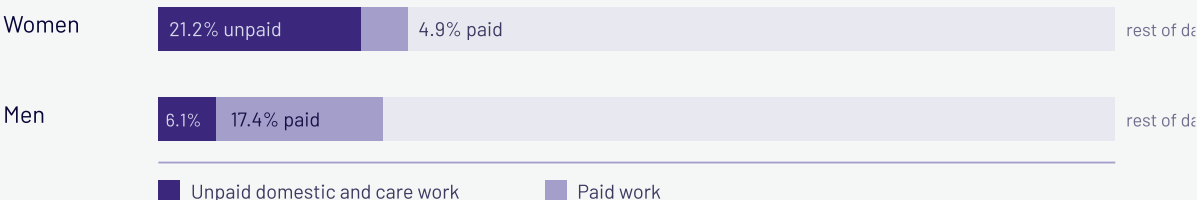
115 min leisure, Jharkhand rural women	148 the average Indian woman	158 the men beside her
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Reducing drudgery does not, redistribute care

Men's 11-minute decline in unpaid work is entirely explained by less own-use production, which fell from 28 to 18 minutes a day; the equivalent fall for women was 23 to 21. The time released let men increase paid employment. It did not do the same for women. Unless accompanied by changes in norms, labour markets and care services, saving time is more likely to increase men's market work than women's economic participation.

EXHIBIT 20 · SHARE OF THE DAY SPENT IN PAID AND UNPAID WORK, PERSONS AGED 6 AND ABOVE, 2024, %

Care runs on women's time and her unpaid day is almost the mirror image of his paid one.



In rural India, about 81% of all work performed by women is unpaid — against 21% for rural men.

Even within the System of National Accounts production boundary, 31.9 percent of rural women's work is unremunerated, against 9.5 percent for rural men. Source: NSO (2025), Statement 38.

The scale

7.5–15%

of GDP: the value of India's unpaid care economy

41.7%

female labour-force participation, against 78.8% for men

53%

of women outside the workforce cite care responsibilities — against 1.1% of men

+50%

projected rise in care demand by 2030

Rural women are absorbing more work, they don't have more choice. As men migrate or leave agriculture, around 84 percent of rural women workers remain in farming yet women own only 13.5 percent of agricultural land and operate about 14 percent of holdings, and are overrepresented in casual, low-paid work. This should not be seen as empowerment but the feminisation of agrarian distress: production added to reproduction and care, within the same finite day.

Older women complete the circuit. A lifetime of unpaid and informal work leaves most without adequate pensions, women's pension income is roughly a quarter below men's with higher disability and depression, and less household spending on their hospital care. Yet they nurse spouses and raise grandchildren so younger women can work. The grandmother is the load-bearing wall of the rural care economy that policy barely sees.

DESIGN THE ECOSYSTEM AS A TIME-SAVING SYSTEM

A care economy that prices care without substituting for women's time merely monetises an extraction it has long normalised.

Childcare, water, clean cooking energy, nutrition support and primary healthcare must sit inside the **23-minute daily mobility radius** that rural women actually command against 59 minutes of travel for rural men.

The workers rural India needs childcare providers, home-care workers, palliative aides, rehabilitation assistants are also the employment strategy it has been searching for.

India is not choosing whether to pay for care. It is already paying in women's foregone earnings, health and happiness. The only question is whether that cost stays invisible or becomes eleven million jobs.

Climate change has opened a new front of challenge and it strikes care through women's time, hitting tribal and marginalised communities hardest

Small families, ageing populations and widespread migration have already compressed the traditional care system. Climate change now intensifies that pressure: it lengthens the daily work of securing water, fuel, fodder and food, while increasing illness, disability and dependency through heat stress, infectious disease, crop failure and extreme weather.

Climate change is measured in degrees. Care systems run on time. The two accounting systems rarely meet.

The adjustment is absorbed almost entirely through women's time. The same women who care for young children and ageing parents are responsible for the environmental work that climate change makes progressively harder. As younger men migrate, the household loses labour when climate shocks demand more of it. The consequence is not simply longer working days; it is a weakening of the family's capacity to provide care at all. It is more visible in India's tribal and forest-edge regions, where livelihoods remain tied to natural resources, settlements are dispersed, public services are sparse and demographic vulnerabilities are already acute.

Climate change is an environmental challenge with gendered consequences, but as a **demographic shock to the care ecosystem**. It accelerates the collision between longer lives, smaller families and greater dependency by consuming the one resource that had quietly held the system together.

Temperature the transmission channel is time in raising

Climate change acts on an already compressed system it don't create new responsibilities, but make existing ones take longer. Water must still be collected, meals prepared, fuel gathered, older people cared for. The difference is the extra journey, the longer queue, the failed harvest, the illness that turns routine care into intensive care. Climate change consumes time before it consumes infrastructure.

The IPCC's Sixth Assessment identifies this transmission channel: climate-induced water scarcity disproportionately affects women and girls, displacing paid work, childcare and education while increasing water requirements during pregnancy, lactation and caregiving. UN Women extends the frame by recognising *environmental care*, the labour of securing water, fuel and fodder as part of unpaid care work. It is this form of care that climate change expands first.

Yet environmental care is largely absent from India's statistical architecture. Time-use surveys measure domestic and caregiving activity, but the additional labour imposed by environmental degradation is not counted. One of the principal ways climate change enters the household grows without appearing in official accounts.

Household infrastructure it does reduce time poverty: Despite improvement in piped water, clean cooking fuel and mechanised washing are associated with around 28 fewer minutes of unpaid work a day. But the gains are unequal. Scheduled Caste and Scheduled Tribe women realise substantially smaller reductions than General category women from equivalent improvements reflecting weaker bargaining power and persistent discrimination.

TWO IMPLICATIONS

First, infrastructure remains one of the most effective care interventions but its returns are socially unequal, and tribal and marginalised households benefit least.

Second, because women's time is already fully committed, every additional hour demanded by climate stress must displace something else: sleep, nutrition, healthcare, paid work, or a daughter's education.

HOW A CLIMATE SHOCK REACHES A HOUSEHOLD

IT LENGTHENS THE DAY FIRST

Before it damages anything, a shock adds journeys: further to water, longer queues, more fuel to gather. The cost appears as hours, not as damage.

THE HOURS COME FROM CARE

Those hours are taken from the only flexible budget in the household, the time a woman was already spending on children, older relatives and the sick.

NOTHING RECORDS IT

Environmental care work are not included both the relief system and the labour statistics, so the largest cost of a heat season or a flood is the one nobody counts.

Demand rises at both ends of life, while the caregiver base contracts

DEMAND RISES AT BOTH ENDS OF LIFE

Climate change increases care demand simultaneously at the two stages- birth and old age where dependency is greatest and the same shrinking family absorbs both.

Analysis of more than 209,000 births from the National Family Health Survey found that each additional consecutive day of extreme heat during pregnancy increased the likelihood of low birth weight, with the greatest effects among poorer and less-educated mothers. Prospective evidence links occupational heat exposure in pregnancy to substantially higher risk of miscarriage. The pathway is biological but also temporal: pregnancy and lactation raise household water needs exactly when heat makes water scarcer.

At the other end, 94 percent of care for older persons in rural India remains family-based. As longevity rises and widowhood becomes more common, care shifts from spouses to sons and, increasingly, daughters-in-law.

THE CAREGIVER BASE CONTRACTS AS DEMAND RISES

Climate change does not simply increase the need for care; it reduces the number of family members available to provide it. Eighteen percent of surveyed households reported migration for employment, with sons accounting for 76 percent of migrants and migration was more common among households experiencing greater climate impacts.

As working-age men move into construction and factory work, women take on not only care but farming, household finances and daily decision-making. In Jharkhand, 80.7 percent of working women are engaged in agriculture.

Expanded responsibility has not brought expanded authority. Across TRI's Community Action Lab geographies the same pattern recurs: women functioning as *de facto* heads of household without being recognised as *de jure* heads managing farms, finances, illness, schooling and care, while excluded from rights and benefits still tied to a male household head.

ADOLESCENT GIRLS BECOME THE SHOCK ABSORBER OF LAST RESORT

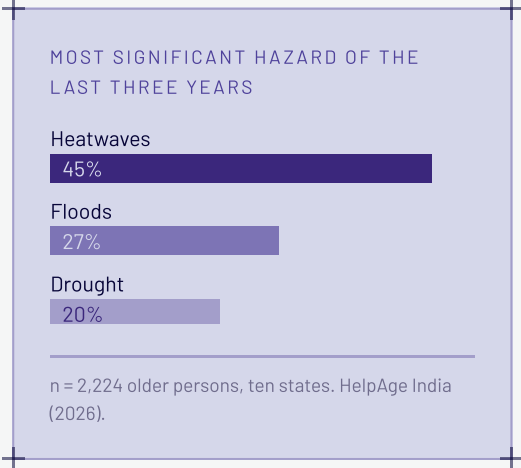
When women's time is exhausted, households draw on their last reserve. Climate shocks increase the likelihood that girls are withdrawn from school to support household provisioning and care, particularly where adult women are already time poor; heat-related school closures push the same way from the opposite direction. This is where the climate-care nexus becomes intergenerational. The girl who leaves school to cover today's care deficit becomes tomorrow's mother with fewer years of education, earlier marriage, earlier childbearing and lower health literacy. **India's future care workforce is being shaped long before it enters the labour market.**

Heat is a care hazard

Climate discourse in India remains organised around floods and cyclones but in rural households increasingly face something else. Among 2,224 older persons across ten states, 45 percent identified heatwaves as the most significant climate hazard of the previous three years, against 27 percent for floods and 20 percent for drought. Heat has become the everyday climate hazard of rural ageing.

Women spend much of the day cooking, caring for children and supporting older family members within and around the home. In the same survey, 40 percent of older people reported excessive indoor heat or poor ventilation, rising to 55 percent among Scheduled Tribe households while 65 percent lived in kutcha or semi-pucca houses. A hazard located inside the dwelling cannot be addressed through outdoor-worker advisories or cooling centres alone.

It is projected that heatwaves add around **90 minutes of unpaid care work a day** for women in India, with up to three-quarters of heat-related productivity losses occurring in unpaid rather than paid work. When schools close because classrooms become too hot, childcare returns immediately to households. Heat expands care demand precisely when it erodes the time available to meet it.



WHAT A HEAT SEASON ADDS TO A RURAL DAY

NINETY MORE MINUTES

A single heatwave day adds around an hour and a half of unpaid work more water carried, cooking rescheduled, livestock and children watched more closely.

THE HOUSE STOPS HELPING

Two in five older people report excessive indoor heat or poor ventilation. The dwelling that should be shelter becomes part of the exposure.

NOBODY RECORDS IT

Heat produces no damage assessment and no relief claim, so the additional hours never appear in any account of what the season cost.

The policy architecture cannot see care

If the evidence is this clear, why is care absent from climate policy? Because it is absent by design. Only 12 of 133 updated Nationally Determined Contributions refer to unpaid care, and among 31 Asian NDCs only Cambodia includes measurable action.

The same gap exists domestically. Heat Action Plans now cover hundreds of Indian districts, largely gender-neutral: they monitor temperatures, health alerts and infrastructure, but not the unpaid care work that heat generates. Older people report welfare support as least effective during heatwaves, and nearly a quarter report exclusion from schemes for which they were eligible.

Because care is invisible within climate policy, it is invisible within climate finance. Adaptation funds invest in infrastructure while overlooking the care systems that decide whether households can absorb shocks at all.

CARE IN CLIMATE GOVERNANCE

12 / 133

updated NDCs mention unpaid care

1 / 31

Asian NDCs with measurable action –
Cambodia

India's NDC is silent. Care time appears in
neither planning nor monitoring.

Piped water, clean cooking fuel and basic domestic technology are not amenities. They are climate-adaptation infrastructure for the care economy.

Climate adaptation must be evaluated not only by the hazards it reduces but by the time it returns to women. Environmental care should become a measurable programme outcome. Adaptation must be designed for the household interior, where women, children and older people actually experience climate risk. And resilience must not be mistaken for unlimited capacity: rural women and their collectives have repeatedly led adaptation, but their time is already fully stretched.

EXHIBIT 21 · CHANGE IN MARRIED WOMEN'S WEEKLY UNPAID HOUSEHOLD LABOUR AFTER THE 2019 KERALA AND BIHAR FLOODS, HOURS PER WEEK

A flood is a care shock — and time-saving assets decide whose time it consumes.



The effect was substantially larger for rural than urban women — and paid work hours rose too. A genuine double burden, leaving essentially nothing for

Source: study of the 2019 Kerala and Bihar floods (see notes). "Time-saving assets" are piped water, clean cooking fuel and basic domestic technology.

The direction

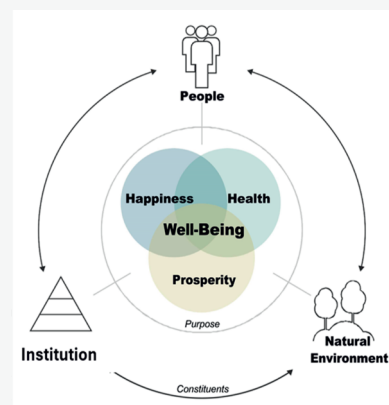
A linear, medical-centric response will fail. Almost every building block of a future care system already exists within walking distance of the households that need it. What is missing is not institutions but a shared care mandate that connects them.

A linear, medical-centric response will fail. The Neighbourhood of Care is the direction

Demand is rising on every front at once: more older people, more chronic illness and disability, and needs that are continuous rather than episodic. The formal system remains organised around facilities, isolated encounters and single-purpose programmes and weakens precisely where the new burden begins. The family is compressed by fertility decline and hollowed by migration. Technology amplifies the system it enters. The state can transfer money but lacks an instrument that finances care. And the whole structure rests on women's unpaid time, which climate change is consuming fastest in tribal and marginalised households.

The response is therefore, lies to redesign the relationships between them. The starting point must be the daily life of the person requiring care, beyond the organisational boundaries of the providers: identify the local institutions already shaping care, reconnect them around shared outcomes, and build through place-based learning.

Not a slower route to the required destination, a faster route to one India has already reached.



Wellbeing as the purpose; people, institutions and the natural environment as its constituents.

THE BUILDING BLOCK ALREADY EXISTS WITHIN WALKING DISTANCE

Gram Panchayat
constitutionally mandated, with responsibility for local development

SHGs and federations
the world's largest network of organised rural women

ASHA
roughly one for every thousand people

Anganwadi
in almost every habitation, staffed by local women

Ayushman Arogya Mandir
population empanelment, NCD screening from thirty, teleconsultation, care within thirty minutes

Rural India's challenge is not an absence of institutions but the absence of a shared care mandate connecting them. A decade of TRI's community practice and the evidence assembled here point to the same conclusion: the future of care lies not in creating new institutions, but in enabling existing ones to function as a single, coordinated care ecosystem.

This is the Neighbourhoods of Care.

What it is

A Neighbourhood of Care is a community-anchored care ecosystem for a defined locality that places the individual and family at its centre and integrates three complementary levels: care at home, care in the community, and care through the formal health system.

It is built on **Locality Compact**; a working alliance of Gram Panchayat representatives, women's collectives (SHG-VO-CLF), community leaders and frontline workers across sectors. Rather than creating new institutions, it aligns existing ones around a shared responsibility for care.

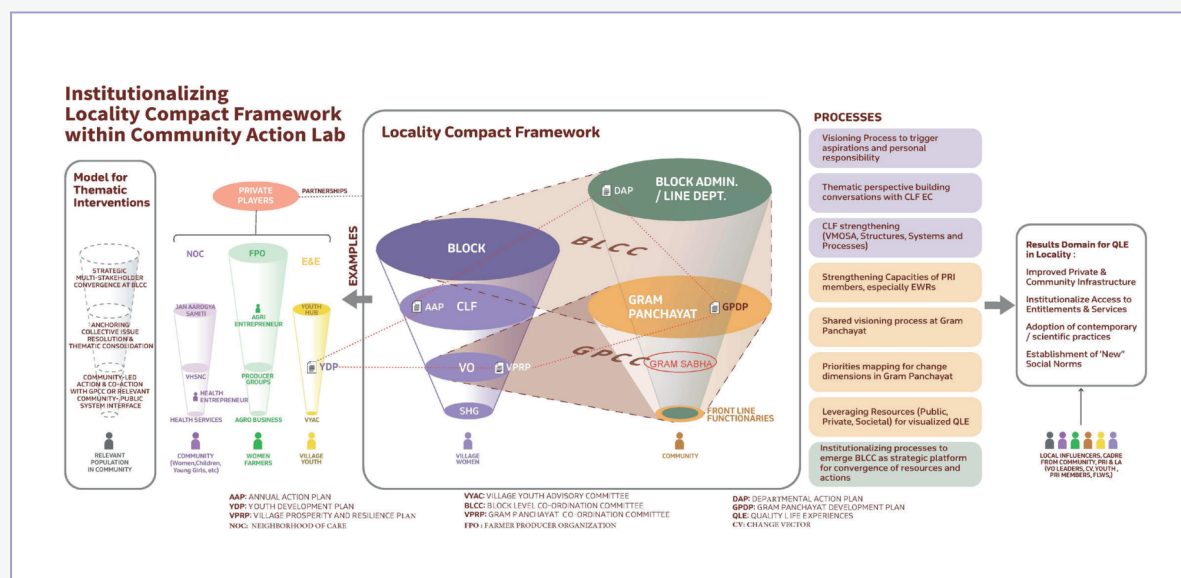
What it is for

To enable every person to live a healthier, longer and more dignified life by reducing malnutrition, morbidity and avoidable vulnerability.

Consistent with the capabilities approach of Amartya Sen and Martha Nussbaum, health and nutrition are understood not merely as inputs to development but as intrinsic components of human flourishing. The unit of action is therefore, the household's continuous wellbeing across the life course.

EXHIBIT 22 · SCHEMATIC OF THE NEIGHBOURHOOD OF CARE

The Neighbourhood of Care, institutionalised through the Locality Compact.



Schematic, not a measured exhibit. The Locality Compact framework as institutionalised within TRI's Community Action Lab. The Neighbourhood of Care is the care-facing thematic intervention within it (NOC, left); FPO and E&E are the parallel livelihood and youth interventions on the same architecture.

How it works: three mutually reinforcing streams

STREAM ONE

At the household level

Restoring care where people live

Community volunteers- *Badlav Didis*, working alongside ASHAs, AWWs and ANMs strengthen the often-neglected foundations of health: self-care, nutrition, healthy ageing, disability support, early recognition of illness, treatment adherence and caregiving practices. As trusted neighbours, they identify the households formal systems routinely overlook to influence the social norms.

STREAM TWO

At the community level

Giving the locality a care mandate

The Village Prosperity and Resilience Plan and the Gram Panchayat Development Plan become instruments for planning care. Panchayats map care-dependent households, align public resources and scheme entitlements, strengthen Anganwadis as community care hubs, and enable SHG-led care enterprises- home care, day care, nutrition services. Coordination is institutionalised through Gram Panchayat and block-level platforms that bring elected representatives, women's collectives and the AAA frontline around a single, locally owned care plan.

STREAM THREE

At the health-system level

Extending care beyond facilities

The Ayushman Arogya Mandir provides the clinical anchor, while teleconsultation, digital decision support and AI-enabled tools strengthen Community Health Officers and frontline workers. Referral, follow-up, rehabilitation and palliative care extend into households, and community institutions such as the Village Health, Sanitation and Nutrition Committee and the Jan Arogya Samiti hold the system accountable to the communities it serves. Technology is used not to replace relationships, but to strengthen continuity of care.

Together these three streams transform fragmented programmes into a coordinated, place-based care ecosystem, one that supports families, strengthens communities, and enables the health system to provide continuous, person-centred care across the life course.

Care at home, care in the community, and care through the formal system, organised as one thing rather than three.

Why this is the direction and not another scheme

It is not another programme layered onto an already crowded policy landscape, but an organising framework that aligns existing institutions around a single purpose, answering all of the structural transitions described in this white paper at once.

CONTINUOUS CARE	Met with continuous community presence, rather than episodic service delivery.	COMPRESSED FAMILIES	The approach strengthens caregiving where demographic change and migration have reduced family care.
DIGITAL DIVIDES	Given a trusted human interface through frontline workers and community institutions.	FINANCING GAP	A recognisable object for public finance: care, rather than illness alone, becomes a legitimate policy concern.
WOMEN'S TIME	Unpaid care converted into visible work, leadership and local employment through community collectives.	CLIMATE SHOCKS	A ready adaptation platform: the same institutions that organise everyday care are first to know which households will need medicines, food, water or evacuation.

AND THE ECONOMICS POINT THE SAME WAY

As the McKinsey Health Institute has argued, the greatest returns on health investment come from prevention, early intervention and community-based care rather than hospital treatment alone. Scaling proven interventions, most preventive and deliverable close to home can return around four dollars for every dollar invested. The Neighbourhood of Care is the institutional architecture for realising those returns where health is actually created.

4:1

estimated global return on scaling proven, largely preventive health interventions

The Neighbourhood of Care is not a new institution. It is a new way of organising the institutions India already has around the simple proposition that care is continuous, local and shared.

Return, finally, to the woman with whom this report began

Systems are abstractions. She is not.

ON THE CURRENT PATH

Her hypertension remains undetected through her forties, because no one reaches her before illness does.

After her husband's death she manages alone. Her son sends money from the city, but money cannot replace the human presence and everyday care she needs.

She becomes one of millions whose final years are defined not by disease, but by the absence of continuous care.

IN A NEIGHBOURHOOD OF CARE

She is screened at forty-five, because a community volunteer knows every household on her lane. After widowhood an SHG-supported care worker, her neighbour checks on her medicines, nutrition and wellbeing.

The Anganwadi that once served her children becomes a place of companionship. The Panchayat's care plan flags her household for priority outreach during heatwaves and water shortages.

When her medicines need adjusting, the consultation happens in her own village, assisted by a frontline worker rather than requiring a costly journey.

Nothing in this story is futuristic. Every institution already exists. **What is missing is the relationship that connects them into a single care ecosystem.**

That is the purpose of the Neighbourhood of Care. It enables families, communities and the health system to work together, a new social compact between the family and the state, between women's unpaid time and public investment, between episodic treatment and continuous care.

India transformed maternal and child survival by building one of the world's largest community health systems. The next frontier is not helping people live longer, but ensuring they live well. The question is not whether India can build another programme, it is whether it can organise the institutions it has around the idea that care is continuous, local and shared.

The twenty-first century will not be judged only by how many lives India saved. It will be judged by how well those longer lives were lived. The Neighbourhood of Care is an opportunity to make that the country's next great public-health achievement.

Sources and notes

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NOTE ON THE EXHIBITS

Exhibits 1–22 are drawn from the cited data, except Exhibit 2, which like Plates 1–4 is reproduced as supplied from the underlying evidence notes and keeps its source palette. Exhibit 22 reproduces the Locality Compact framework; Exhibit 14 is explicitly illustrative, and the context lines in Exhibit 5 are schematic. Where a series endpoint is published and the path between endpoints is interpolated for legibility, the exhibit footnote says so.

Exhibits have been renumbered sequentially for this edition; the working draft's chapter-level numbering and full chapter reference lists are maintained separately. Self-reported morbidity in rural India systematically understates true disease burden – a caution that applies wherever survey-reported health status is used.

Contributors

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Nineteen years in public health and public policy in action across the tribal regions of central India and the North East. He anchored the LWE-Aspirational Districts Programme, incubated the Integrated COVID Response Resource Centre and was on the core team behind the first Mamta Vahan call centre. His work is focused at the intersection of gender, climate, local institutions and care systems.

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Abbreviations

ANM	Auxiliary Nurse Midwife	NCD	Non-Communicable Disease
ASHA	Accredited Social Health Activist	NFHS	National Family Health Survey
AWC / AWW	Anganwadi Centre / Anganwadi Worker	NRHM / NHM	National Rural Health Mission / National Health Mission
AB-PMJAY	Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana	OOPE	Out-of-Pocket Expenditure on health
CHC	Community Health Centre	PHC	Primary Health Centre
DALY	Disability-Adjusted Life Year	PRI	Panchayati Raj Institution
DBT	Direct Benefit Transfer	RHS	Rural Health Statistics
GBD	Global Burden of Disease study	SC	Sub-Centre
HWC	Health and Wellness Centre (Ayushman Arogya Mandir)	SHG	Self-Help Group
IMR	Infant Mortality Rate, per 1,000 live births	SRS	Sample Registration System
LASI	Longitudinal Ageing Study in India	TFR	Total Fertility Rate
MMR	Maternal Mortality Ratio, per 100,000 live births	TUS	Time Use Survey
		UHC	Universal Health Coverage
		YLD / YLL	Years Lived with Disability / Years of Life Lost

Care is continuous, local and shared.

347m

Indians aged 60 or older by 2050

249

minutes a day: the unpaid-work gap
between women and men

11m

jobs from investing 2% of GDP in the care
economy

Demographic Transition, Evolving Families and the Future of the Care Ecosystem in Rural India.