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**Re-imagining the Care Economy:
From Private Burden to Social and Economic
Infrastructure**



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Re-imagining the Care Economy: From Private Burden to Social and Economic Infrastructure

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Executive Summary

India’s demographic profile is shifting - a growing share of elders and declining fertility, compounded by rapid urbanisation that is eroding the traditional family structures that have historically provided care. Indian states are at varying stages of this demographic transition– from high child dependency to accelerating elderly dependency. The pressures of declining fertility and ageing have increasingly prompted some state governments to respond through measures aimed at reversing demographic trends or easing the financial cost of raising children.

Evolving demographics have fundamentally impacted the demand for care work across the life cycle- for children, the elderly, and persons with disabilities. However, supply gaps persist. Care work is primarily informally provided within households by women and is unpaid. Despite women’s unpaid care and domestic work contributing about 15-17% of the GDP in economic value⁶, investments in formal care provision remain limited. Formal care is systematically underprovided and often expensive owing to the underlying market failures.

Existing policy instruments are primarily maternity-centric, treating fertility as a demographic variable rather than focusing on whether families can access care services, thus, reinforcing the gendered provision of care rather than redistributing it. This reflects in the continued stagnation in urban female labour force participation, below replacement level urban fertility rates for over two decades, and a mismatch between desired and actual fertility. **The core problem arises from care services being treated as a private household responsibility rather than as a social and economic infrastructure.**

⁵ The authors thank Totini Mitra and Mozaien Tak for their research assistance.

⁶Mitali Nikore et al., *Formulating a Strategy for India's Care Economy: Unlocking Opportunities* (March 2024), <https://static.pib.gov.in/WriteReadData/specificdocs/documents/2024/mar/doc202435319501.pdf>.

Policymakers must proactively address the problem of unavailability of quality and affordable care services by re-imagining care from being a “women’s issue” to a foundational infrastructural pillar for functioning of families, labour market efficiency, and long-run economic growth.

Investments in the care economy present three interconnected opportunities for India. **First, the care sector can generate significant employment in both domestic and global markets with rising demand for care workers.⁷ Second, greater investment in the care economy can deepen family-friendly policies** that reduce time poverty, cushion households from childcare income shocks especially in the informal sector, and raise caregiver labour force participation. Finally, **care economy investments can redistribute unpaid care responsibilities from households to the state and markets, while gender-neutral policies can actively encourage sharing of care labour between men and women.**

In this context, it is imperative to examine the current care landscape. India's care economy encompasses the demand-side service delivery of childcare and eldercare, and the supply-side initiatives of skilling of the care workforce. The models span public, private, and non-profit providers across a multi-tiered fiscal and institutional structure.

Childcare is a central component on the demand side. Union government provision is anchored in two institutional pillars: the Integrated Child Development Services (ICDS) program and the Palna scheme, while states have built on this foundation with complementary or supplementary initiatives. **Challenges in the public sector like high child-to-caregiver ratios, urban provision gaps, center-state cost-sharing gaps, uneven coverage, and regulatory variability impact scale and consistency.**

Private childcare models, on the other hand, are concentrated in urban areas, shaped by evolving demands and statutory requirements. Dominant models include premium commercial, corporate-supported, and mixed models combining private provision with public subsidies. Whereas, NGO and community-based models leverage CSR funding, philanthropic networks and state partnerships. **Across private and non-profit providers, affordability, weak long-term financing pathways and inadequate quality assurance are persistent challenges to scale.**

⁷ The domestic demand for care workers is projected to exceed 30 million by 2050 (based on authors own calculations, shown in Annexure 1) alongside a significant rise in international demand for care workers.

Policy provisions related to childcare also include maternity and paternity leaves. However, the maternity-centric design with minimal paternity provisions, and limited applicability to the informal sector not only designate women as default caregivers but also distort employer hiring incentives. **The *motherhood penalty* thus arises not from maternity protection per se, but from its isolation within a broader care regime. This needs pooled financing instruments and incremental reforms in gender-neutral childcare leaves.**

International evidence suggests that a key reason for deficiencies in the Indian childcare system is the absence of framing it as an employment-enabling infrastructure. **The core challenge is building an institutional architecture that ensures adequate access, regulatory norms, and sustainable financing, allowing childcare to function as reliable social infrastructure.**

Eldercare is the second big pillar on the demand side. India's public eldercare primarily spans institutional care, contributory pensions, income support, and health financing. At the state level, policies vary by design, scale, and depth, reflecting the variations in demographic stage, fiscal capacity, and administrative commitment. **Structurally, the public system operates with limited coverage, weak regulatory mechanisms, and financing gaps.**

Institutional eldercare outside the public system is concentrated in urban areas. Models in the private sector are mainly designed as premium senior living while non-profit models deliver a multitude of services including mobile health and nutrition at a relatively lower-cost. **Here, challenges of affordability and reliable funding pipelines impact accessibility.**

A key enabler in the care landscape is the supply of skilled caregivers. Development of a high-quality care workforce requires structured training and practical experience in a combination of technical competencies and interpersonal skills. The Union Budget signals a commitment to the care economy: expanding training capacity for 1.5 lakh caregivers and 1 lakh allied health professionals over the next five years.⁸ This is a step in the right direction.

Domestic training capacity for care workers is growing across public and private providers, though unevenly in both scale and quality. At the centre level, trainings are delivered through the Pradhan Mantri Kaushal Vikas Yojana (PMKVY), implemented by the

⁸ Ministry of Finance, Government of India, *Budget Speech 2026–27 of the Finance Minister* (Government of India, February 1, 2026), https://www.indiabudget.gov.in/doc/budget_speech.pdf

Ministry of Skill Development and Entrepreneurship (MSDE). Few states have also proactively embedded skill training with employment opportunities. Private sector skill-training providers are concentrated in urban areas, generally offering shorter and practical-skill oriented courses. **However, trainer quality, slow evolution of standardised certification, and uncertain employment pathways leave persistent gaps in availability of trained care workers.**

Recently, Artificial Intelligence (AI) has sparked debates around productivity and replaceability of workers. However, the inherent need for human judgement in care work and the evidence of AI applications across care segments demonstrates AI's supplemental value to skilled human labour, rather than a replacement. **Leveraging AI is therefore, conditional on a skilled workforce, with investments in care training central to its effective application.**

The above discussion shows that care services and workforce development models currently remain fragmented, instead of operating as an integrated system serving the life cycle of care needs. **A strategic and comprehensive market development approach that combines care infrastructure, financing, workforce development and regulatory oversight is crucial to address the gaps in care provision and re-frame it as a social and economic infrastructure.**

These efforts must be anchored in four key pillars, each functioning not in isolation but converging as part of a coordinated response across ministries, departments, levels of government and sectors. Further, this approach emphasises the need to view care beyond the narrow purview of the Ministry of Women and Child Development (MoWCD), and instead re-orient care across all aspects of service delivery, policy planning and institutional design.

First, the expansion of innovative financing for the development of care infrastructure and “carepreneurs” (care sector entrepreneurs). Community-based multi-generational care facilities can be developed through an outcome-based government-to-government (G2G) fund housed within the Ministry of Finance - *Parivar Seva Kosh* (family care fund). Next, the Ministry of Corporate Affairs can leverage existing National and state CSRXchange portals to direct CSR and philanthropic funding towards care sector projects. Further, concessional finance can be offered to care entrepreneurs and co-operatives through a 'Carepreneur' Fund, constituted as a special purpose vehicle (SPV) by the Ministry of MSME. The Ministry can further complement this effort by establishing "care incubators" and facilitate financing for the incubated enterprises through the Fund. Finally, model concession agreements can be

developed to operationalise Public Private Partnerships (PPPs) for investments in greenfield and brownfield care facilities.

Second, professionalisation and expansion of the care workforce to meet growing domestic and global care demands. MoSDE can spearhead a national skill gap assessment in the care sector. To institutionalise specialisation and highlight clear career pathways, National Skill Development Corporation (NSDC) can standardise trainings, certifications, and occupational frameworks across the full spectrum of care work. Further, existing international partnerships of NSDC can be strengthened through Government-to-Government (G2G) and Business-to-Business (B2B) arrangements for joint accreditation and co-development of training modules in the care sector. MSDE could also align skilling initiatives in the care sector with the labour mobility clauses in existing trade agreements and bilateral partnerships.

Third, policy reforms for integration of care service priorities across the policy landscape. The Ministry of Labour and Employment (MoLE) can introduce phased reforms in parental leaves beginning with statutory paid paternal leaves in the private sector, followed by a gender-balanced parental leave policy. Next, the Ministry of Cooperation can recognise care as a priority sector and issue model guidelines for care co-operative development, in line with existing regulatory frameworks. Further, care infrastructure can be embedded within urban planning by the Ministry of Housing and Urban Affairs (MoHUA) through inclusion of qualitative norms for care facilities within URDPFI guidelines and classifying care as “essential social infrastructure” via measures like land reservation and linking care indicators with project appraisal and Finance Commission performance grants.

Local-level access to care can be expanded through collaborations with Ministry of Social Justice and Empowerment (MoSJE) and Ministry of Education (MoE). MoSJE can support state governments and ULBs in establishing multigenerational care facilities. MoE can support with provision of necessary physical infrastructure for childcare by allowing co-location within government school premises. As schools are well suited due to their community proximity and variable schedules, this creates scope for shared use of underutilised space, in addition to repurposing of school infrastructure affected by closure or consolidation due to decreasing enrolments. MoE can support state governments in identifying and converting such school infrastructure.

Fourth, institutionalisation of quality care through regulatory and assurance standards for improving consistency in care service delivery across providers. MoWCD and MoSJE can establish quality standards for care facilities across public, private, and community-based providers, allowing for state-level fine-tuning and differentiation by the type of care. Additionally, building on the Comptroller and Auditor General’s audit guidelines, MoWCD and MoSJE can establish monitoring systems, linking state’s performance to financial incentives.

In conclusion, this paper argues that care is a strategic public good, not a private burden to be disproportionately borne by women. That said, care is not only a matter of gender equity, but a precondition for productivity, demographic resilience, and social cohesion. In the current context of evolving demographics and family structures, the government must intervene to fill the gaps in care provision, and support families. **Therefore, the path forward requires a reorientation – from isolated, scheme-driven interventions to a coherent, cross-ministerial framework – such that care services function like social and economic infrastructure.**

Introduction

Care services are central to the functioning of society and support economic development. These activities aid the development and well-being of children, older persons, persons with disabilities (PwDs), and dependent individuals.⁹ There are two key elements to care activities - whether they are paid or unpaid, and whether they support individuals directly or indirectly. Direct care includes activities such as feeding or supervising a child, while indirect care encompasses domestic tasks like cooking and cleaning. At present, care services are delivered through a mix of formal arrangements like childcare centres, eldercare institutions, and home-based personal care, and informal provision of unpaid care performed within households.¹⁰ In India, women spend on average more than 2.5 times as many minutes as men on domestic and caregiving tasks¹¹, reflecting significant gender imbalance in unpaid care and domestic work.

With an economic value of women's unpaid domestic and care services equivalent to 15-17% of GDP¹², India needs to focus on enabling affordable and reliable care provision, not as a residual welfare measure but as a core development strategy. This requires re-imagining care activities as an essential social infrastructure, strengthened by care infrastructure and expansion of the care workforce. Shifting the focus requires recognising the central role of care activities in supporting families, enabling individuals to realise their fertility aspirations, and adapting to demographic transition and changing family structures. These factors, in turn, shape labour supply, productivity, long-term human capital formation, economic growth, and societal well-being.

This paper aims to provide a pathway for prioritising care economy investments as core social infrastructure. Section 1 examines the need for family-friendly policies. Section 2 presents the value and strategic nature of investments in the care economy. Section 3 reviews existing policies, programs, and prevalent care models across different providers. Section 4 presents policy recommendations for a robust care economy. Section 5 offers concluding remarks.

⁹ Government of India, Ministry of Finance, *Economic Survey 2023–24*, chap. 8, "Employment and Skill Development" (Ministry of Finance, July 2024), <https://www.indiabudget.gov.in/budget2024-25/economicsurvey/doc/eschapter/echap08.pdf>

¹⁰ International Labour Organization, "Care Economy," Topics and Sectors, accessed March 14, 2026, <https://www.ilo.org/topics-and-sectors/care-economy>.

¹¹ Ministry of Statistics and Programme Implementation (MOSPI), *Time Use Survey 2024: Fact Sheet* (Government of India, 2025), https://mospi.gov.in/sites/default/files/publication_reports/TUS_Factsheet_25022025.pdf

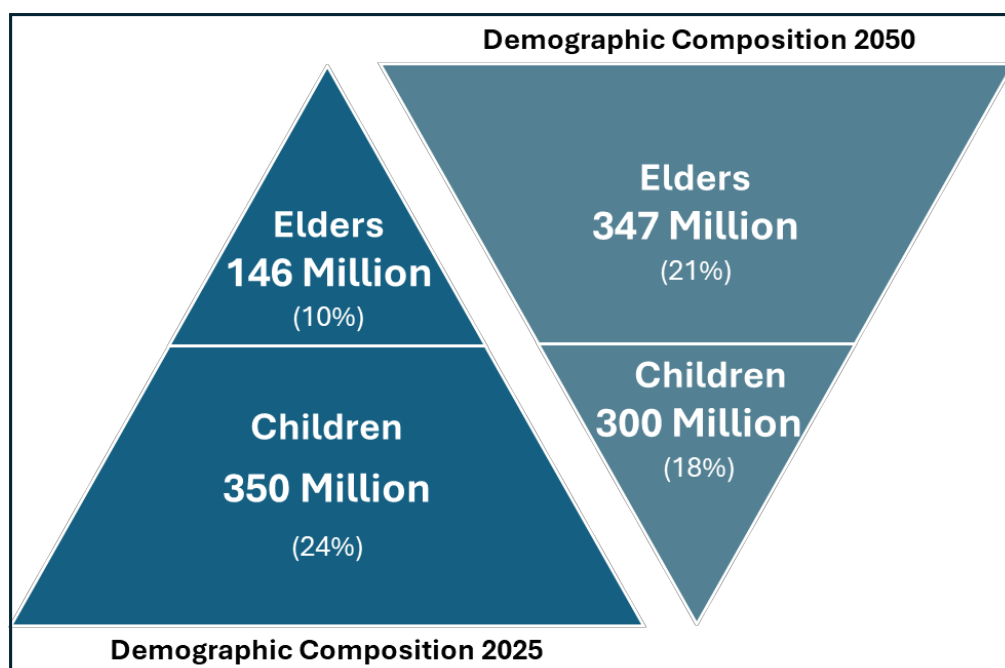
¹² Nikore et al., *Formulating a Strategy for India's Care Economy*.

1. The need for coordinated efforts on family-friendly policies

India's demographic structure has changed significantly over the past two decades, marked by declining fertility, improved life expectancy, and a gradual shift in age composition across all states. According to population projections by the United Nations Department of Economic and Social Affairs (UN DESA), approximately 24% of India's population was below the age of 14, while around one-tenth aged 60 years and above in 2025.¹³ This translates to approximately 350 million children and 146 million older persons requiring varying degrees of care support.

By 2050, the overall demographic structure is expected to shift substantially. The share of elderly persons is projected to reach around 21% and that of children around 18%, i.e. 347 million elders and 300 million children.¹⁴ **The rising population of elders and sizable child population indicates the sustained demand for care services throughout the life cycle, putting pressure on households.**

Figure 1.1 Changing Demographic Composition



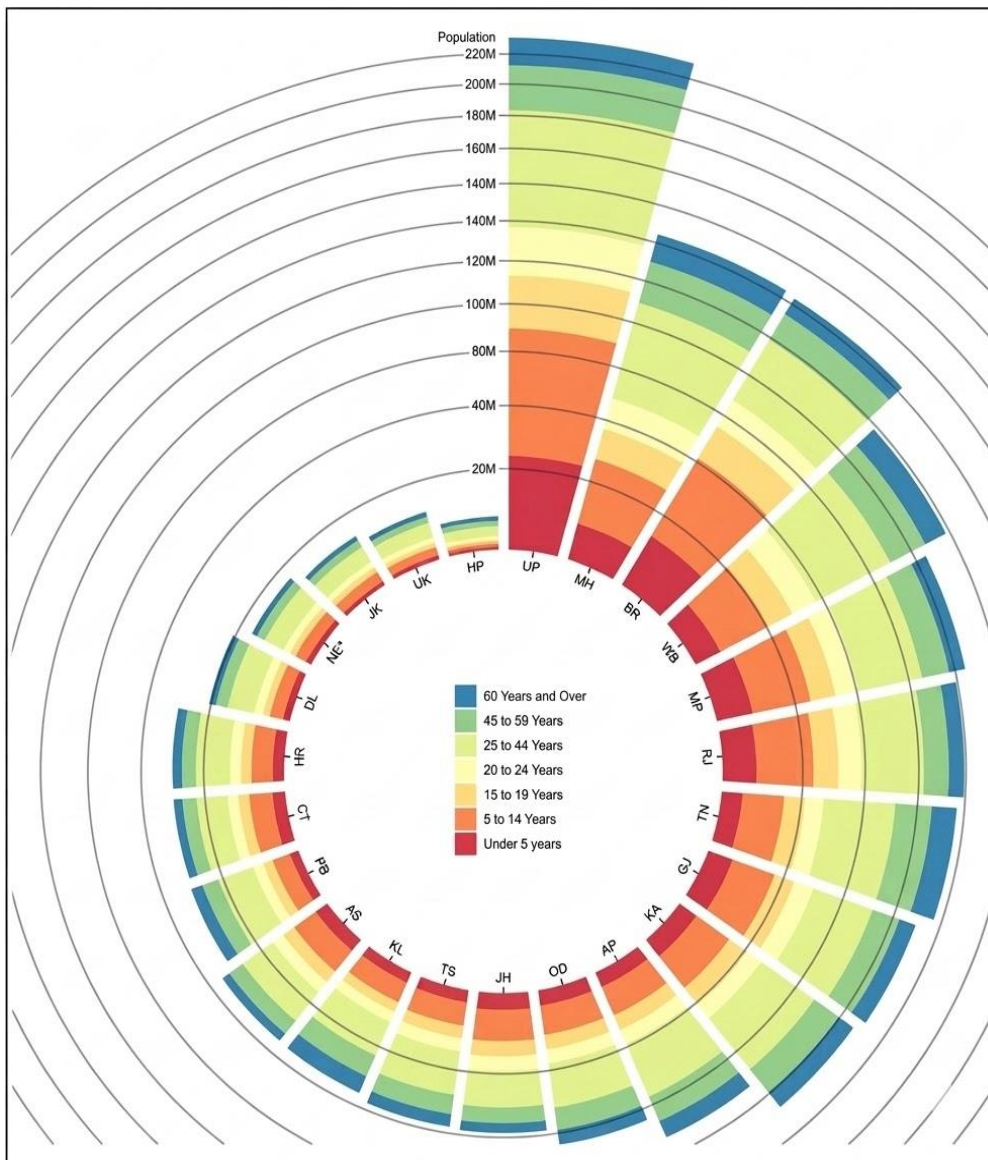
Source: UNFPA, UN Population Projections¹⁵

¹³ United Nations, Department of Economic and Social Affairs, Population Division, *World Population Prospects 2024* (United Nations, 2024), <https://population.un.org/wpp/>

¹⁴ Ibid.

¹⁵ United Nations, Department of Economic and Social Affairs, Population Division, "Population Pyramids: India 2050," interactive data visualization, *World Population Prospects* (United Nations, 2024),

Figure 1.2 Differences in demographic composition across states



Source: Author’s calculations using Population Projections for Indian States 2011-2036¹⁶

However, the age distribution varies significantly across states. This has major policy implications for the evolution of care demand across states in the coming decades - both in terms of volume and type. For instance, despite having similar population sizes, the age structures in Maharashtra and Bihar differ widely: Maharashtra has a much larger share of

<https://population.un.org/wpp/graphs?loc=356&type=Demographic%20Profiles&category=Population%20Pyramids&year=2050>

¹⁶ Office of the Registrar General & Census Commissioner, India, *Population Projections for Indian States 2011–2036* (Government of India, 2020),

https://mohfw.gov.in/sites/default/files/Population%20Projection%20Report%202011-2036%20-%20upload_compressed_0.pdf

elderly people and a smaller share of children under 14. This shapes how care services are demanded, delivered and prioritised across these states.

Economic valuation estimates suggest that unpaid domestic and care work contributes approximately 15-17% of GDP¹⁷, yet, most of it is generated and consumed within households as unpaid labour, bypassing market transactions. *Underlying market failures result in under provision of formal care services and relatively high costs in the organized sector.* This systematic undervaluation of unpaid care reinforces gendered division of labour by weakening the incentives to expand formal care services and simultaneously limiting the social and economic recognition of women who perform it.

These imbalances are reflected in gendered time allocation patterns. The Time Use Survey 2024 shows that women spend an average of 289 minutes per day on unpaid domestic services and 137 minutes on unpaid care activities. In contrast, men spend 88 minutes and 75 minutes per day on these activities, respectively.¹⁸ Participation rates also vary sharply - 92.9% of women aged 15-59 years engage in unpaid domestic work, compared to only 30.4% of men.¹⁹

Further, urban-rural differences amplify gendered care burdens, with urban women spending more time on unpaid care activities.²⁰ This must be understood in the context of the rapid spatial transformation in India. The Economic Survey 2025-26 notes that based on the Global Human Settlements Layer (GHSL) satellite-based settlement data, nearly 63 percent of the population resided in urban built-up settlements in 2015.²¹ This spatial transformation is accompanied with a shift in the family composition- from joint family households to predominantly nuclear families - suggesting a breakdown in the traditional family structure. *In the absence of informal family care support and robust public care infrastructure, time constraints are intensified, especially for women.*

¹⁷ Nikore et al., *Formulating a Strategy for India's Care Economy*.

¹⁸ MOSPI, *Time Use Survey 2024: Fact Sheet*

¹⁹ Ministry of Statistics and Programme Implementation (MoSPI), *Time Use in India, 2024 (January–December 2024)* (New Delhi: Government of India, 2025), https://www.mospi.gov.in/sites/default/files/publication_reports/TUS_Report_2024_28.03.2025F.pdf.

²⁰ Ibid.

²¹ Government of India, Ministry of Finance, *Economic Survey 2025–26*, chap. 15 (Ministry of Finance, 2026), <https://www.indiabudget.gov.in/economicsurvey/doc/eschapter/echap15.pdf>

Together, this underscore how unpaid care work continues to structure women's lives and limit their economic choices. Nikore et. al. (2023) describes the unequal burden as *care penalty*, a systemic time tax that limits women's access to paid employment, education, and political participation.²² This kind of a penalty has varied manifestations that alter life trajectories of women.

First, care responsibilities leave women time-poor, limiting their ability to pursue education, training, or upskilling. Consistent with this, there is a strong positive correlation (0.65) between share of young women that cite care burden as their primary reason for not participating in economic activities and the share of young women that are not in education and employment.²³ This time constraint channels women into a narrower set of low-paid, informal, and home-based occupations, reinforcing occupational segregation and dampening aggregate productivity gains. **Second, the care penalty is cumulative.** Career interruptions for childbirth, childcare and eldercare lead to slow wage growth, fewer promotions, and lower lifetime earnings.²⁴ Over time, these compound and turn into a persistent wage gap.

Policies have responded varyingly to the evolving care needs. Sikkim, with a TFR of 1.1, was one of the first states to introduce fertility-linked salary increments for government employees, extended paternity leave, IVF support, and monthly financial assistance for mothers in private sector, in 2022. Whereas, Andhra Pradesh, a state that previously enforced two-child limits through electoral disqualification and employment restrictions, has proposed cash incentives and free education in March 2026, at a notable scale and fiscal commitment.

The new Labour Codes, while acknowledging gig, platform, and some unorganised workers within a broader social security framework, largely follow the architecture of the Maternity Benefits Act (2017). Maternity leave and employer-provided crèche mandates depend on establishment size and minimum employee tenure. Resultantly, maternity coverage remains constrained, with women in smaller or informal establishments effectively excluded.

²² Mitali Nikore et al., *Leveraging Care Economy Investments to Unlock Economic Development and Foster Women's Economic Empowerment in G20 Economies*, T20 Policy Brief (T20 India, 2023), https://t20ind.org/wp-content/uploads/2023/06/TF6_610_CareEconomy.pdf

²³ Sudipto Mitra and Arpita Ramesh, *The Care Economy: A Case for Expanding the Role of the Private Sector*, Policy Brief No. 35 (Indian Council for Research on International Economic Relations, 2025), https://icrier.org/pdf/PB35-Care_Economy.pdf

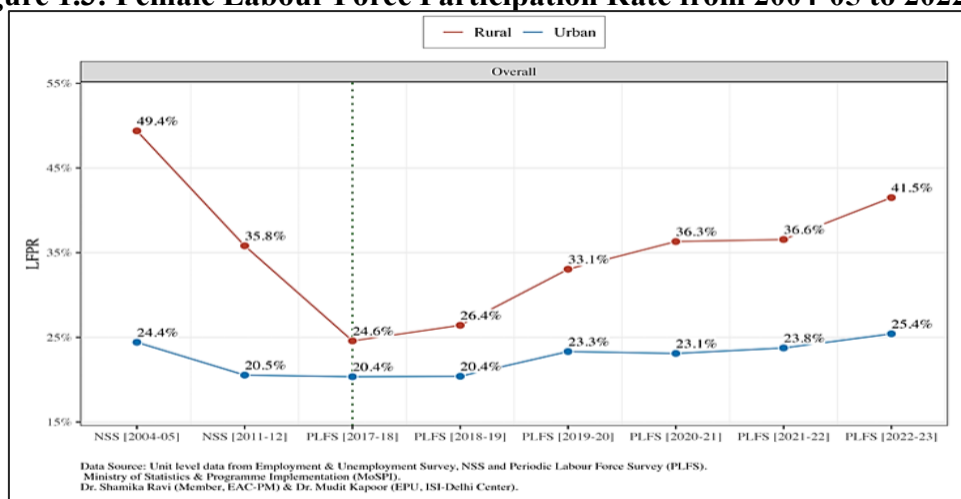
²⁴ Henrik Kleven et al. (2019), "Child Penalties across Countries: Evidence and Explanations," *American Economic Review* 109, no. 4: 1223–1263, <https://doi.org/10.1257/aer.20172210>; Goldin, C. (2014). A grand gender convergence: Its last chapter. *American Economic Review*, 104(4), 1091–1119. <https://doi.org/10.1257/aer.104.4.1091>.

Yet these responses share a common limitation: they are oriented towards fertility as a demographic variable rather than towards care infrastructure that determines whether families can afford and sustain caregiving across the life cycle. Current policies remain maternity-centric, framing care service needs as a “women’s issue”. Additionally, they only partially address the expanding needs of elderly care amid India’s ongoing demographic transition. This, in principle, isolates women with the sole responsibility of care and further reinforces the gendered division of care labour.

A combination of the above factors helps explain the muted impact on urban female labour force participation (FLFP) and the growing divergence between women’s fertility intentions and realised fertility outcomes.

There has been a significant recovery of FLFP rate in rural areas since 2017-18, in contrast to the urban FLFP which has remained persistently low at around 20-25% for nearly two decades. *Urban FLFP is consistently lower than rural FLFP across states and is especially depressed in urban households with children.*²⁵ This divergence points to structural gaps in urban care infrastructure, further compounded by the shift toward nuclear family arrangements that reduce access to informal caregiving support. This also suggest that inadequate urban care provision dictates women’s choice to enter and remain in the labour market.

Figure 1.3: Female Labour Force Participation Rate from 2004-05 to 2022-23

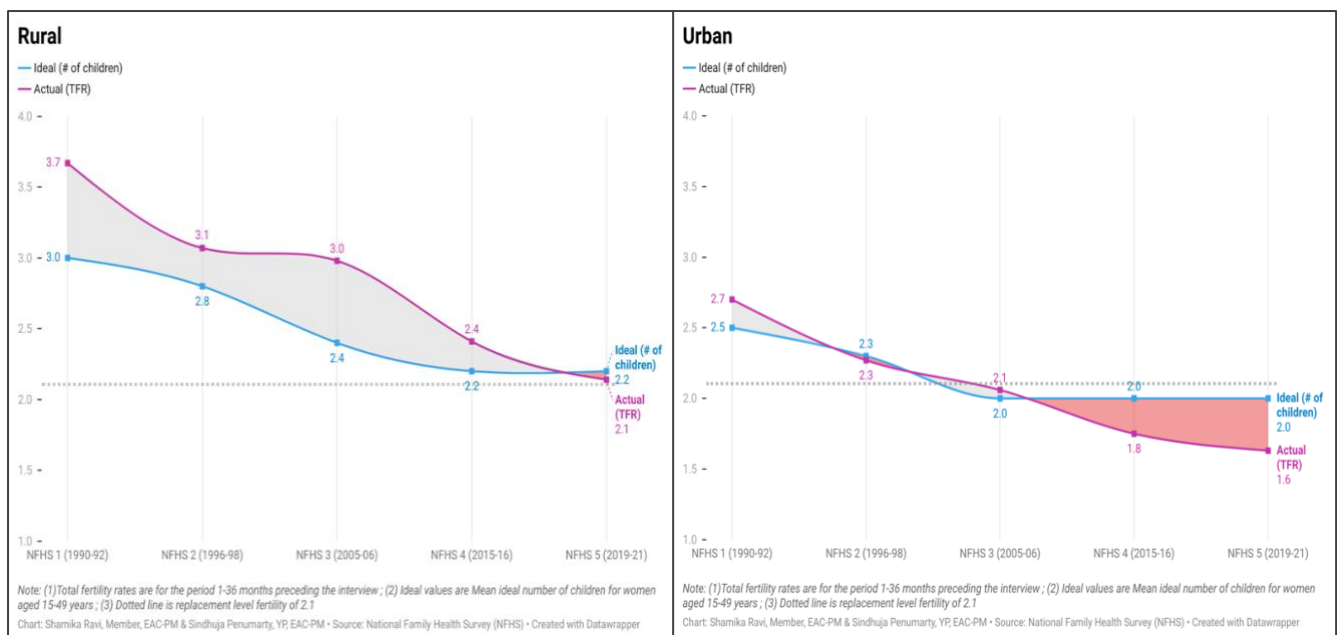


Source: Reproduced from Ravi and Kapoor (2024)

²⁵ Shamika Ravi and Mudit Kapoor, *Female Labour Force Participation Rate: An Observational Analysis of the Periodic Labour Force Survey (PLFS) from 2017–18 to 2022–23*, EAC-PM Working Paper Series No. EAC-PM/WP/34/2024 (Economic Advisory Council to the Prime Minister of India, 2024), <https://eacpm.gov.in/wp-content/uploads/2024/12/EACPM-WP-Female-LFPR-India.pdf>

A closer examination of the National Family Health Survey (NFHS) reveals a striking decline in both desired and actual fertility (Figure 1.4). *The gap between desired and actual fertility is widening over time and is more pronounced in urban areas.* Data from NFHS-4 and 5 indicates that the desired fertility has remained stable at 2.2 in rural and 2 in urban areas. The shortfall between preferred and realised fertility is substantially larger in urban areas (0.4 child) than in rural areas (0.1 child). *This may be explained by the greater dependence of urban parents on formal childcare, which is often costly or limited, and greater work–life balance constraints.*²⁶

Figure 1.4: Ideal Vs. Actual Fertility: Rural and Urban (NFHS 1 to 5)



Source: Author’s own calculations using NFHS (1-5)

The demographic transition along with the growing constraints on families, especially the women, strengthens the case for placing care services at the centre of family-friendly policies. When traditional family structures break down and care deficits persist, the government must step in through supportive policy.

Therefore, it is imperative to re-imagine care services, the supporting infrastructure and the care workforce requirements, as a futuristic sector of growth rather than a narrow and residual intervention positioned within the Ministry of Women and Child Development (MoWCD). Development of the care economy must be an effort that converges

²⁶ Shamika Ravi and Sindhuja Penumarty, "The Right Choice, Baby: Family Size Aspirations Mustn't Go Unmet," *Mint*, August 20, 2025, <https://www.livemint.com/opinion/online-views/india-population-total-fertility-rate-unfpa-reproductive-agency-national-family-health-survey-urban-rural-childcare-11755585449804.html>

across ministries as a horizontal policy priority - recognising its role in expanding female labour force participation, generating formal employment, building human capital, and supporting healthy ageing. Effective care systems intersect with labour markets (Ministry of Labour & Employment), urban planning and housing (MoHUA), health and long-term care (MoHFW), skill development (MSDE), social justice and ageing (MoSJE), and fiscal policy (MoF). ***Institutionalising inter-ministerial convergence is essential to move care from a fragmented welfare scheme to a strategic pillar of economic and social policy.***

Section 2 elaborates on the value generated by the care economy and presents the strategic nature of investments in the care economy.

2. Care Economy investments as a strategic response

There is a strong case for investing in the care economy as a strategic response to the emerging trends discussed above. Investments in the care economy can serve as a lever for employment generation, enhancing family and individual welfare, and reducing gender disparities.

2.1 Care economy as a lever for employment generation

Quantitative estimates highlight the scale of unmet need for care services and its policy urgency. **To meet the international standards of quality care, India is estimated to require 31-38 million formal care workers by 2050 - 15.6 million in eldercare and between 15-22 million in childcare.**²⁷ Meanwhile, the International Labour Organisation (ILO) estimates that investment in universal childcare and long-term care services could generate up to 299 million jobs globally by 2035.²⁸ These trends reflect both demographic pressures and rising standards for quality care.

Domestically, investments of 2% of GDP in the health and care sector are estimated to generate 11 million jobs, with a majority of them going to women.²⁹ Whereas, care workforce professionalisation and formalisation can extend and strengthen India's existing position as a global exporter of healthcare professionals into the broader care economy,³⁰ generating new labour export channels and significant remittance flows. **Therefore, expanding and formalising care services could unlock substantial employment opportunities in both**

²⁷ Authors' own calculations, presented in Annexure 1.

²⁸ Laura Addati, Umberto Cattaneo, and Emanuela Pozzan, *Care at Work: Investing in Care Leave and Services for a More Gender-Equal World of Work* (Geneva: ILO, 2022), <https://www.ilo.org/publications/major-publications/care-work-investing-care-leave-and-services-more-gender-equal-world-work>; Laura Addati, Umberto Cattaneo, Valeria Esquivel, and Isabel Valarino, *Care Work and Care Jobs for the Future of Decent Work* (Geneva: ILO, 2018), https://www.ilo.org/sites/default/files/wcmsp5/groups/public/@dgreports/@dcomm/@publ/documents/publication/wcms_633135.pdf.

²⁹ International Trade Union Confederation (ITUC), *Investing in the Care Economy: A Pathway to Growth* (Brussels: ITUC, 2017), https://www.ituc-csi.org/IMG/pdf/care_economy_2_en_web.pdf

³⁰ Top destination for Indian healthcare professionals include: United States, United Kingdom, Canada, Australia, and Gulf Cooperation Council (GCC) countries. For nurses, India ranked among the top three globally, alongside the Philippines and Poland.

Organisation for Economic Co-operation and Development (OECD), *International Migration Outlook 2025* (Paris: OECD Publishing, 2025), https://www.oecd.org/en/publications/international-migration-outlook-2025_ae26c893-en; Jeanne Batalova, "Global Demand for Medical Professionals Drives Indians Abroad," *Migration Policy Institute*, December 2020, <https://www.migrationpolicy.org/article/global-demand-medical-professionals-drives-indians-abroad>.

domestic and global labour market contexts, and facilitating the transition of unpaid care work into formal employment opportunities.³¹

2.2 Care investments as a lever for strengthening family-friendly policies

While creating employment opportunities is essential, it is insufficient without the policy architecture to support caregivers. Family-friendly policies (FFPs) including paid parental leave, affordable childcare, maternity cash transfers, and breastfeeding support provides the time and infrastructure needed to reduce child mortality, strengthen early development (ECD), and enable caregivers' labour market participation³².

However, coverage remains fragmented, especially in regions with high informal employment. In India, over 90% of women workers are in the informal sector³³, where statutory maternity protections are limited. Whereas, globally, only 44.9% of mothers receive maternity benefits, forcing many to work until childbirth and return to work shortly thereafter.³⁴

In the absence of FFPs, families are forced to absorb all the costs associated with both childcare and elder care privately: income losses, higher infant mortality, limited labour participation³⁵, potential fertility delay or foregone fertility³⁶ and elder neglect³⁷. The resulting time poverty, mental health consequences, and weakened intergenerational support, undermine not only economic sustainability but also social cohesion.³⁸ **Ultimately, strengthening FFPs requires progressive financing that pools government, employer, and employee**

³¹ Nikore et al., *Formulating a Strategy for India's Care Economy*.

³² UNICEF, ILO, and WIEGO, "Family-Friendly Policies for Workers in the Informal Economy," July 2009, <https://www.unicef.org/media/102821/file/Family-Friendly%20Policies%20for%20Workers%20in%20the%20Informal%20Economy%20.pdf>

³³ Govindan Raveendran and Joann Vanek, *Informal Workers in India: A Statistical Profile*, WIEGO Statistical Brief No. 24 (WIEGO, August 2020), https://www.wiego.org/wp-content/uploads/2020/10/WIEGO_Statistical_Brief_N24_India.pdf

³⁴ UNICEF, ILO, and WIEGO, "Family-Friendly Policies"

³⁵ Ibid.

³⁶ UNFPA, *The Real Fertility Crisis: The Pursuit of Reproductive Agency in a Changing World*, State of World Population 2025 (New York: UNFPA, 2025), <https://unfpa.org/sites/default/files/pub-pdf/swp25-layout-en-v250609-web.pdf>

³⁷ Addati et al., *Care Work and Care Jobs*; IIPS and UNFPA India, *India Ageing Report 2023: Caring for Our Elders* (UNFPA India, 2023), https://india.unfpa.org/sites/default/files/pub-pdf/20230926_india_ageing_report_2023_web_version_.pdf

³⁸ World Health Organization, "Mental Health of Older Adults," fact sheet, World Health Organization, October 8, 2025, <https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults>; IIPS and UNFPA India, *India Ageing Report 2023*; UN Women, *Progress of the World's Women 2019–2020: Families in a Changing World* (UN Women, 2020), <https://www.unwomen.org/en/digital-library/publications/2019/06/progress-of-the-worlds-women-2019-2020>.

contributions, with targeted benefits extended to low-income and informal households most at-risk.

2.3 Care investments as a lever for bridging gender gaps in unpaid care work

Finally, it is imperative to discuss the deeper structural issue of the stark gender imbalance in care service provision, without which the employment and family welfare dimensions cannot be addressed.

About 79% of women aged 15-29 cite unpaid domestic and care responsibilities as the primary constraint to pursuing education or employment opportunities, compared to only 3% of men³⁹. This contrast reflects not just a labour market gap but a systematic misallocation of human capital driven by the unequal distribution of unpaid care work.

Public investment in care infrastructure therefore, can help redistribute unpaid care responsibilities from individual households to the state, community and private institutions, while also encouraging more equitable sharing between men and women⁴⁰. Subsidized and accessible childcare services, particularly for the 0-6 age group where care demands are the most intensive, combined with gender-neutral parental leave, can free women's time for paid employment and actively encourage men's participation in care work.

Altogether, investments in the care economy are not a welfare expenditure, but a strategic high-return investment for generating formal employment at scale, strengthening family-friendly policies and caregiver support, and correcting the gender distortion in human capital allocation in the economy.

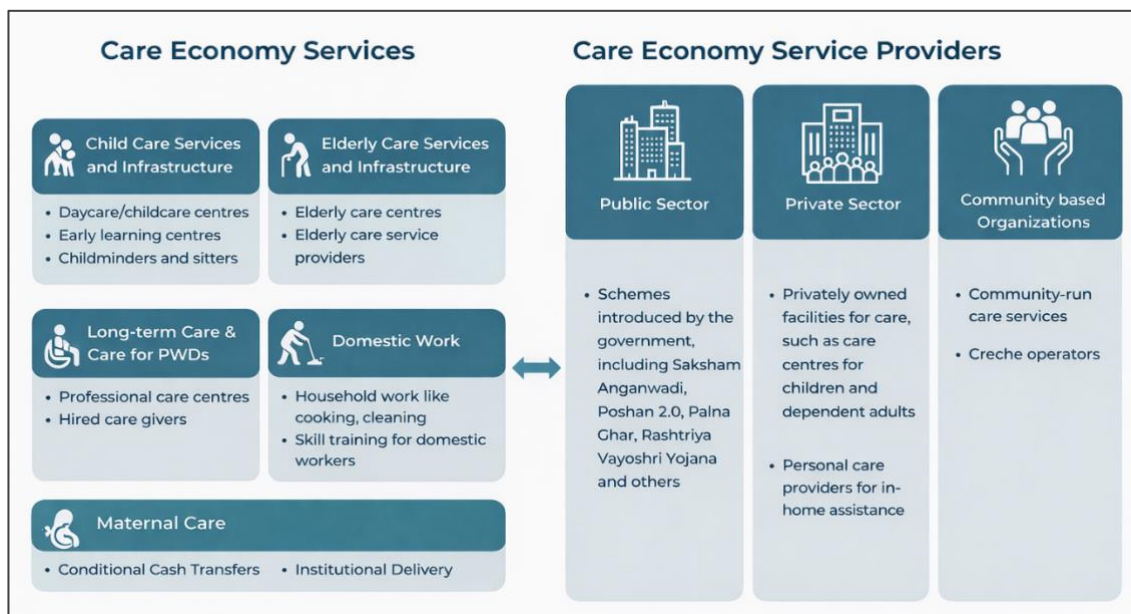
³⁹ Mitra and Ramesh, *The Care Economy*

⁴⁰ Hyun Hee Ban, Veena Bandyopadhyay, and Alexandra Barrantes, "Care Economy and Gender-Transformative Social Protection in India and the G20 Countries," T20 Policy Brief, July 2023, <https://t20ind.org/wp-content/uploads/2023/08/Social-Protection-In-India.pdf>.

3. Current Care Services and Workforce Development Models

The continuum of care services - childcare, elderly care, parental and maternity support, long-term care for PwDs, and domestic services - enable economic participation and social well-being. India's current care landscape comprises multiple, overlapping models involving public, private, and non-profit actors operating through a multi-tiered fiscal and institutional structure.

Figure 3.1: The care economy landscape



While the Union government steers national flagship programmes, many states have begun fiscal efforts towards pensions, maternity benefits, infrastructure for health, and social protection. Private providers, particularly in urban areas, have expanded rapidly in response to public provisioning gaps. However, the absence of a unified regulatory and financing framework raises concerns around affordability, access, quality, and workforce conditions.⁴¹

Below we will discuss some prominent interventions and models in childcare, eldercare and workforce development.

⁴¹ K. Madan Gopal et al., *Senior Care Reforms in India: Reimagining the Senior Care Paradigm* (New Delhi: NITI Aayog, Government of India, 2024) https://www.niti.gov.in/sites/default/files/2024-02/Senior%20Care%20Reforms%20in%20India%20FINAL%20FOR%20WEBSITE_compressed.pdf ; Protiva Kundu and Revati Patil, *Financing Childcare in India: A State Responsibility*, Policy Brief (New Delhi: Forum for Crèches and Childcare Services, November 2023), <https://www.cbgaindia.org/wp-content/uploads/2023/11/Financing-Childcare-in-India-A-state-responsibility-1.pdf>

3.1 Childcare Services

3.1.1 Childcare Provision Models

(i) *Public Sector: Central and State Government*

The Central Government's approach to childcare has been shaped largely through its long-standing focus on nutrition, early childhood development (ECD), and maternal welfare. The vast institutional base of the Integrated Child Development Services (ICDS), with approximately 1.4 million Anganwadi Centres, each staffed with an Anganwadi Worker and Helper, provides near-universal geographic coverage. It serves roughly 8-9 crore children aged 0–6 years and 1 crore pregnant and lactating women nationwide.⁴² *With total beneficiary coverage exceeding 10 crore, the average caseload is about 60–70 children per worker, including women beneficiaries the effective service burden per worker is substantially higher, reinforcing concerns about overstretched frontline capacity.*

Within this architecture, the Palna Scheme (2022), under Mission Shakti, is an incremental extension towards institutional day-care for children aged 6 months to 6 years. Delivered primarily through Anganwadi-cum-Crèches (AWCCs), it reflects a policy preference for leveraging existing ICDS infrastructure. The scheme requires a cost sharing of 40:60 between the state and central government for establishing AWCCs.⁴³

With a target to establish 17,000 new AWCCs by 2026-27, the scheme is an essential step in recognising childcare as a women's labour market participation enhancing measure. As of July 2025, approximately 14,599 AWCCs across 34 States and UTs were approved, serving about 29,000 beneficiaries, mainly from informal-sector households.⁴⁴ **However, its current coverage remains insufficient relative to rising demand, particularly in urban areas. As the scheme is operationalized mostly in existing Anganwadi centres, it has naturally expanded more in rural areas than in urban areas. This calls for a more deliberate urban**

⁴² Ministry of Women and Child Development, *Annual Report 2024–25* (Government of India, 2025) https://wcd.gov.in/documents/uploaded/1752655749_unGJajpBQ1.pdf

⁴³ Press Information Bureau, Government of India, "Ministry Approves 14,599 Anganwadi Cum Crèches under Palna Scheme," Government of India, 2025, <https://www.pib.gov.in/PressReleaseDetailm.aspx?PRID=2147385®=3&lang=2>

⁴⁴ Press Information Bureau, Government of India, "Palna Scheme under Mission Shakti," Government of India, April 7, 2025, <https://www.pib.gov.in/PressReleaseDetailm.aspx?PRID=2119769®=3&lang=2>

strategy, with Palna centres located closer to communities and workplaces, tailored to cater to the migrant and informal workers in the urban area.

At the same time, beyond issues of coverage and urban targeting, the scheme faces several structural constraints that limit its impact at scale:

- Cost-sharing under centrally sponsored schemes has resulted in uneven state participation.⁴⁵
- Inherited ICDS service norms like limited operating hours, high caregiver-to-child ratios, and infrastructure gaps pose constraints for viability of AWCCs as full-day care institutions.⁴⁶
- Past crèche programs saw declining fund utilisation, raising sustainability concerns.⁴⁷

State Governments also play a decisive role in shaping childcare provision, with policy maturity reflecting the state-level variations in fiscal capacity, labour-market structure, demographic pressures, and administrative priorities. Evidence shows that most state-level interventions take the form of institutional day-care models broadly similar to Palna in design, but differ substantially in financing, hours of operation, governance arrangements, and degree of integration with central schemes.⁴⁸ These differences are best understood through the lens of complementarity versus substitution.

The **complementary models** build on the Anganwadi-Palna architecture while introducing additional design features or financing. Kerala illustrates this layered approach through initiatives like workplace crèches, mobile crèches and day-care centres for migrant workers, and the K4 Care programme integrating childcare, elder care and maternity care for postpartum

⁴⁵ Kundu and Patil, *Financing Childcare in India*.

⁴⁶ Lok Sabha Secretariat. (n.d.). *Unstarred question No. AU925* (185th session). Parliament of India. https://sansad.in/getFile/loksabhaquestions/annex/185/AU925_KPwyIQ.pdf?source=pqals; IWWAGE – Institute for What Works to Advance Gender Equality and Mobile Crèches, *Financing Quality Childcare Facilities in India* (IWWAGE, September 2024), <https://iwwage.org/wp-content/uploads/2024/09/Financing-Quality-Childcare-Facilities-in-India-by-IWWAGE-and-Mobile-Creches.pdf>; Ministry of Women and Child Development, Government of India, "Palna Statistics," Mission Shakti, accessed March 2026, <https://missionshakti.wcd.gov.in/statisticsPalna>

⁴⁷ William Joe and Malavika Subramanyam, *Evaluation of ICDS Scheme of India* (Institute of Economic Growth, Delhi; NITI Aayog, 2023), <https://www.niti.gov.in/sites/default/files/2023-03/Evaluation%20of%20ICDS%20Scheme%20of%20India.pdf>

⁴⁸ Kundu and Patil, *Financing Childcare in India*; United Nations Development Programme, *A Synthesis of Evidence on Early Childhood Development in India: Key Challenges and Pathways Forward* (UNDP, 2025), https://www.undp.org/sites/g/files/zskgke326/files/2025-07/web_spread_17_july-a_synthesis_of_evidence_undp.pdf

mothers. Similarly, Meghalaya's ECD Project broadens the scope of central frameworks through externally funded, inter-departmental convergence, including home- and centre-based care and maternal mental health support. States like Delhi have been implementing the Palna scheme, locating creches alongside Anganwadis in municipal corporation run schools. **In these states, Palna-type services function as a base platform, with states adding depth, flexibility, or sector-specific targeting.**

In contrast, many states developed **substitute models** for establishing creches at locations beyond Anganwadi centres. Karnataka's Koosina Mane with its explicit budgetary commitment and trained caregivers demonstrates the feasibility of a fully state-funded crèche system targeted at working mothers, particularly those engaged in MGNREGA and allied occupations.⁴⁹ Whereas, Odisha's Ama Kalika Kendra, financed through the District Mineral Foundation, provides extended-hour childcare in mining and high-vulnerability regions.⁵⁰ **These models demonstrate that states can move beyond central schemes where fiscal space and administrative capacity permit.**

Additionally, several states address particular gaps through **issue-specific or pilot-oriented childcare models**. For instance, Chhattisgarh's Project Manthan focuses on psychosocial and mental health-oriented childcare in 6 districts,⁵¹ and Punjab's Aarambh initiative strengthens early childhood care and parental engagement through play-based learning approaches.⁵² **While addressing important dimensions of care quality and child development, these models function largely as programme add-ons rather than as comprehensive childcare systems.**

Across states, however, several common structural challenges continue to persist:

- Few states have a comprehensive, state-wide childcare policy that integrates service provision, care workforce development, regulation, and sustainable financing.

⁴⁹ Asian Development Bank, "Koosina Mane," presentation, July 8, 2025,

https://events.development.asia/system/files/koosina-mane-ppt_08.07.2025-1.pdf

⁵⁰ Government of Odisha, *KALIKA Policy* (Government of Odisha, February 2025),

<https://inpr.odisha.gov.in/sites/default/files/2025-02/KALIKA-%20Policy.pdf>

⁵¹ Brian Alfred Boye, "Project Manthan: A Beacon of Hope for Tribal Youth," UNICEF, January 2026,

<https://www.unicef.org/india/stories/project-manthan-beacon-hope-tribal-youth>

⁵² Idhries Ahmad, "Aarambh: Joyful Beginnings for Life," UNICEF India, April 2025,

<https://www.unicef.org/india/stories/aarambh-joyful-beginnings-life>

- Provision remains uneven across districts and urban areas, often dependent on pilots, external funding, or sector-specific targeting (e.g., migrants, mining regions).
- Regulatory standards, staffing norms, and monitoring mechanisms vary widely, impacting scalability and consistency. Even where innovative models exist, institutionalisation within state budgets and administrative structures remains partial.⁵³

These patterns suggest that the challenge lies not in the absence of well-intentioned schemes at the central or state level, but in the lack of a clearly articulated childcare framework. *The move towards creating a childcare framework that aligns objectives, financing, service norms, and stronger coordination with states and urban local bodies is essential for childcare to function effectively as economic and social infrastructure.* Annexures 2 and 3 list the different central and state government led childcare provisioning models.

(ii) *Private Sector*

Private sector childcare models have expanded primarily in urban and peri-urban areas in response to evolving needs and the statutory crèche requirements introduced under the Maternity Benefit (Amendment) Act, 2017. Despite the statutory mandate, implementation remains uneven and operationally constrained due to employer cost concentration, limited availability of compliant space, regulatory ambiguity across states, quality assurance challenges, and logistical difficulties in ensuring access for eligible employees.⁵⁴

Private provision of childcare in India is structured around three broad delivery models – Premium commercial, corporate or CSR funded, and mixed PPP models. These are discussed in detail in Annexure 4.

Premium commercial centres cater largely to high-income households, offering low caregiver-to-child ratios, curriculum-based programmes, and high-quality infrastructure. While financially viable through parent fees, these models remain inaccessible to most urban

⁵³ Kundu and Patil, *Financing Childcare in India.*; UNDP, *A Synthesis of Evidence on Early Childhood Development in India.*

⁵⁴ International Finance Corporation and Bright Horizons, *The Benefits and Challenges of a Workplace Crèche: Employer-Supported Childcare in India* (IFC, 2019), <https://www.ifc.org/content/dam/ifc/doc/mgrt/the-benefits-and-challenges-of-a-workplace-creche-final-1.pdf>; Kundu and Patil, *Financing Childcare in India.*

households and have limited contribution to expanding equitable childcare access. **Corporate or CSR-supported centres**, typically located at workplaces, reduce care constraints for formal-sector employees and are closely tied to corporate budget cycles and CSR priorities. A study of 50 corporate childcare centres by Nikore Associates found that 65% face closure risk within 3 years if corporate profitability declines or CSR budget priorities shift. Their sustainability is therefore uncertain, particularly following corporate restructuring or withdrawal of CSR support.⁵⁵ **An emerging mixed PPP model** combines parent fees with public subsidies to serve middle-income households. While this model shows promise in balancing affordability and quality, its scalability depends on predictable funder support, and integration with public childcare schemes.

Across all three models, strengthening regulatory frameworks, linking private provision with public financing mechanisms, uniform regulations and accreditation standards are essential to ensure that private childcare functions as a stable complement to public care infrastructure.

(iii) NGO and Community-Based Organisation (CBO) Models

NGO and community-based organisation (CBO) models constitute an important component of India's childcare ecosystem, particularly in contexts where both public provisioning and private markets are weak.⁵⁶ However, these models vary significantly across urban and rural settings, reflecting variations in financing sources, delivery arrangements, and household affordability.⁵⁷ Most documented CBO/NGO models in India rely on external funding, whether government grants, CSR, philanthropic funding, or employer contributions.

Urban NGO-led childcare is largely concentrated in major metropolitan areas like Delhi, Mumbai, Bengaluru, and Chennai, where access to CSR funding, philanthropic networks, and employer partnerships enables more diversified financing. In contrast, rural NGO and CBO

⁵⁵ International Finance Corporation and Bright Horizons, *The Benefits and Challenges of a Workplace Crèche*.

⁵⁶ Ibid. ; Mobile Crèches, *Annual Report 2024–25* (Mobile Crèches, 2025), <https://mumbaimobilecreches.org/wp-content/uploads/2025/12/Annual-Report-2024-25.pdf>

⁵⁷ Amit Kumar and Karina Bhasin, "Caring for India's Future: How Community Childcare is Empowering Families in Delhi's Bawana," UNDP India, October 29, 2025, <https://www.undp.org/india/blog/caring-indias-future-how-community-childcare-empowering-families-delhis-bawana>

models operate predominantly through government partnership frameworks like MGNREGA-linked on-site crèches. Annexure 5 lists some of these models.

Across contexts, community-based models demonstrate cost-effective and community-embedded service delivery, often achieving high levels of trust, parental engagement, and outreach to vulnerable groups such as migrant workers, informal-sector households, and first-time women workers.⁵⁸ However, their financial sustainability remains constrained. In rural areas in particular, parent affordability is extremely limited, typically below ₹150–300 per month⁵⁹, making continued operation heavily dependent on government subvention or donor support. Even in urban settings, reliance on CSR and philanthropic funding exposes these models to financing volatility and limits their ability to scale beyond project-based footprints.⁶⁰

Overall, NGO and CBO models function effectively as demonstration and gap-filling mechanisms, showcasing adaptable childcare designs and innovative workforce arrangements. *Their long-term contribution to the care ecosystem, however, depends on stronger integration with public financing frameworks, predictable funding arrangements, and clearer pathways for scaling through state or municipal systems, rather than continued reliance on short-term grants.*

3.1.2 From Maternity to Shared Parenting: Reframing Childcare Leave Policy in India

The *Maternity Benefit (Amendment) Act, 2017* mandates 26 weeks of paid maternity leave for women with up to two children.⁶¹ However, the employer-financed design concentrates costs at the firm level. International evidence confirms that it raises the expected costs of employing women of childbearing age (25–35) and is associated with discrimination in hiring, retention,

⁵⁸ Kumar and Bhasin, "Caring for India's Future."

⁵⁹ Based on Author's field study in rural areas

⁶⁰ United Nations Development Programme, *Learnings and Insights for Strengthening Urban Childcare Ecosystem* (UNDP, November 2024), https://www.undp.org/sites/g/files/zskgke326/files/2024-12/2024.11.25_final_rev_li_report_design.pdf

⁶¹ Ministry of Labour and Employment, *The Maternity Benefit (Amendment) Act, 2017* (Government of India, 2017), <https://www.labour.gov.in/static/uploads/2025/07/b474f27e24a77e762d68b87bf12a8662.pdf>

and promotion.⁶² Although the Four Labour Codes extend social security coverage to gig, platform and some unorganised workers, they largely retain the Maternity Benefit Act's employer-linked framework. This means for many women in small or informal establishments, access to comprehensive maternity protection remains constrained.⁶³

While maternity leave alone is an incomplete explanation for India's low urban FLFP despite rising female educational attainment, its interaction with employer incentives plausibly contributes to this disconnect. Additional factors like absence of mandated paternal leave and selective childcare leaves, imply women as default caregivers, amplifying this effect.

Paternity leave provisions remain minimal and fragmented. Male central government employees are entitled to 15 days of leave under the Central Civil Services (Leave) Rules,⁶⁴ while no statutory mandate applies to the private sector.⁶⁵ Many state governments paternity leaves are also in line with the central policy, with Sikkim being an exception in offering 30 days. On the other hand, government Child Care Leave (CCL), which was originally designed for women⁶⁶, extended its eligibility to single male parents after a reform in 2018. However, its female-centricity limits its ability to shift household care norms, as partnered fathers remain excluded.

Further, India's maternity and parental leave architecture is predominantly applicable to the formal sector, where less than 20% of the working women are employed. Maternity protections for informal sector workers are mediated through a combination of central and state schemes (see Annexure 6). While providing many benefits⁶⁷, these offer partial offsets and are entirely

⁶² Loli Arribas-Banos et al., "Leaving No Parent Behind: Lessons From Family Friendly Policies in Nepal," *World Bank Blogs* (blog), March 7, 2025, <https://blogs.worldbank.org/en/investinpeople/Leaving-no-parent-behind-Lessons-from-family-friendly-policies-in-Nepal>; Serena Canaan, Anne Lassen, Paul Rosenbaum, and Hulda Steingrimsdóttir, "Maternity Leave and Paternity Leave: Evidence on the Economic Impact of Legislative Changes in High-Income Countries," *Oxford Research Encyclopaedia of Economics and Finance* (2022), <https://doi.org/10.1093/acrefore/9780190625979.013.806>.

⁶³ Ministry of Labour and Employment, *Compliance Handbook for Employers under the Four Labour Codes* (Government of India, 2026), <https://www.labour.gov.in/static/uploads/2026/02/83978455025732b99b0165def80ab171.pdf>

⁶⁴ All India Services (Leave) Rules, 1955 https://dopt.gov.in/sites/default/files/Revised_AIS_Rule_Vol_I_Rule_03.pdf

⁶⁵ Rajya Sabha Secretariat, "Unstarred Question No. 1857," 256th Session, Parliament of India, March 17, 2022, <https://sansad.in/getFile/annex/256/AU1857.pdf?source=pqars>

⁶⁶ CCL allows up to 730 days of leave over a lifetime for the care of two eldest children below 18 years, covering education, illness, and caregiving needs. It is associated with 4-8 percentage point gain in retention

⁶⁷ Including conditional cash transfers, in-kind support linked to antenatal care, institutional delivery, etc

maternal-centric. **In this context, the *motherhood penalty* arises not from maternity protection per se, but from its isolation within a broader care regime, thus underscoring the need to transition toward shared parenting infrastructure.**

Internationally, there is a shift towards offering gender-neutral parental leaves (see Annexure 7), as opposed to either maternity or paternity leaves. Among the G20 countries, nearly 50% of the countries have legal provisions that offer parental leave and partially fund benefits to the primary caregiver, regardless of their gender.⁶⁸ Nordic countries have implemented “use it or lose it” father quotas - Sweden's 90-day individual allocation and Iceland's equal 6 month split, significantly increase paternal leave uptake, and have positive spillovers on female workforce participation by redistributing care responsibilities more equitably between parents.⁶⁹

India’s labour-market structure necessitates adaptation rather than replication. A purely employer-financed shared parental leave regime disproportionately burdens small and medium enterprises. *A transition from maternity-centric to joint or shared parental leave therefore requires institutional redesign. Partial public subsidisation through pooled financing could mitigate firm-level disincentives. Incremental reforms, beginning with universalising CCL eligibility to all fathers, can provide a feasible pathway toward genuinely shared parenting frameworks.*

3.1.3 International Comparison: Where India Stands on Childcare Systems

Comparative international evidence indicates that the key distinction between Indian childcare and high-performing global systems lies in the absence of childcare being configured as an employment-enabling infrastructure. Childcare is largely treated as a private responsibility where household resources affect access.⁷⁰

⁶⁸ Nikore et al., *Formulating a Strategy for India's Care Economy*.

⁶⁹ Ann-Zofie Duvander and Mats Johansson, “What Are the Effects of Reforms Promoting Fathers’ Parental Leave Use?” *Journal of European Social Policy* 22, no. 3 (2012): 319–330, <https://doi.org/10.1177/0958928712440201>; Johanna Windwehr, Ann-Zofie Duvander, Anne Lise Ellingsæter, Guðný Björk Eydal, Živa Humer, and Hiroki Nakazato, “The Nordic Model of Father Quotas in Leave Policies: A Case of Policy Transfer?” *Social Politics: International Studies in Gender, State & Society* 29, no. 1 (2022): 190–214; Canaan et al., “Maternity Leave and Paternity Leave.”

⁷⁰ Anna Gromada and Diana Richardson, *Where Do Rich Countries Stand on Childcare?* (UNICEF Office of Research–Innocenti, 2021), <https://www.unicef.org/innocenti/media/5431/file/UNICEF-Where-Do-Rich-Countries-Stand-on-Childcare-2021.pdf>; UNICEF. (2024). *Global report on early childhood care and*

- **Structural and guaranteed access policy:** Cross-country assessments show that countries like Sweden, Denmark, and Germany treat childcare as a core component of family and labour-market policy, supported by predictable public financing, enforceable access guarantees, and responsibility at the local government level⁷¹. By contrast, India’s scheme-driven approach makes access contingent on programme design, state participation, and administrative capacity rather than on enforceable service obligation. This often results in uneven coverage, particularly in urban and high-mobility contexts.
- **Support for labour market participation:** International best practices emphasise full-day care aligned with standard work schedules, recognising childcare as a prerequisite for sustained FLFP. Germany and France have expanded centre-based care to support women’s return to work and reduce employment discontinuity.⁷² However, India’s flagship programs like the ICDS and Anganwadi are designed around nutrition and ECD. Initiatives like Palna are incremental, rather than a structural redesign, affecting care duration, staffing norms, or service density.
- **Quality and Regulatory Standards:** High-performing systems across OECD have regulatory frameworks governing caregiver qualifications, child-to-staff ratios, safety norms, and routine inspections, irrespective of provider type. In India, regulatory capacity has limited enforceable standards across schemes and states.

India’s core challenge, therefore, is not model selection but building the institutional framework for adequate access, scale, regulation, workforce norms, and financing, that allow childcare to function as reliable social infrastructure.

education: The right to a strong foundation. <https://www.unicef.org/media/158496/file/Global-report-on-early-childhood-care-and-education-2024-1.pdf>.

⁷¹ Gromada and Richardson, *Where Do Rich Countries Stand on Childcare?*

⁷² UNICEF, *Global Report on Early Childhood Care and Education: The Right to a Strong Foundation* (2024)

3.2 Eldercare Service Provision

Eldercare is characterised by evolving care needs – from moderate support to managing chronic conditions, cognitive decline and palliative care. The requirements of eldercare services, therefore, are unpredictable in both duration and intensity.

3.2.1 Eldercare Models

(i) Public Sector Provision: Central and State Government Schemes

The Union Government's elderly care framework is anchored primarily with the Ministry of Social Justice and Empowerment (MoSJE) and the Ministry of Health and Family Welfare (MoHFW). The MoSJE enacted the 'Maintenance and Welfare of Parents and Senior Citizens Act of 2007 (MWPSA Act)' to ensure the well-being of elderly persons. The system has evolved incrementally, with different programmes addressing distinct dimensions of ageing-related needs like institutional care, income support, and health financing (see Annexure 8). From a policy standpoint, the National Policy on Senior Citizens (NPSC, 2011) emphasises family-based care while acknowledging the need for institutional care facilities. Further, MoSJE formulated the "Minimum Standards for Senior Citizen Homes" in March 2024 as a comprehensive guide outlining benchmarks and criteria for the establishment and operation of senior citizen homes⁷³.

Within institutional care, the National Action Plan for Senior Citizen (NAPSrC) which was revamped as Atal Vayo Abhyuday Yojana (AVYAY) effective April 2021, consolidates India's central government programmes for elderly welfare with the aim to support dignified ageing. It includes the Integrated Programme for Senior Citizens (IPSrC) which supports residential care facilities, the Rashtriya Vayoshri Yojana which provides assistive devices for low-income elderly persons, a national elder helpline, the SAGE program to catalyse private innovation in eldercare, and training programmes for geriatric caregivers.⁷⁴

⁷³ Ministry of Social Justice and Empowerment, "Minimum Standards for Senior Citizen Homes (Old Age Homes)," Office Memorandum No. AG-15040/1/2023-Sr.C-I, Government of India, March 15, 2024, <https://socialjustice.gov.in/writereaddata/UploadFile/88731710935901.pdf>

⁷⁴ Ministry of Social Justice and Empowerment, "Long-Term Care Infrastructure for Senior Citizens," Press Information Bureau, Government of India, February, 2026, <https://www.pib.gov.in/PressReleasePage.aspx?PRID=2222704®=3&lang=1>

Income support is provided through the Indira Gandhi National Old Age Pension Scheme (IGNOAPS) with monthly pensions to elderly individuals Below Poverty Line (BPL), augmented with state top-ups. Additionally, the Atal Pension Yojana (APY) extends income security post-retirement through a guaranteed monthly pension of ₹1,000-₹5,000, funded by contributions made between the age of 18 and 40, with benefits commencing at age 60. The scheme is aimed especially at unorganised sector workers, has enrolled millions of subscribers, providing lifelong income support.⁷⁵

On healthcare provision, the National Programme for Health Care of the Elderly (NPHCE) forms the backbone of public geriatric health services.⁷⁶ It is delivered through geriatric clinics, hospitals, and regional geriatric centres, providing services like outpatient care, physiotherapy, counselling, and day-care linkages. This architecture is further strengthened by Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) which now extends coverage to all citizens aged 70 years and above.⁷⁷ This marks a significant shift from poverty-targeted to age-based universal health coverage and hospitalisation costs. Alongside this, the Central Government Health Scheme (CGHS) provides broad healthcare coverage to eligible central government pensioners, easing the financial burden of medical expenses in old age.⁷⁸

While providing important support, there are structural gaps in the current eldercare landscape.

- Notwithstanding its wide scope, AVYAY faces scale constraints. It supports about 700 senior homes, and about 7.93 lakh elderly persons through assistive devices. This is modest when viewed against India's large and growing elderly population.⁷⁹
- Although the NPSC and the Minimum Standards for Senior Citizen Homes sets out broad objectives, there is no unified authority responsible for licensing, accrediting, or

⁷⁵ Ministry of Commerce and Industry, "Launch of Collateral Support for Export Credit under Export Promotion Mission (EPM) – Niryat Protsahan," Trade Notice No. 21/2025–26, Press Information Bureau, Government of India, 2026, <https://www.pib.gov.in/PressNoteDetails.aspx?NoteId=154432&ModuleId=3®=44&lang=1>

⁷⁶ Directorate General of Health Services, *Operational Guidelines: National Programme for Health Care of the Elderly (NPHCE)* (Ministry of Health and Family Welfare, Government of India), <https://dghs.mohfw.gov.in/uploads/assets/LJMgNGFbD5xOkkeigXNAONJb52dW43Q8pu7CFLay.pdf>

⁷⁷ Suryakant Garg, Kailash Kumar Bebartha, and Neelam Tripathi, "The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) after Four Years of Implementation – Is It Making an Impact on Quality of Inpatient Care and Financial Protection in India?" *BMC Health Services Research* 24, no. 1 (2024): Article 919, <https://doi.org/10.1186/s12913-024-11393-2>

⁷⁸ Directorate General of Health Services, "FAQs on CGHS Cards," Ministry of Health and Family Welfare, Government of India, 2025 https://cghs.mohfw.gov.in/CGHSGrievance/FormFlowXACTION?hmode=ftpFileDownload&fileName=25042025103702_-FAQs-on-CGHS-Cards-.pdf&folderName=Circular&isGlobal=1

⁷⁹ Ministry of Social Justice and Empowerment, "Long-Term Care Infrastructure for Senior Citizens."

ensuring quality standards in elder care facilities⁸⁰. In practice, regulation is largely left to states under the MWPSA Act and related rules, leading to differences in standards and oversight across the country.

- While hospitalisation coverage for older persons has expanded under Ayushman Bharat (PM-JAY), insurance remains largely inpatient-focused, with community-based and long-term care services still comparatively underdeveloped.⁸¹

These gaps emphasise the need to prioritise coordination across welfare, health, and income-support schemes.

At the state-level, eldercare provision varies by policy design, scale, and institutional depth, reflecting differences in demographic stage, fiscal capacity, administrative commitment, and the extent of integration of care services into existing social infrastructure. While some states have structured community-based elderly care models, others rely on NGO partnerships or centrally supported schemes (see Annexure 9).

Kerala's notable public-community partnership-based initiatives like Kudumbashree focus on training and deployment of local caregivers in home-based eldercare and everyday assistance, recognising the value of care beyond medical needs. Simultaneously, it creates meaningful livelihood opportunities for local women. Complementing this, the Vayomaithri Programme provides healthcare, medical check-up and treatment through mobile clinics, supported by elderly-friendly community institutions like neighbourhood senior groups and local self-governance bodies. Together, these efforts position eldercare as a collective responsibility linked to social inclusion and women's employment, rather than a welfare measure alone.⁸²

Other states have also adopted sector-specific approaches. In 2023, Tamil Nadu launched the State Policy on Senior Citizens aiming to ensure reliable access to healthcare, nutrition, social

⁸⁰ Vijaykumar Harbishettar, Mahesh Gowda, Saraswati Tenagi, and Mina Chandra, "Regulation of Long-Term Care Homes for Older Adults in India," *Indian Journal of Psychological Medicine* 43, no. 5 (2021), <https://pmc.ncbi.nlm.nih.gov/articles/PMC8543622/>

⁸¹ Madan Gopal et al., *Senior Care Reforms in India*.

⁸² Kudumbashree Mission, "Harsham: Geriatric Care Programme," Government of Kerala, accessed March 23, 2026, <https://www.kudumbashree.org/pages/637> ; Local Self Government Department, Government of Kerala, "Kudumbashree's 'Vayomaithri' Programme Launched for Geriatric Care," May 18, 2022, <https://lsgkerala.gov.in/index.php/en/kudumbashree/news/kudumbashrees-vayomaithri-programme-launched-geriatric-care>

security benefits, safe housing, and quality institutional care.⁸³ Similarly, Maharashtra's Senior Citizens Policy Implementation Scheme (2018) ensures dignified ageing through 5% hospital bed reservations, bus concessions for persons belonging to Scheduled Tribes (ST), dedicated health services, and police helpline.⁸⁴ Although a few states have begun taking steps in this direction, the broader picture remains uneven.

- In most states, a dedicated eldercare policy is absent or eldercare initiatives lack clearly earmarked budgetary support. This often leads to dependence on centrally sponsored schemes or short-term initiatives.
- Service standards and regulatory oversight differ significantly across regions, and many programmes continue to treat eldercare primarily as a health issue rather than developing a comprehensive, structured system of long-term care.

Expanding community and institutional care, strengthening standards, and embedding eldercare within state budgets and administrative systems remain ongoing priorities.

(ii) Private Sector and NGO Models

Institutional eldercare outside the public system is generally spatially concentrated in the southern states and major metropolitan areas⁸⁵. A majority of the supply is in the independent living category, followed by assisted living and skilled senior care like geriatric care centres and continuous care communities.⁸⁶ High user costs and variable quality regulations shape these services.⁸⁷

The private senior living market is expected to expand at a compound annual growth rate (CAGR) of 25%-30%, catering predominantly to high-income households.⁸⁸ According to

⁸³ Social Welfare and Women Empowerment Department, Government of Tamil Nadu, *Tamil Nadu State Policy for Senior Citizens, 2023*, G.O. (Ms) No. 59, SW6(1) Department, September 4, 2023, https://cms.tn.gov.in/cms_migrated/document/GO/swwe_e_59_2023.pdf

⁸⁴ Social Justice and Special Assistance Department, Government of Maharashtra, "Senior Citizens Policy Implementation Scheme," 2025, <https://socialwelfare.maharashtra.gov.in/en/scheme/senior-citizens-policy-implementation-scheme/>

⁸⁵ JLL and Association of Senior Living India, *Elevating the Golden Years: Senior Living Opportunities in India's Evolving Market* (ASLI, 2024), https://www.asli.org.in/wp-content/uploads/2024/11/ASLI_Elevating-the-Golden-Years.pdf

⁸⁶ Ibid

⁸⁷ Madan Gopal et al., *Senior Care Reforms in India*; IIPS and UNFPA India, *India Ageing Report 2023*;

⁸⁸ Mordor Intelligence, "India Senior Living Market Analysis," Mordor Intelligence, accessed March 2026, <https://www.mordorintelligence.com/industry-reports/india-senior-living-market>

industry estimates, facilities in metropolitan hubs such as Delhi NCR, Mumbai, Bengaluru, and Chennai typically charge monthly fees ranging from ₹25,000 to over ₹1.5 lakh.⁸⁹ These costs place institutional care far beyond the reach of most of India's elderly who live in rural areas or belong to low- and middle-income groups with limited pension security.

NGO-led community-based models have increasingly shifted toward outreach-oriented and "Ageing in Place"⁹⁰ strategies to address these gaps (Annexure 10). Organizations such as HelpAge India provide lower-cost essential services, including mobile health units, nutrition programs, and digital literacy training.⁹¹ While these models are vital for social inclusion, their scalability is often restricted by critical dependence on CSR funding and government grants, which limits their reach to specific geographic pockets.

Kerala's Sayamprabha Homes and Vathilpadi Sevanam represent a hybrid model integrating public funding with community-level delivery through existing networks such as ASHA workers and Kudumbashree. These initiatives are embedded within local health systems, combining institutional reach with community participation, helping shift eldercare from fragmented schemes to a more coherent and rights-oriented system of long-term support.⁹² Replication in other states, however, requires high institutional capacity and sustained political commitment, conditions that vary across India.

⁸⁹ Elderly Care India, "Affordability of Senior Living in India," Elderly Care India (blog), 2025, <https://elderlycareindia.org/resources/blogs/affordability-of-senior-living-in-india/>

⁹⁰ Ageing in place refers to older people's ability to live safely and independently in their own homes and communities as they age, rather than relocating to institutional care facilities.

⁹¹ <https://www.helpageindia.org>

⁹² Government of Kerala. (2025). The Kerala Panchayat Raj (Amendment) Act, 2025 (Act 5 of 2025). https://prsindia.org/files/bills_acts/acts_states/kerala/2025/Act5of2025KL.pdf

3.3 Overview of Efforts in Care Workforce Development

Care work demands a combination of technical competencies like clinical knowledge, health monitoring and assistive care; interpersonal skills such as patience, communication and emotional quotient; and capabilities to manage non-routine tasks, high pressure situations and good judgement. Both structured training and practical experience are necessary to develop high quality skills.

Domestic training capacity for care workers is expanding through public institutions and private providers, though scale and quality vary widely. The Union Budget 2025-26 signals a commitment to the development of a care workforce: training of 1.5 lakh caregivers in the coming year and expanding the training capacity for allied health professionals by 1 lakh over five years.⁹³ Below we discuss some existing efforts in the training and development of the care workforce.

3.3.1 Care Workforce Development Models

(i) Public Provision: Central and State Government Schemes

Development of skilled care providers in India is supported through a combination of central skill development frameworks and state-led training initiatives. These efforts vary across sectors and geographies.

At the central level, the Ministry of Skill Development and Entrepreneurship (MSDE) operationalises the flagship Pradhan Mantri Kaushal Vikas Yojana (PMKVY) through the National Skill Development Corporation (NSDC). NSDC is the coordinating and ecosystem-building entity that provides financing and overarching quality assurance frameworks for industry-specific Sector Skill Councils (SSC) that ultimately guide skill training, certification and placements. The Home Management And Care Givers Sector Skill Council (HMCGSSC) and Healthcare Sector Skill Council (HSSC) are the two main SSCs related to occupations in the care sector.

⁹³ Ministry of Finance, *Budget Speech 2026–27*

Skill trainings in the care sector are competency-based, modular programmes aligned with the National Skill Qualification Framework (NSQF) focussing on ECD, health, safety, and nutrition, offering tiered certifications over three to six months, combining classroom instruction with practical internships. These efforts to build a trained care workforce under existing skilling programmes show both progress and limitations. Across the Short-Term Training and Special Projects components, the overall placement rate was only 41% (23.18 lakh placed out of 56.14 lakh certified), suggesting that although entry-level care roles are being formalised through certification, the transition into sustained employment remains a significant challenge.⁹⁴

Parallel to MSDE's skilling framework, the Ministry of Women and Child Development (MoWCD) runs a large-scale training for Anganwadi Workers (AWWs) covering nutrition, ECD, health, and hygiene. Through recent initiatives like Poshan Bhi Padhai Bhi (PBPB), 11,364 State-level Master Trainers and 1,877 AWWs have been trained as of June 2024 to support the Navchetna (0–3 years) and Aadharshila (3–6 years) curriculum frameworks.⁹⁵ While a significant push, a uniform national certification pathway that formally recognises AWWs as qualified ECD professionals within the broader skills ecosystem is required.

State level measures have been taken proactively by Kerala and Karnataka through initiatives linking trained care workers with employment pathways and state recognition mechanisms. Kerala Kudumbashree Mission's K4 Care project offers a one-month certified course training women for providing care for the elderly, bedridden, and post-natal patients, in partnership with the National Institute for Physical Medicine and Rehabilitation (NIPMER). In its first phase, 605 trainees secured paid employment, reflecting the effective livelihood linkages within Kerala's community networks⁹⁶ and embedding within the state's broader livelihood architecture.

⁹⁴ Comptroller and Auditor General of India, *Performance Audit of Pradhan Mantri Kaushal Vikas Yojana (PMKVY)*, Report No. 20 of 2025 (New Delhi: Comptroller and Auditor General of India, 2025), https://cag.gov.in/uploads/download_audit_report/2025/Report-No.-20-of-2025_PA-PMKVY_English-PDF-A-06943abec463479.68516873.pdf

⁹⁵ Ministry of Women and Child Development, "'Poshan Bhi Padhai Bhi' Initiative of Saksham Anganwadi and Poshan 2.0 to Bring Focus of Anganwadi System on Early Childhood Care and Education," Press Information Bureau, Government of India, July 24, 2024, <https://www.pib.gov.in/PressReleaseIframePage.aspx?PRID=2036464®=3&lang=2>.

⁹⁶ Local Self Government Department, Government of Kerala, "Employment in the Field of Elderly Care Through the Kudumbashree K4 Care Project: NIPMER and Kudumbashree Jointly Train 1,000 Women," 2024, https://lsgd.kerala.gov.in/en/latest_news/employment-in-the-field-of-elderly-care-through-kudumbashree-k4-care-project-nipmer-and-kudumbashree-jointly-train-1000-women/

In Karnataka, the Koosina Mane crèche scheme integrates childcare provisioning with skill-building under MGNREGA, training around 351 job-card-holding women as caregivers to support childcare services for rural working families. This enables women to move beyond casual wage labour while enabling addressing the childcare barrier to women's sustained participation in paid work.⁹⁷ States like Haryana, under the State Crèche Policy 2022, link crèche worker remuneration to the state minimum wage norms, and mandate training and refresher courses through state skill missions or recognised partners, signalling a gradual shift toward formal wage structures and standardised training.⁹⁸

Across both central and state schemes, care workforce development remains varied and fragmented, with training systems operating parallelly and evolving at different paces. As highlighted in the UNDP note, the care sector continues to face challenge like a shortage of trained professionals, limited structured training opportunities, and weak institutional support.⁹⁹

While job roles exist within MSDE's skilling architecture and state-run capacity-building programmes, standardised curricula, trainer qualifications, certifications, and placement pathways for care workers must be systematically developed and institutionalised.

(ii) Private Sector and NGO Initiatives

Private sector and NGO initiatives contribute to care workforce development through modular and blended training programmes, often targeting women care entrepreneurs and community-based caregivers. Private training providers such as Titili¹⁰⁰ are particularly active in urban and peri-urban settings and complement public efforts by offering shorter, market-oriented courses emphasising practical skill-building for home- and community-based care, entrepreneurship,

⁹⁷ Mahadevan, U., "Koosina Mane: Strengthening Rural Childcare for Working Women," Asian Development Bank Knowledge Events, July 9, 2025, https://events.development.asia/system/files/koosina-mane-ppt_08.07.2025-1.pdf.

⁹⁸ Women and Child Development Department, Government of Haryana, *Haryana State Crèche Policy 2022*, Gazette Notification No. 45/01/2023-3SW (Chandigarh: Government of Haryana, July 21, 2023), <https://cdnbbsr.s3waas.gov.in/s34c144c47ecba6f8318128703ca9e2601/uploads/2023/07/2023072571.pdf>; Women and Child Development Department, Government of Haryana, "Haryana Crèches," <https://wcdhry.gov.in/haryana-creches/>

⁹⁹ United Nations Development Programme (UNDP), "Boosting Female Labour Force Participation Through Strengthening Urban Care Ecosystem," <https://www.undp.org/india/projects/boosting-female-labour-force-participation-through-strengthening-urban-care-ecosystem>

¹⁰⁰ Titli Early Childhood Training Institute, "Early Years Programs," <https://www.titli.co/early-years-programs>.

and digital competencies. However, the absence of standardised certification, integrated employment frameworks, and adequate wage incentives continues to constrain workforce scaling.

Strengthening trainer quality, establishing unified certification standards, and building sustained public–private training partnerships represent key opportunities for improving outcomes.

3.3.2 Partnerships with Foreign Institutions

Recognising the need for global-standard skills and international credential recognition, Indian training bodies are increasingly engaging in partnerships with foreign institutions.¹⁰¹ MSDE through its International Cooperation Division, NSDC, Directorate General of Training (DGT) and other implementing organizations, in coordination with the Ministry of External Affairs (MEA), works to facilitate the mobility of skilled Indian workers abroad. This is done by harmonising skill qualifications, mutual recognition of certifications, and accreditation of training providers, through Government to Government (G2G) and Business to Business (B2B) partnerships with skill training and certification agencies.

Such partnerships also focus on capacity-building of Indian master trainers, facilitating knowledge transfer and quality enhancement. MSDE has signed bilateral agreements with eight countries facilitating technical exchanges, collaborative training, and mutual recognition of qualifications, with healthcare explicitly included as a priority sector.

An example of such integration is the Indo-Japan Technical Intern Training Programme (TITP), administered under a bilateral Memorandum of Cooperation in 2017, which includes caregiving as a job category. About 11% of the trainees as of December 2025 were in the care sector, where they undergo three to five years of structured on-the-job training in Japan's elderly care sector before returning to India. This represents a developing but concrete pathway for care worker mobility and international skills exposure¹⁰².

¹⁰¹ NSDC International, NSDC International. <https://www.nsdcenternational.com/>; Press Information Bureau, Government of India, "International Skilling and Overseas Placement," December 8, 2025, <https://www.pib.gov.in/PressReleasePage.aspx?PRID=2200375®=3&lang=1>

¹⁰² National Skill Development Corporation (NSDC), "TITP Updates," <https://nsdcindia.org/home-titp>

3.4 Applications of Artificial Intelligence in the Care Economy

Care work presents a unique paradox. It is one of the most socially and economically valuable activities, yet it remains largely underpaid, undercounted in standard economic metrics and characterised by limited measured productivity growth. This reflects its non-routine and relational nature, and substantial positive externalities that are not fully captured in market transactions. Women bear a disproportionately large share of this burden.

Care services are labour-intensive, with limited scope for substituting human labour with capital without compromising quality. Infact, standard labour productivity metrics are not well-suited for measuring care and can be detrimental to care quality , like higher case load per worker directly compromises outcomes.¹⁰³ Moreover, the value added by care services is difficult to quantify given its qualitative nature, leading to systematic undervaluation. Yet, care is essential for human development, dignity and well-being of families and communities.

Artificial Intelligence (AI) begins to challenge some of these structural constraints. Recent targeted interventions of AI in eldercare, early childhood education and healthcare diagnostics suggest that AI can improve efficiency and accessibility in care provision, which is both economically and socially significant given current demographic pressures and systemic gaps.

AI in Elderly and Disability Care

AI-enabled assistive technologies address mobility, safety, and independence challenges in eldercare. Walkfit, an AI-powered sensor attachment for walking sticks is a low-cost innovation that detects postural asymmetry patterns to predict fall risk. For PwDs, tools like Trestle Labs' Kibo language processing platform, and DeepVision Tech's sign language translation tools are expanding access to education and employment in cost-effective ways.

India's proposed Assistive Technology (Standards and Accessibility) Rules, 2025, shows regulatory intent with aims to establish certification, procurement, device categorization frameworks and mandatory Bureau of Indian Standards (BIS) safety compliance. Such foundational regulatory initiatives are critical given one in three persons globally requires

¹⁰³ Addati et al., *Care Work and Care Jobs*.

assistive tech. Therefore, India's ability to meet the demands and standards, depends on the affordability and reliability of supply-chains rather than on regulatory architecture alone.¹⁰⁴

AI in Healthcare

India's healthcare sector presents strong evidence for AI's impact, witnessing rapid integration across diagnostics, drug discovery, and system-level management. Tools like Qure.ai's deep learning qXR for detection of chest-related conditions and SigTuple's automated blood microscopy address constraints like shortage of trained pathologists and affordability of conventional diagnostics in low-resource settings.¹⁰⁵ At an institutional level, the Ayushman Bharat Digital Mission's (ABDM) ambition to digitise over 500 million health records aims to create an interoperable data infrastructure for predictive modelling and forecasting.

While these are significant gains, several risks persist. The deployment of AI in healthcare faces challenges related to data bias, interoperability, and gaps in digital infrastructure. The Digital Personal Data Protection Act (2023) provides a regulatory foundation for safeguarding patient data, while NITI Aayog's Roadmap on AI for Inclusive Societal Development emphasises AI as a tool to augment rather than replace care workers like home healthcare aides. It underlines inclusion, skill amplification and digital access over automation-driven displacement.¹⁰⁶ Scholarly evidence suggests that AI holds strong potential in healthcare, provided that governance, accountability, and data standards are sufficiently robust.¹⁰⁷

AI in Early Childhood Education

AI-driven learning tools are emerging to address gaps in quality and access, particularly in underserved communities. Appu, a voice-based generative AI tutor leverages large language models (LLMs) to create interactive and adaptive storytelling and numeracy exercises, while

¹⁰⁴ Panda, M., and T. C. Gaddam, "Assistive Technology Landscape in India: The Story So Far and Road Ahead," *Journal of the Epidemiology Foundation of India* 3, no. 1 Suppl. (2025): 37-45, <https://efi.org.in/journal/index.php/JEFI/article/view/314>.

¹⁰⁵ International Telecommunication Union (AI for Good), "Meet Qure.ai, a Healthtech Startup Leveraging AI and Deep Learning," 2024, <https://aiforgood.itu.int/meet-quire-ai-a-healthtech-startup-that-leverages-ai-and-deep-learning-to-make-x-rays-and-ct-scans-accessible-and-affordable-in-under-resourced-areas/>; SigTuple, "Products," <https://sigtuple.com/products>

¹⁰⁶ NITI Aayog, *Roadmap on AI for Inclusive Societal Development* (New Delhi: Government of India, 2025), https://niti.gov.in/sites/default/files/2025-10/Roadmap_On_AI_for_Inclusive_Societal_Development.pdf.

¹⁰⁷ Sushanta Kumar Das, Ramesh Kumari Dasgupta, Saumendu Deb Roy, and Dibyendu Shil, "AI in Indian Healthcare: From Roadmap to Reality," *Intelligent Pharmacy* 2, no. 3 (2024): 329–334, <https://doi.org/10.1016/j.ipha.2024.02.005>

PadhAI, uses AI-based speech recognition to assess reading and comprehension across multiple Indian languages. These innovations can function offline on low-end smartphones, making it suitable for rural and remote contexts.¹⁰⁸

Interventions like Appu are reported to improve student performance after participation.¹⁰⁹ While such figures require independent validation, they suggest early promise of AI-assisted ECE interventions. If deployed inclusively, AI-based systems can personalize learning at scale and reduce early education inequalities.

Way Forward

Across all three segments, there is a pattern of the technology moving at a fast pace, while institutional frameworks are still emerging. India's Digital Personal Data Protection Act (2023) and NITI Aayog's AI roadmap are meaningful steps towards creating frameworks for safeguards related to data privacy, interoperability, algorithmic fairness, and equitable digital access. Even so, effective governance is crucial to ensure responsible technology deployment in line with the framework's objectives. With strong regulatory oversight and inclusive implementation strategies, AI holds significant potential to expand care services effectively.

Further, **in the context of rising care demands across the life cycle, AI can be best understood as a supplemental tool rather than a substitute for human care labour.** As seen in the evidence so far, applications of AI in diagnostics, monitoring, and accessibility can address delivery gaps that are most acute in low-resource settings. However, these gains are largely task-specific and do not eliminate the core labour-intensive feature of care work. AI may improve the inputs available to care workers, rather than replace human judgement, especially in contextually complex situations. The relational, physical, and emotional dimensions of care, as well as its non-routine nature and need for judgement necessitate human interaction. *The case for AI in care is therefore not one of replacement, but of augmentation, where its value is conditional on the workforce it supports, re-iterating the vitality of investing in care workforce training and development.*

¹⁰⁸ Google, "Transforming Early Childhood Education with Appu, the GenAI-Powered Learning Companion," *Google Blog*, 2024, <https://blog.google/intl/en-in/transforming-early-childhood-education-with-appu-the-genai-powered-learning-companion/> ; Pratham UK, "Pratham Launches 'PadhAI': Transforming Literacy with AI-Powered Reading Assessments," 2024, <https://pratham.org.uk/pratham-launches-padhai-transforming-literacy-with-ai-powered-reading-assessments/>.

¹⁰⁹ Rocket Learning. <https://rocketlearning.org/>

3.5 Key Areas for Further Investment in the Care Economy

As demographic transition, urbanisation, family structure changes, and labour-market transformation intensify, the need to recognise care as economic and social infrastructure is urgent. It requires a shift from fragmented interventions to a coherent system aligning services, workforce development, and finance across all providers.

1. Expansion of quality care and infrastructure:

- i. **Scaling full-day childcare services** beyond the 4-5-hour operations to match working parents' schedules and enable sustained workforce participation.¹¹⁰
- ii. **Improving caregiver-to-child ratios** from prevailing levels (exceeding 1:50) to international observed ratios of 1:10-15 requires upto 38 million caregivers by 2050.
- iii. **Investment in physical infrastructure** including purpose-built centres, equipment, and learning materials, particularly in underserved regions.
- iv. **Strengthening eldercare:** Institutional eldercare coverage is limited. There is a need for urgent expansion of community-based inter-generational centres, palliative care, and home-based services.

2. Scaling community-based workforce development: Models like Kerala's Kudumbashree which trains local women as caregivers can address local care demand as well as livelihoods.

3. Formal workforce development with standardized pathways:

- i. **Establishing unified, NSQF-aligned training curricula** recognized across states and providers to professionalise care work and improve placements.
- ii. **Career progression frameworks** offering advancement from entry-level to supervisory and trainers, for improving sector attractiveness and retention
- iii. **Integration with international certifications** through partnerships with foreign institutions (ILO, ERS, and Southeast Asian training bodies) to enable care worker mobility and align Indian standards with global norms

4. Regulatory and quality assurance frameworks: Establishing minimum standards for staffing, qualifications, learning outcomes, etc. across providers can ensure quality consistency. Legally enforceable standards like in Australia¹¹¹ and Singapore¹¹² demonstrate how compliance and independent monitoring can institutionalise quality while retaining contextual flexibility.

¹¹⁰ Nikore et al., *Formulating a Strategy for India's Care Economy*.

¹¹¹ Australian Children's Education and Care Quality Authority (ACECQA), "National Quality Framework," <https://www.acecqa.gov.au/national-quality-framework>

¹¹² Early Childhood Development Agency (ECDA), "Early Childhood Development Agency," <https://www.ecda.gov.sg/>.

4. Policy Recommendations: Unlocking the Care Economy

India's care economy, currently valued at 15-17% of GDP¹¹³, yet largely informal, underfinanced, and dependent on women's unpaid labour, requires urgent, coordinated policy action. With up to 38 million care workers needed by 2050 and persistent gender inequities limiting women's economic participation, coordinated public investment in care services offers a dual opportunity: meeting demographic care demands and creating quality employment for millions.¹¹⁴

The effectiveness of care systems depends on how services are organised and staffed, making the integration of care provision and workforce development a core policy concern rather than a residual social issue. **Care services must be prioritised with a strategic and comprehensive market development approach backed by infrastructure adequacy, financing arrangements, workforce development, and regulatory oversight.**

India's care economy requires a coordinated policy approach built on four pillars. First, expand financing through public investment, public-private partnerships, and corporate social responsibility to fund multigenerational community care infrastructure. Second, build a professional care workforce and encourage carepreneurship through standardized training, certification, incubators for care entrepreneurs, and establishing care co-operatives. Third, review key provisions and policies across sectors such as urban planning, parental leave, and repurposing existing government facilities to create innovative care services. Fourth, establish quality assurance standards to ensure consistent service quality across public, private, and NGO providers. Together, these pillars transform care from an invisible, undervalued sector into a formalized economy that generates quality employment, supports women's economic participation, and meets India's growing care needs.

¹¹³ Nikore et al., *Formulating a Strategy for India's Care Economy*.

¹¹⁴ Author's calculations presented in Annexure 1

Pillar 1: Innovative financing for care infrastructure and services

1. Expand public sector support through a flagship outcome-based fund

As noted in section 3 above, the Anganwadi scheme under the ICDS program and the centrally sponsored Palna scheme are the flagship childcare related programs. The Anganwadi centres operate in both rural and urban areas across the country are the cornerstone of early childhood care, but have high child-to-caregiver ratios.¹¹⁵ Whereas, the Palna scheme provides financial support for establishing creches for children under 6 at existing Anganwadi centres.

Moving forward, there is a need to expand these efforts beyond singular creches and childcare facilities and consider the development of care centres embedded within communities, serving multiple care recipients including the elderly, children, PwDs and other groups. Stakeholder consultations by the Confederation of Indian Industry, Karmannya Counsel and Nikore Associates emphasized the need for community-driven multigenerational activity centre-based models.

Multigenerational care facilities align with the evolving needs of India's demographic transition- where the elderly population is projected to peak, while childcare demands remain substantial. These facilities can function as all-inclusive hubs offering both center-based and home-based childcare and elder care services. By normalizing shared care environments, they can reduce stigma associated with institutional care, foster social engagement and mitigate isolation. At the same time, they would enable efficient resource utilization through economies of scale - shared infrastructure, trained staff, and nutritional services across multiple cohorts.

To support the creation of these multi-generational, community driven care infrastructure and services, **an outcome-based government-to-government fund, *Parivar Seva Kosh (family care fund)***, can be created by the Government of India, housed within the Ministry of Finance. These community care centres would ideally be demand driven and may be developed by multiple line ministries at the central level (MoWCD, Ministry of Social Justice and Empowerment (MoSJE), others), state governments, urban local bodies (ULBs) and

¹¹⁵ Press Information Bureau, Government of India, "13.63 Lakh Anganwadi Centres (AWCs) of the 14 Lakh AWCs Sanctioned Across the Country Are Operational as on 01.06.2018," <https://www.pib.gov.in/newsite/PrintRelease.aspx?relid=181218®=3&lang=2>.

Panchayati Raj institutions (PRIs). Those interested may apply for financing by submitting proposals that comply with established quality standards.

The *Parivar Seva Kosh* can have an inter-departmental committee to enable project selection, prioritising financing for multi-generational and innovative care solutions. Financing from this fund would be tied to achievement of outcomes, such as an increase in female labour force participation rates in the areas serviced by the care facility.

2. Enable PPPs for expansion of care infrastructure and services

Public–private partnerships (PPPs) can serve as an important innovative financing mechanism to expand care infrastructure. Like other infrastructure sectors such as transport, railways, and energy, the government can develop standardised policy and regulatory frameworks and model concession agreements to operationalise PPPs for creating greenfield and brownfield care facilities.

The Ministry for Housing and Urban Affairs (MoHUA) can spearhead the development of these frameworks for different types of care facilities in urban areas, in consultation with relevant line ministries such as MoWCD, MoSJE, and others. Similarly, for rural areas, the frameworks may be developed by the Ministry of Rural Development. These frameworks should identify risk mitigation mechanisms and financing models relevant to the care sector and define key performance indicators.

3. Create mechanisms to leverage CSR and philanthropic funding

Indian corporations increasingly recognize government partnerships as valuable mechanisms for scaling impact, particularly when government and corporate social responsibility (CSR) objectives converge. The Indian CSR Outlook Report 2024 shows that a majority of corporate leadership (69%) demonstrated openness to government partnerships in CSR projects.¹¹⁶ CSR leaders find livelihood and skill development as accessible thematic areas for collaboration.

¹¹⁶ CSRBOX, *India CSR Outlook Report 2024* (CSRBOX, 2024), <https://csrboximpact.in/storage/publications/India-CSR-Outlook-Report-2024.pdf>.

Further, 60% of corporate leaders prefer CSR projects lasting 2-3 years or more, indicating a focus on long-term impact, consistent with government timelines and sustainability goals.¹¹⁷

The Ministry of Corporate Affairs established the National CSR Xchange portal in 2022 - a digital marketplace connecting companies and implementing agencies for CSR projects.¹¹⁸ Several states have also established CSR desks to facilitate CSR and philanthropy investments.

In the context of the care economy, it is critical to leverage the existing National and state-level CSR Xchange portal as a platform for offering corporate partnerships, directing CSR funding to relevant projects and onboarding implementing agencies in the care sector.

The platform can be utilised for financing a multitude of projects: establishment of care infrastructure, upgrade of existing facilities (including Palna centers), multi-generational care centers and expanding training of care workers under the Skill India Mission. Ministries such as the MoWCD, MoSJE, Ministry of Skill Development and Entrepreneurship (MoSDE), Ministry of Medium, Small and Micro enterprises (MSMEs) and state governments can encourage implementing agencies, including SHGs or NGOs providing care services or workforce training to register with the portals.

Ministries can also establish special purpose vehicles (SPVs) to support a range of PPP models in care provision where the private sector, SHGs and NGOs collaborate. This SPV could also be structured to accept financing from international organisations, philanthropies, and CSR donors. Moreover, any new centrally sponsored / state sponsored schemes in the care sector can be designed to ensure provisions for support by CSR and philanthropic investors.

4. Establish 'Carepreneur Fund' and support 'Care Incubators'

The Ministry of MSMEs may consider establishing a 'Carepreneur' Fund as a special purpose vehicle (SPV) to provide financial incentives in the form of low-interest rate loans to registered

¹¹⁷ CSRBOX, *India CSR Outlook Report 2024*

¹¹⁸ Ministry of Corporate Affairs, Government of India, "National CSR Exchange Portal Question," December 18, 2023, <https://sansad.in/getFile/loksabhaquestions/annex/1714/AU2391.pdf?source=pqals>

MSMEs/ Co-operatives providing care services across the country. Incentives may be offered to existing entrepreneurs as well as to start-ups that wish to operate in the care sector.

Financial incentives like interest subvention and credit guarantees can also be introduced to support entrepreneurs providing care services in urban low-income or rural and underserved areas through the ‘Carepreneur’ fund, where affordability of services could be a challenge. Further, women-led MSMEs / Co-operatives / SHGs providing care services can be given additional benefits - such as outcome-based grants.

If designed as an SPV, the ‘Carepreneur’ Fund can attract financing from a variety of sources, including Central and state governments, CSR, and philanthropies. This dynamic financing structure can attract capital on an ongoing basis and can be operated by a professional agency.

In addition, the Ministry of MSMEs can also work with MSME Development Institutes across the country to establish ‘Care Incubators’. These ‘Care Incubators’ can support the development of care sector related enterprises, which can eventually be financed by the ‘Carepreneur’ Fund, once their business solution is market-ready.

Pillar 2: Development of a high-quality Care Workforce

Care workers are expected to have high levels of patience and empathy, while managing the physical health and mental well-being of their dependents. As noted in section 2, India’s demand for childcare and eldercare workers is set to increase in the coming decades, alongside the requirements for nurses and health workers. India can also contribute to meet the massive global care workforce demand, estimated at 299 million by 2035.¹¹⁹ Realising this employment potential in the care sector requires sufficient investments in developing the care workforce.

To accelerate human capital development, there is a need for comprehensive skilling, re-skilling and upskilling of youth to create a trained care workforce that can not only meet the demand of the domestic market in India but can also contribute towards India becoming the global care workforce capital, thereby contributing to the Indian economy through remittances and global linkages.

¹¹⁹ Addati, Cattaneo and Pozzan, *Care at Work* (Geneva: International Labour Organization, 2022).

1. Develop standardized skill training, certification, and career progression pathways

Under the Skill India Mission's umbrella program, Prime Minister Kaushal Vikas Yojana (PMKVY) 4.0 (2022-23 to 2026-27), there is an expanded focus on flexible, inclusive, technology-oriented, market driven trainings, aiming to improve employability. There is also an expanded focus on recognition of prior learning (RPL) and on-the-job trainings.

Given this expanded focus, the Ministry of Skill Development and Entrepreneurship (MoSDE), and NSDC may undertake a national assessment on the skill gap in the care sector. Basis the assessment, NSDC may consider developing a comprehensive occupational framework that defines job roles, hierarchies, and specialisations across the different dimensions of care work, be it childcare, elderly care, or long-term care for highly dependent children / adults.

For each role, the NSDC could design modular skilling channels for training of care workers. This may include short term training, specialisation modules, as well as on-the-job training / RPL-based certifications. **Further, RPL certifications may be extended to Anganwadi and ASHA workers for formal recognition of existing skills and to enable qualified care workers to obtain skill premiums in compensation.** These efforts would institutionalise seniority and specialisation, thereby highlighting clear career pathways to new entrants and strengthen their retention.

Private sector partnerships can be leveraged to expand training and capacity building programs, in line with the partnerships and accreditation guidelines laid out in PMKVY 4.0. The MoSDE may consider incentivising private skill training institutes, for a limited period, to introduce specialised training modules on care services through measures such as curriculum development grants, training subsidies, or placement-linked incentives. These incentives would encourage institutes to expand training capacity and actively promote these courses, thereby increasing enrolment in newly introduced care sector training programs.

To develop a skill training framework for the care sector, formulate skilling modules, and undertake partnerships with international skill training institutes, the MoSDE may **strengthen and expand the mandate of the existing Domestic Workers and Care Sector Skill Council under the NSDC framework** to develop specialised occupational standards, certification pathways, and training modules for childcare, eldercare, and long-term care services . The

strengthened council can also develop standards for care worker qualifications, wage bands, and minimum care service performance benchmarks.

2. Establish partnerships with international training institutes

Building on existing international cooperation frameworks, the NSDC could prioritize the care sector within both G2G and B2B partnerships. This can be done in addition to mutual recognition of qualifications, by introducing **joint international accreditation to Indian training institutes and co-creation of training modules by foreign and Indian skill training institutes both in the public and private sector**. This would help Indian training providers to embed international best practices in the care sector and improve global employability.

In parallel, MSDE could align skilling initiatives with emerging labour mobility provisions, such as those in the recently concluded free trade agreements (FTAs) between India and the European Union, the United States, and the Gulf Co-operation Council. These clauses incentivise movement of skilled persons between regions. To support care workers in leveraging these formal labour mobility channels, the MoSDE may introduce joint certification mechanisms tailored to the requirements of care workers in the destination countries. Other targeted G2G partnerships with a focus on care worker mobility could further strengthen structured pathways for overseas employment.

Pillar 3: Policy Reforms

1. Introduce shared parental leaves

India's current parental leave framework mainly focusses on maternity leave, as discussed in section 3. Studies suggest that providing parents paid time off for childcare contributes to healthy child development, improves maternal health, and enhances families' economic security.¹²⁰

¹²⁰ Karina Kozak, Ashley Greaves, Jane Waldfogel, et al., "Paid Maternal Leave Is Associated with Better Language and Socioemotional Outcomes During Toddlerhood," *Infancy* 26, no. 4 (2021): 536–550, <https://doi.org/10.1111/infa.12399>; Jody Heymann et al., "Paid Parental Leave and Family Wellbeing in the Sustainable Development Era," *Public Health Reviews* 38, no. 1 (2017): 21, <https://doi.org/10.1186/s40985-017-0067-2>.

Moreover, international evidence demonstrates that shared parental leave policies increase men's participation in care work.¹²¹ As per a recent '*Advisory for employers to promote women workforce participation*', issued by the Ministry of Labour and Employment (MoLE) in 2024, employers are advised to:

- ensure a balance between employment and caregiving responsibilities for both men and women to foster an equitable workplace, including implementing family-friendly measures such as paternity leave, parental leave, family emergency leave and flexible working arrangements.
- take measures that not only encourage women but also men to take up flexible working time arrangements, including teleworking, to participate in care responsibilities.¹²²

Building on this Advisory, the MoLE could introduce *phased reforms in parental leave provisions*. **The first phase could begin by extending statutory paternity leave for employees in the private sector. In the second phase, MoLE may revisit the length of these leave entitlements from a gender-neutral lens and consider mandating a more gender balanced combination of maternity, paternity and gender-neutral parental leaves.**

The Government of India may institute a strong regulatory framework to support the establishment of market-based instruments for financing maternity, paternity, and gender-neutral parental leave. For instance, agencies such as the Life Insurance Corporation (LIC) could introduce innovative parental leave insurance products. It could be designed as a contributory product where employees and employers co-pay out of the monthly salary while in employment, and receive payouts when on parental leave. Such models can facilitate employers to shift to gender-neutral parental leaves from the current model of 100% employer-funded maternity leave. Government could also consider bearing a part of the parental leave monthly contribution for low-income earners.

¹²¹ Maria C. Huerta, Willem Adema, Jennifer Baxter, et al., "Fathers' Leave and Fathers' Involvement: Evidence from Four OECD Countries," *European Journal of Social Security* 16, no. 4 (2014): 308–346, <https://doi.org/10.1177/138826271401600403>.

¹²² Ministry of Labour and Employment, Government of India, *Advisory for Employers to Promote Women Workforce Participation* (New Delhi: Government of India, n.d.), https://labour.gov.in/sites/default/files/012524_booklet_ministry_of_labour_employment_revised2.pdf.

2. Strengthen regulatory framework to accelerate the formation of Care Co-operatives

A care co-operative is defined by the ILO in Recommendation No. 193 on the Promotion of Co-operatives (2002), as autonomous, voluntarily formed, jointly owned and democratically controlled enterprise established to meet members' shared economic, social and cultural needs.¹²³ In the care sector, this encompasses worker-owned, user-owned, and multi-stakeholder models delivering childcare, eldercare, disability and home-based services in line with core co-operative principles. Evidence from the ILO suggests that care co-operatives formalize unpaid care work, improve wages and working conditions, reduce worker turnover (attrition), enable multi-stakeholder participation (workers, users, communities), fostering gender equality, decent employment, and community-led service delivery.¹²⁴

Across advanced and emerging economies, co-operatives are major care providers: in Italy, 14,000 social co-ops serve 5 million people and employ 400,000 workers (€9bn annual turnover), while Sweden's co-ops deliver about 10% of childcare and Japan concentrates nearly 70% of its worker co-operatives in the care sector, including user-owned health systems covering 5% of hospital beds.¹²⁵ Similar community-based models are expanding in Latin America through ILO-supported initiatives, strengthening formal employment and gender equity in response to persistent care deficits.¹²⁶

India's experience also offers scalable models like Kerala's Kudumbashree women-led community network and the SEWA Sangini Childcare Workers' Co-operative in Gujarat. These models are based on co-operative principles and provide integrated care services, strengthen local-level care provision and free women's time for economic participation (elaborated in section 3).

¹²³ International Labour Organization, *Promotion of Cooperatives Recommendation, 2002 (No. 193)*, ILC 90th Session (Geneva: International Labour Organization, June 20, 2002), https://base.socioeco.org/docs/ilo-res_193-1.pdf

¹²⁴ Lenore Matthew, *Providing Care through Cooperatives 2: Literature Review and Case Studies* (Geneva: International Labour Organization, 2017), https://ccr.ica.coop/sites/default/files/2021-11/wcms_546178.pdf.

¹²⁵ CICOPA, "Cooperatives as Key Partners for the Provision of Care Services," February 24, 2025, <https://www.cicopa.coop/news/cooperatives-as-key-partners-for-the-provision-of-care-services/>; GEO (Grassroots Economic Organizing), "Koreikyo: Japanese Home Care Co-op Run by and for Seniors," accessed April 5, 2026, <https://geo.coop/articles/koreikyo-japanese-home-care-co-op-run-and-seniors>.

¹²⁶ International Labour Organization. (2025). Cuidando desde el territorio: Estrategias y experiencias de cuidados comunitarios [Caring from the community: Strategies and community care experiences]. https://www.ilo.org/sites/default/files/2025-10/ESS_Cuidando%20desde%20el%20territorio_es.pdf

Institutionally, India already has a multi-layered, sector-agnostic co-operative legal framework that is capable of accommodating care as a service sector activity. This framework includes the Co-operative Societies Act, 1912; State Co-operative Societies Acts; and the Multi-State Co-operative Societies Act, 2002 for co-operatives operating in multiple states. **The Ministry of Cooperation can recognise care as a priority sector and accelerate care co-operative formation by issuing model national guidelines that promote childcare, eldercare, and other forms of care, in line with existing regulations. The Ministry can provide states with registration guidance, and encourage clarificatory circulars to streamline approvals.**

3. Embed establishment of care infrastructure within urban planning

The Ministry of Housing and Urban Affairs (MoHUA) can strengthen care infrastructure development by embedding explicit provision requirements for childcare centres, multi-generational community care facilities, and related services into city-level master plans, urban development norms and planning guidelines.

The Urban and Regional Development Plans Formulation and Implementation (URDPFI) Guidelines issued by MoHUA serve as national reference standards for the preparation and implementation of state- and city-level master plans and local area plans. Substantively, URDPFI Guidelines prescribe norms for land-use distribution, density, transport networks, commercial facilities, environmental management and both physical infrastructure (like water, sewerage) and social infrastructure (like education, health, open spaces). Although advisory rather than legally binding, most state town and country planning departments use them as de facto benchmarks for framing their planning regulations, development control rules and service-level standards.

First, **MOHUA can operationalise URDPFI Guidelines to include quantitative norms for care facilities like crèches, anganwadis, day-care centres, elder-care services, and disability support centres, linked to population density, women’s labour force participation, and transit accessibility, making these benchmarks mandatory in master plans and zonal plans.**

Second, **MOHUA may issue binding advisories that classify care facilities as “essential social infrastructure”, mandating land reservation, rationalised user charges, and**

integration of care indicators into project appraisal and Finance Commission-linked performance grants. Cities demonstrating adequate creation and equitable spatial distribution of care infrastructure could be prioritised for funding and fiscal incentives.

By prescribing ward-level norms linked to population density, transit access, and low-income clusters, the Ministry can guide states and urban local bodies to reserve land, provide serviced plots, and use instruments like inclusionary zoning, impact fees, and flexible FAR or ground-floor norms to prioritise care.

Embedding these requirements within master plans would also enable convergence with affordable housing, transit-oriented development, and smart city initiatives, facilitating co-location of care services with housing, workplaces, and public transport hubs. This approach would advance gender-responsive and inclusive urban design by reducing unpaid care burdens, shortening travel times for caregivers, and ensuring that women, children, PwDs, and the elderly have safe, accessible, and affordable care options close to home and work.

Moreover, local-level access to care facilities can also be expanded through collaboration with other central ministries, specifically the Ministry of Social Justice and Empowerment (MoSJE) and Ministry of Education (MoE). MoSJE can support state governments and ULBs in establishing multigenerational care facilities. Whereas, MoE can play a critical role in expanding access to care infrastructure by repurposing existing government schools. Schools are well-suited locations for care services due to their proximity to communities, existing familiarity for families, while co-location can reduce logistical burdens by enabling older siblings to accompany younger children to care facilities. The variations in school schedules across states and by level of classes (such as shorter hours for younger classes) creates scope for shared use of underutilised space during the school day. Additionally, schools that have experienced closures, consolidation or low or zero enrolments present an opportunity for re-use, particularly in high-cost urban settings.¹²⁷ MoE can support state governments in identifying and converting such schools into operational care facilities.

¹²⁷ Ministry of Education, *Lok Sabha Unstarred Question No. 27: Annexure* (New Delhi: Government of India), https://www.education.gov.in/sites/upload_files/mhrd/files/parliament_annexure_en/27parl.pdf; Ministry of Education, *Rajya Sabha Unstarred Question No. 2922: Schools with Zero Student Enrolment, Annexure (Part a-c)*, answered on 18 March 2026, https://www.education.gov.in/sites/upload_files/mhrd/files/parliament_annexure_en/RSUQ_2922_en.pdf

Finally, through the National Institute of Urban Affairs (NIUA), MOHUA can build capacity of ULBs to map care gaps, run gender and care audits of city plans, integrate universal accessibility features into urban design, and ensure that care infrastructure planning is tied to everyday mobility patterns and safety of women, children, elderly persons, and PwDs.

Pillar 4: Quality Assurance Mechanisms

The expansion of care infrastructure and services must be accompanied by quality assurance mechanisms to ensure safety, achievement of developmental outcomes, and dignified employment for care workers. Establishing clear standards and enabling state-level fine-tuning, are essential to building a resilient care economy.

1. Establish national minimum quality standards for care services

The Ministry of Women and Child Development and Ministry of Social Justice and Empowerment can establish national quality standards for care facilities across public, private, and community-based providers covering staffing ratios, infrastructure norms, health and safety protocols, and service delivery guidelines. These standards should be differentiated by care type like childcare, eldercare and multi-generational care to reflect varying risk profiles and service needs.

Caregiver-to-child ratios can align with international best practices. As discussed earlier, *available evidence suggests that current staffing ratios in Anganwadis are often observed to be higher than those in many OECD and UNICEF-referenced early childhood systems where staff-to-child ratios are typically lower, especially for younger children.*¹²⁸ For eldercare, India could consider aligning with international benchmarks observed in OECD countries, where

¹²⁸ Anoop Jain, Dilys M. Walker, Rasmi Avula, Nadia Diamond-Smith, Lakshmi Gopalakrishnan, Purnima Menon, Sneha Nimmagadda, Sumeet R. Patil, and Lia C. H. Fernald, "Anganwadi Worker Time Use in Madhya Pradesh, India: A Cross-Sectional Study," *BMC Health Services Research* 20, no. 1 (2020): 1130, <https://doi.org/10.1186/s12913-020-05857-4>; OECD, *Childcare and Elderly Care: What Occupational Opportunities for Women?*, OECD Labour Market and Social Policy Occasional Papers No. 27 (Paris: OECD Publishing, 1997), <https://doi.org/10.1787/047834852710>; UNICEF, *Strengthening Early Childhood Education and Care Systems for Ages 0–3 in Europe and Central Asia* (Geneva: UNICEF, 2021), <https://www.unicef.org/eca/media/36911/file/Strengthening%20Early%20Childhood%20Education%20and%20Care%20Systems%20for%20Ages%200-3%20in%20Europe%20and%20Central%20Asia.pdf>;

there are on average around 5 formal long-term care workers per 100 persons aged 65 and above.¹²⁹ The MoWCD has issued National Minimum Standards for creche facilities. Such standards could be developed to cater to all childcare and eldercare facilities.¹³⁰

Infrastructure norms may specify minimum space standards, adequate lighting and ventilation, age-appropriate and accessible sanitation, safe drinking water, CCTV installation for safety monitoring, and tie-ups with nearby healthcare facilities. Facilities should also maintain prescribed records, undertake periodic safety inspections, and share location and operational details with local police and relevant welfare authorities.

2. Enable state-level customization within national frameworks

While national standards provide the baseline, states and ULBs must be given the flexibility to adapt quality norms to local contexts, resource availability, and demographic patterns. States may customize operational aspects to align with their requirements including language of instruction, integration with state-specific nutrition schemes, and partnership models with local co-operatives.

3. Institutionalise monitoring, data and service quality benchmarks

Building on the Comptroller and Auditor General's audit guidelines, MoWCD and MoSJE could establish ongoing monitoring systems. This could include three main components: **(i) regular facility inspections** by district-level Child Development Project Officers using standardized checklists; **(ii) beneficiary feedback** at pre-determined regular intervals through monitoring committees that could comprise of parents or guardians, family members, facility supervisors, and administrative representatives; and **(iii) a unified management information system** capturing facility-level data on key indicators like enrolment, staffing, nutrition delivery, and health check-ups. States demonstrating consistent improvement in quality indicators could receive performance-linked incentive grants.

¹²⁹ OECD, *Who Cares? Attracting and Retaining Care Workers for the Elderly*, OECD Health Policy Studies (Paris: OECD Publishing, 2020), <https://doi.org/10.1787/92c0ef68-en>

¹³⁰ Ministry of Women and Child Development, *National Minimum Guidelines for Setting Up and Running Crèches under Maternity Benefit Act 2017* https://wcd.gujarat.gov.in/uploads/departments/Children_dep_6ZShPhLF45emlBfqsDAQ7DEwVPRyOT4W.pdf

5. Conclusion

India stands at a demographic and economic inflection point. The rise in the elderly population, persistently low urban fertility and increasing fertility gap, combined with the stagnation of women's labour force participation are not isolated trends - they are interconnected symptoms of a care deficit that has long been treated as a household problem rather than a national policy priority.

The analysis presented in this paper makes clear that care is neither a welfare residual nor a women's issue. It is a social and economic infrastructure that is essential to the functioning of a modern economy. *When care systems fail, families absorb the cost invisibly, women withdraw from or forgo entry into the labour force, fertility aspirations go unrealised, and the elderly are left without dignified support. These outcomes have adverse effects on human capital, productivity, and long-run growth that are crucial for India as it navigates changing demographics and family structures.*

The path forward requires a reorientation - from isolated, scheme-driven interventions toward a coherent, cross-ministerial care architecture anchored in four commitments: mobilising adequate and innovative financing; building a skilled, recognised, and fairly remunerated care workforce; reforming policy frameworks to distribute care responsibilities more equitably across genders and between households and the state / markets; and establishing quality standards that apply uniformly across all providers.

None of these pillars can function in isolation. Financing without workforce development produces empty infrastructure. Regulatory standards without financing remain aspirational. Parental leave reform without accessible childcare shifts the burden rather than reducing it. *What is required is coordinated, convergent action across ministries, tiers of government, and sectors - sustained not by short-term project cycles but by a long-term vision of care as a cornerstone of India's social and economic architecture.*

The demographic window to act is finite. India currently possesses the working age population to build this infrastructure, train this workforce, and position itself as a global leader in care services. Delaying investment does not defer the cost - it accumulates it. Reimagining care as a strategic public good, rather than a private burden disproportionately borne by women, is not only a matter of gender equity. It is the precondition for a more productive, demographically resilient, and socially cohesive India.

ANNEXURES

Annexure 1: Step-by-Step Methodology for Care Workforce Demand Projections (2025-2050)

Step 1: Population Projections for Children (0-14 years) The child population (0-14 years) is divided equally (50% each) into two age cohorts of 0-6 years age and 7-14 years based on Census 2011 projections. Childcare worker requirements are estimated for children in the 0-6 years age group, in line with the existing ICDS provision norms.

Step 2: Population Projections for Elderly Persons (60+) Elderly population projections based on demographic transition trends by 2050.

Table 1: Population Projections (Steps 1-2)

Step		Population Category	2025	2050	Calculation
Step 1		Total Children (0-14 years)	35,00,00,000	30,00,00,000	UNFPA Population Projections
	1a:	Children (0-6 years)	17,50,00,000	15,00,00,000	Total Children × 50%
Step 2		Elderly (60+ years)	14,60,00,000	34,70,00,000	UNFPA Population Projections

Step 3: Applying the Care Worker Ratio Standards¹³¹

- **Childcare workers:**

Scenario 1: Lower end of care intensity - 10 workers per 100 children (0-6 years)

Scenario 2: Higher end of care intensity - 15 workers per 100 children (0-6 years)

- **Elder Care Workers:** 4.5 workers per 100 elderly persons (60+)

¹³¹ Modelling assumptions calibrated to international ranges: Prevailing standards in OECD countries indicates that early childhood systems typically operate with lower staff-child ratios for younger children. For children under 3 years, it is recommended to have 1 trained staff member per 3-5 children, with observed ratios (including support staff) often around 1:5-9. For preschool-age children (3-6 years), 1 staff per 10-14 children is common. High-quality systems tend to maintain substantially higher staffing densities, particularly for infants. OECD countries average around 5 long-term care workers per 100 persons aged 65+, with lower thresholds (around 4-5) sometimes used in policy discussions as minimum adequacy benchmarks. This includes both health professionals (nurses, aides) and direct care workers. OECD, *Childcare and Elderly Care*, 1997.

Step 4: Childcare Worker Requirements Divide the number of children (0-6 years) by the ratio requirement under both scenarios.

Step 5: Elder Care Worker Requirements Divide the number of elderly persons (60+) by the ratio requirement.

Step 6: Translation to Millions Convert worker requirements to millions for easier reference.

Table 2: Care Worker Requirements (Steps 3-6)

Step		Care Type	Ratio Standard	2025 Workers	2050 Workers
Step 3		Childcare (0-6)			
	3a	Scenario 1	10 per 100 children	1,75,00,000	1,50,00,000
	3b	Scenario 2	15 per 100 children	2,62,50,000	2,25,00,000
Step 4		Elder Care (60+ years)	4.5 per 100 elderly	65,70,000	1,56,15,000
Step 5		Childcare (in millions)		17.5 – 26.25 million	15 – 22.5 million
Step 6		Elder Care (in millions)		6.57 million	15.61 million
Total Care Worker Requirement (Step 5+6):				24.1 - 32.8 million	30.6 - 38.1 million

Calculation:

- Year 2025**

- Childcare:**

- Scenario 1: $17,50,00,000 \div 100 \times 10 = 1,75,00,000$

- Scenario 2: $17,50,00,000 \div 100 \times 15 = 2,62,50,000$

- Elder Care:** $14,60,00,000 \div 100 \times 4.5 = 65,70,000$

- Year 2050**

- Childcare:**

- Scenario 1: $15,00,00,000 \div 100 \times 10 = 1,50,00,000$

- Scenario 2: $15,00,00,000 \div 100 \times 15 = 2,25,00,000$

- Elder Care:** $34,70,00,000 \div 100 \times 4.5 = 1,56,15,000$

Annexure 2: Childcare Schemes under Union Government

Scheme Name	Year Launched/ Restructured	Target Age Group	Key Services	Implementation Mechanism	Budget/Coverage
ICDS - Saksham Anganwadi and Poshan 2.0	Launched 1975, Restructured 2021	0-6 years	Supplementary Nutrition Programme (SNP), Early Childhood Care and Education (3-6 years), early stimulation (0-3 years), upgraded AWC infrastructure	Directly by State Governments/UTs	~1.4 million Anganwadi centres serving 10.7 million children; Annual allocation exceeding ₹20,000 crores
Palna Scheme (Mission Shakti)	Launched 2017, Reorganized 2022	6 months - 6 years	Crèche facility for all mothers (irrespective of employment status), early stimulation, preschool education, health check-ups, immunization, supplementary nutrition	Directly by State Governments/UTs through AWC-cum-Crèches and standalone crèches	~11,395 AWCCs approved States/UTs serving ~29,00 beneficiaries (as of March
Mission Vatsalya (Integrated Child Protection Scheme)	Launched 2009, Reorganized 2022	Children in difficult circumstances	Family-based non-institutional care (children's homes, open shelters, specialized adoption agencies)	Directly by State Governments/UTs	Digital platform for unified MIS

Source: Compiled from Annual Reports of MoWCD

Annexure 3: Childcare Schemes under State Governments

State	Scheme Name	Year/Status	Target Group	Key Features	Implementation Details
Kerala	Crèches in the workplace (Kerala Maternity Benefits Amendment Rules)	2022	below 3 years and preschool children up to 6 years	Restructure Anganwadi centres to serve as crèches; Safe places for adolescent girls after school hours	Integrated with existing Anganwadi infrastructure
Kerala	Mobile crèches and day-care centres for migrant workers	2022-23	Children of migrant workers	Clubs together Anganwadis with limited premises for providing day-care	Child Budget of Kerala, 2024
Kerala	K 4 Care	2023	Elderly, postpartum mothers, and children	Community-based caregiving with professional support; employment generation for trained women	Leverages Kudumbashree participatory governance model
Karnataka	Koosina Mane	2023-	Children of MGNREGA workers and rural workers	Healthcare, nutrition, and safety; 351 MGNREGA job card-holding women trained as caregivers	~4,000 Gram Panchayats; ₹40 crore in 2025-26 budget
Odisha	Ama Kalika	Ongoing	Children under 3 years of agricultural labour & daily wagers in	Holistic care with good food, health checks, growth tracking, early learning activities	Over 90 centres; 6 AM to 4 PM operations; funded through District Mineral Foundation

			tribal and mining districts		
Odisha	Care Centre Policy	Upcoming (2022 policy under revision)	All children, priority to disadvantaged communities	Workplace-based childcare across government and private sectors; community-led models in industrial zones	Stand-alone centres in offices, hospitals, schools; inclusion focus on tribals, minorities, migrants
Haryana	Haryana State Crèche Policy	2022	6 months - 6 years	Free universal crèche access; 8–10-hour daily operations; trained caregivers	500+ facilities serving 10,015 children (197 standalone units); Workers: ₹15,000/month, Helpers: ₹7,500/month
Tamil Nadu	TN We-SAFE (Tamil Nadu Women Employment and Safety Programme)	2024-29	Children of working women	Expanding Anganwadi cum crèches (Palna) & piloting 'Anbukudil' crèche-cum-after school care centres	World Bank-funded; PPP model through Tamil Nadu Working Women's Hostel Corporation Limited (TNWWHCL)
Meghalaya	Early Childhood Development in Meghalaya Project	2023-28	Children 0-6 years (focus 0-8 years)	Integrated home and centre-based care; maternal mental health support	USD 40.5 million (ADB) + USD 15.27 million (state); Inter-departmental convergence

Chhattisgarh	Project Manthan	2020	Children in tribal residential institutions	Psychosocial support and mental health services, counselling, therapy, capacity building of caregivers	Partnership with UNICEF India; 6 districts in Bastar region
Punjab	Aarambh	2024	Young children and parents	Strengthening ECCE through parental engagement and play-based learning	Technical support from Rocket Learning NGO; uses everyday household materials

Source: Compiled from various government sources

Annexure 4: Private Childcare Models

Model Type	Key Characteristics	Financial Model	Sustainability Profile
Premium Commercial	Specific urban centres; staffing ratios 1:6-1:8 for preschool; curriculum-based; AC facilities	Parent fees ₹8,000-25,000/month	Sustainable for high-income segments; restrict access to a significant population of urban and rural households
Corporate CSR-Funded	On-site childcare at factories/offices; employer subsidized; approximately 433 centres identified through partnerships; staffing 1:8-1:10	Employer CSR contributions + parent fees	Dependent on corporate budget cycles and CSR priorities; unsustainable post-divestment
Mixed-Model (Emerging)	Tiered fee structure targeting middle-income households; hybrid public-private partnerships; approximately 250-300 centers identified	Parent fees ₹1,500-4,000/month + government/NGO subsidy	Partially sustainable; requires ongoing subsidy

Annexure 5: NGO/ CBO Childcare Models

Organization	Model Type	Coverage	Cost per Child	Sustainability Model
Mobile Creches	Community co-operative; tripartite (government-NGO-community), employer-run, demonstration models	5000+ centres across 20 states; 55,000 children annually	₹33-70/day	Employer/donor funding + government partnerships (433 MGNREGA on-site centres)
Apnalaya	Community childcare centres with women empowerment focus; home-based model	145 centres; 435 mothers employed	₹300-500/month	CSR partnerships (29 CSR partners); ₹11.73 crores secured
SEWA Sangini	Women's co-operative childcare; structured routine; nutrition focus	12 centres in Gujarat serving 480 children	₹450-500/month	Parent fees + co-operative income generation
Aveksha Day Care¹³²	Free Full-Day daycare services for children of construction workers and industrial labourers offering curriculum-based activities	20 centers each serving 20-30 children per center, mainly in Telangana with plans of expansion.	Set upto Rs 2 lakh for set up of the center, with operational cost of Rs 40,000 per month per center	Individual /CSR contributions for initial setup, SIDBI covers operational expenses, state government provided space for some centers, private construction firms fund for children of their own construction workers.

¹³² Medicircle News, "AVEKSHA, Four-Day Care Centres, for the Kids of Industrial Workers Inaugurated," April 16, 2024, <https://medicircle.in/aveksha-fourday-care-centres-for-the-kids-of-industrial-workers-inaugurated>

Annexure 6: Wage Compensation Schemes for Informal-Sector Women

Scheme Name	Target Group	Key Services / Benefits	Implementation	Coverage / Notes
Pradhan Mantri Matru Vandana Yojana (PMMVY)	Pregnant & lactating women (first pregnancy)	Conditional cash transfer linked to ANC, institutional delivery, child immunisation	MoWCD direct benefit transfer; linked to health facility milestones	National scheme; cash incentive — not wage compensation
Assam Maternity Wage Compensation Scheme (WCS)	Pregnant & lactating women in informal sector	Direct wage compensation during pregnancy and early postpartum	State government cash transfer; linked to ANC / delivery evidence	Explicit wage replacement model (rare among states)
Odisha Mamata Scheme	Pregnant & lactating women	Conditional cash incentives for ANC, institutional delivery, nutrition practices	State Health & ICDS convergence	Widely used state maternity incentive (service-conditional)
Madhya Pradesh MMSSPSY	Pregnant & lactating women	Cash assistance linked to ANC and institutional delivery	State Health / WCD implementation	State-level cash maternity support (conditional)
Tamil Nadu - Dr. Muthulakshmi Reddy Maternity Benefit Scheme	Pregnant & lactating women	Cash assistance conditional on ANC, institutional delivery, immunisation	State WCD & Health Dept delivery	One of the largest/most comprehensive state cash maternity schemes
Telangana — KCR Kit / MCH Kit Scheme	Pregnant women (institutional delivery)	In-kind delivery kit (essentials) + cash assistance at institutional delivery	State Health Dept at point of delivery	Reduces OOP delivery costs; not wage replacement

Annexure 7: Joint/Share Parental Leave Policy in Selected Countries

Country	Total Paid Leave	Father's Quota (Non-Transferable)	Pay Rate	Key Features & FLFPR Impact
Sweden¹³³	480 days/child (shared)	90 days/parent (3 months each; up from 60 pre-2024) + flexible family pot	80% salary (capped); 90 days flat-rate	Longest in Nordics; fathers take ~30% total. Linked to +0.3% maternal earnings/month fathers use (OECD, 2025)
Iceland	12 months/child (39–52 weeks equiv.)	6 months/parent (4.5 use-or-lose each; 1.5 transferable)	80% salary (capped)	Equal split since 2000/2021 reforms; fathers ~40% uptake, narrowing employment gaps 10–15% (OECD, 2025)
Norway	49 weeks (100% pay) or 59 weeks (80% pay)	15 weeks father quota (expandable)	100% / 80% salary	90% fathers use quota; boosts egalitarian housework 20–30%, child outcomes (OECD, 2025)
Spain	16 weeks maternity + 16 weeks paternity (both non-transfer) + up to 3 years shared unpaid/parental	16 weeks paternity (mandatory 6 weeks uninterrupted)	100% salary	EU-aligned; fathers' uptake ~40%; closes care time gaps, minimal penalty (OECD, 2025)

¹³³Free Policy Briefs, "Addressing Care Economy Gaps: Policy Briefs and Reforms," Policy Brief No. FPB20240205, 2024, <https://freepolicybriefs.org/wp-content/uploads/2024/02/fpb20240205.pdf>

Annexure 8: Central Government Schemes for Elderly Care in India

Scheme Name	Year Launched / Restructured	Target Age Group	Key Services	Implementation Mechanism	Budget / Coverage
Atal Vayo Abhyuday Yojana (AVYAY)	Restructured recently (Umbrella Scheme)	60+ years (Focus on indigent/destitute)	Shelter homes, adult day-care centres, mobile medicare units, counselling.	MoSJE via NGOs (Reimbursement model: 50% construction cost + partial operational expenses).	Coverage: <50,000 elders (0.03% of elderly population). Facilities: ~40-50 govt-aided facilities nationwide.
National Programme for Health Care of the Elderly (NPHCE)	Launched by MoHFW (Ongoing)	60+ years	Geriatric clinics (OPD), physiotherapy, domiciliary (home) visits for bedridden, health education.	MoHFW via State Health Societies (District Hospitals, CHCs, PHCs, Regional Geriatric Centres).	Operational across districts; integrated into primary and secondary health facilities.
Ayushman Bharat – PMJAY (Ayushman Vay Vandana Card)	Expanded to cover 70+ population	All citizens aged 70 years and above	Cashless hospitalisation (secondary & tertiary care) up to ₹5 lakh per year	Implemented through National Health Authority and State Health Agencies via empanelled hospitals	Covered under PMJAY budget; universal age-based health cover for 70+

Indira Gandhi National Old Age Pension Scheme (IGNOAPS)	Ongoing	60-79 years; 80+ years (BPL households)	Monthly financial pension.	MoRD (Direct Benefit Transfer / State delivery).	Amount: ₹200–₹500/month (varies by age; noted as insufficient in reports).
Atal Pension Yojana (APY)	2015	18–40 years (targeted unorganised sector workers but also include others)	Guaranteed monthly pension (₹1,000–₹5,000) after age 60; defined contribution-based savings; spouse continuation benefit	Administered by PFRDA; operated through banks and post offices; auto-debit from savings accounts	Central government co-contribution (initial phase for eligible subscribers); over 6+ crore subscribers (recent cumulative enrolment)

Annexure 9: State Government Eldercare Initiatives

Scheme Name	Year Launched / Restructured	Target Age Group	Key Services	Implementation Mechanism	Budget / Coverage
Vayomithram (Kerala)	2010-11	65+ years (Plan to reduce to 60)	Free mobile clinics (medicines), palliative care, help desks, special medical camps (eye), entertainment events.	Kerala Social Security Mission (Dept of Social Justice); Municipal/Corp focus.	Budget: ₹22 Crore (2025). Coverage: 95 units (6 Corps, 85 Municipalities).
Kudumbashree Elder Care Model (Kerala)	Active (Reported 2023-24)	General Elderly	Day care, nutrition kits, first aid, palliative support.	Kudumbashree Mission (SHG Network); 90 women trained per district.	Coverage: 2.9 lakh seniors; 168 centres; 95 mobile units.
Integrated Elder Care Scheme (Tamil Nadu)	Active (Reported 2023)	Elderly visiting PHCs	Basic health screening, nutrition support.	Primary Health Centres (PHCs).	Coverage: 300,000+ elders.
Senior Citizens Policy Implementation Scheme (Maharashtra)	2018	60+ years	5% hospital bed reservation; ST bus concessions; police helpline; hospital services	Social Welfare Department	NA

Annexure 10: Private Sector and NGO Elder Care Models in India

Model Type	Provider Examples	Coverage	Key Features	Barriers
Private Sector	Antara Senior Living, Columbia Pacific, Max India	Urban/Tier-1 Cities (Delhi, Mumbai, Bengaluru, Chennai)	Specialized "silver economy" services; luxury assisted living; 24/7 medical supervision.	Lacks rural presence; uneven quality regulation.
NGO-Led Community	HelpAge India, Apnalaya, Dignity Foundation	500-1,000 centers nationally, largely lower-income Urban & Rural pockets focus	"Ageing in Place" focus; mobile health units; digital literacy; nutrition support.	Funding Instability: Heavy reliance on CSR and government grants; limited scalability.
Hybrid Public-Private	Kerala's Sayamprabha Homes, Vathilpadi Sevanam	State-wide (pioneered in Kerala)	Integration with local health systems (ASHA/Kudumbashree); public funding with community delivery.	Replication Gaps: Requires high state institutional capacity and sustained political commitment.