The Care Economy Boom

A $300 billion opportunity set to generate over 60 million care jobs by 2030

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Table of Contents

List of Abbreviations

ABDM	Ayushman Bharat Digital Mission
CAGR	Compound Annual Growth Rate
CNA	Certified Nursing Assistant
CSR	Corporate Social Responsibility
ECCE	Early Childhood Care and Education
GDP	Gross Domestic Product
ILO	International Labour Organization
LTCI	Long-Term Care Insurance
MoHFW	Ministry of Health and Family Welfare
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
NITI Aayog	National Institution for Transforming India
NSS	National Sample Survey
OECD	Organisation for Economic Co-operation and Development
PF	Provident Fund
PMJAY	Pradhan Mantri Jan Arogya Yojana
PPP	Public–Private Partnership
PWDs	Persons with Disabilities
RPL	Recognition of Prior Learning
SHG	Self-Help Group
UNFPA	United Nations Population Fund
WHO	World Health Organization

Executive Summary

India is standing on the edge of one of its largest untapped employment and growth opportunities, and it sits in plain sight. Care work already keeps households, cities, and labour markets functioning, yet it remains **mis-defined, undervalued, and largely invisible** in economic planning. This report argues that the care sector must be reimagined not as a residual social function, but as a core economic sector with the scale, stability, and longevity to anchor India's next phase of growth.

The first shift this study makes is definitional. Existing frameworks borrow heavily from global models that do not fully reflect how care is delivered in India. This report redefines the care economy for the Indian context by mapping 13 distinct personas across childcare, eldercare, disability support, rehabilitation, mental health, wellness, beauty, domestic services, and care enterprise management. Together, these personas capture the real structure of paid care in India: fragmented but vast, skilled but unrecognised, formal in demand yet informal in practice. Without this expanded and grounded definition, large parts of India's care workforce remain statistically invisible and therefore politically neglected.

Care has shifted from being a private household responsibility to becoming essential economic infrastructure in India, quietly sustaining labour participation, urban life and demographic transitions, yet remaining largely invisible in policy despite being critical to how the economy actually functions.

This report redefines the care economy for the Indian context by mapping 13 distinct personas across **childcare, eldercare, disability support, rehabilitation, mental health, wellness, beauty, domestic services, and care enterprise management.**

Seen through this lens, the economic potential of the sector is unmistakable. **India's care economy already employs an estimated 36 million workers. With targeted investment in skilling, certification, formalisation, and demand creation,this number can exceed 60 million jobs by 2030, creating a market value of $300 Billion.** Few sectors offer this scale of employment creation within such a short horizon, and fewer still do so with jobs that are **locally delivered, resistant to automation,**

India's care economy already employs an estimated 36 million workers. With targeted investment in skilling, certification, formalisation, and demand creation, this number can exceed 60 million jobs by 2030, creating a market value of $300 Billion.

and tied to long-term demographic demand. Care is not a transient employment boom; it is a structural growth engine.

Contrary to persistent assumptions, **care jobs are neither low-value nor inherently precarious.** Where roles are formalised, certified, and linked to organised service delivery, care work offers stable, predictable, and often comparatively high-paying employment, especially for women and youth. The constraint is not demand, but design. **Care has no natural ceiling for growth, provided workers can move along a skilling continuum** that recognises experience, enables specialization, and rewards progression.

Care demand is also not confined to metros. It is distributed across **Tier 1, Tier 2, Tier 3 cities, peri-urban regions, and rural areas,** following people rather than infrastructure. This makes care one of the few sectors where growth is inherently decentralised. With the right policy and enterprise support, care services can generate quality employment where people already live, strengthening local economies and reducing distress migration.

Yet despite these advantages, India's care economy continues to grow by default rather than by design. **Demand is rising due to ageing, chronic disease, childcare needs, and changing family structures,** but workers absorb the risks of informality, income volatility, and lack of protection. Enterprises struggle to scale without regulatory clarity or predictable demand. Households face high costs and uneven quality. Left unaddressed, these fault lines will deepen as demographic pressures accelerate.

This moment demands fiscal and institutional intent. **The upcoming Union Budget presents an opportunity to recognise care as economic infrastructure** through dedicated budgetary allocations for care services, skilling, and worker protection, rather than dispersing support across fragmented schemes. **A National Care Services Mission, aligned with the vision of *Viksit Bharat,*** can provide the anchor for this shift, bringing together employment generation, women's workforce participation, human capital development, and social resilience under a single, outcome-driven framework. Such a mission would signal that care is not welfare expenditure, but productive investment.

The NURTURE framework outlined in this report offers a practical blueprint to operationalise this vision. By linking mission-led governance, skill pathways, regulation, technology, social protection, demand creation, and enterprise growth, it shows how India can convert an invisible workforce into a structured industry. Care is one of the few sectors with unlimited growth potential, deep employment multipliers, and direct relevance to India's long-term development goals. The choice before policymakers is no longer whether care should be prioritised, but whether India is ready to build it deliberately as part of its Viksit Bharat journey.

Care work in India is marked by experience without progression, where years of practical skill do not translate into certification, wage mobility or security, making a government-led skilling continuum, formalisation framework and salary standardisation essential to transforming care from informal labour into a respected profession

> Rosalyn Carter
>
> There are only four kinds of people in the world: Those who have been caregivers. Those who are currently caregivers. Those who will be caregivers, and those who will need a caregiver.

Defining the Care Economy in the Indian Context

The International Labour Organization defines the care economy as the set of activities and services involved in meeting the physical, mental and emotional needs of individuals across the life course. For the purposes of this Thought Leadership paper, we adopt this internationally recognised understanding but extend it to reflect India's market structure and service ecosystem. In the Indian context, paid care work spans not only childcare, eldercare, disability support, rehabilitation, mental-health services and home-based long-term care, but also wellness, traditional therapy and beauty-care professions that operate as organised vocational sectors and deliver health-adjacent services at scale.

This expanded definition is grounded in economic and service delivery considerations rather than cultural or philosophical framing. Wellness, grooming, traditional therapy and beauty-care providers constitute a significant share of India's urban service workforce, operate through formal and semi-formal enterprises, and meet rising demand for physical, emotional and functional well-being—particularly among working households, older adults and individuals managing stress or chronic conditions. Including these roles enables a more accurate representation of India's paid care ecosystem and captures a wider economic base undergoing rapid growth, skill diversification and enterprise formalization.

Accordingly, for this paper, **the care economy is defined as the system of paid services and professions that support the health, well-being and daily living needs of individuals across the life course,** delivered through both organised and unorganised providers. This encompasses childcare, eldercare, disability support, home-based long-term care, rehabilitation, mental-health and palliative services, as well as wellness, grooming and traditional therapeutic services and the enterprises that coordinate and deliver them. Positioned as a labor-intensive and demand-driven sector, the care economy represents one of India's most significant opportunities for employment generation, enterprise development and inclusive economic growth.

With a clearer definition in place, the next question is unavoidable: if the care economy is this extensive and fast-growing, why does so little of it appear in India's economic planning?

India's paid care economy is not a single workforce, it is a constellation of people whose skills, roles and daily realities look very different, but whose work keeps households and cities running. We examine the full spectrum of workers who make up the care ecosystem: those providing basic assistance with daily living, those delivering structured rehabilitation or therapeutic support, those offering specialized clinical or mental-health care, and those running or managing care enterprises themselves.

> The care economy is the system of paid services and professions that support the health, well-being and daily living needs of individuals across the life course, delivered through both organised and unorganised providers.

- Domestic Help
- Live-In Full Time help
- Live-Out Full Time help
- Beauty Assistant
- Eldercare Sitter
- Childcare Assistant
- Rehab Aides
- Special Needs Workers
- Senior Living Facility Staff
- Beauty and Wellness Tech
- Certified Nursing Assistant
- Counselor
- Palliative Assistant

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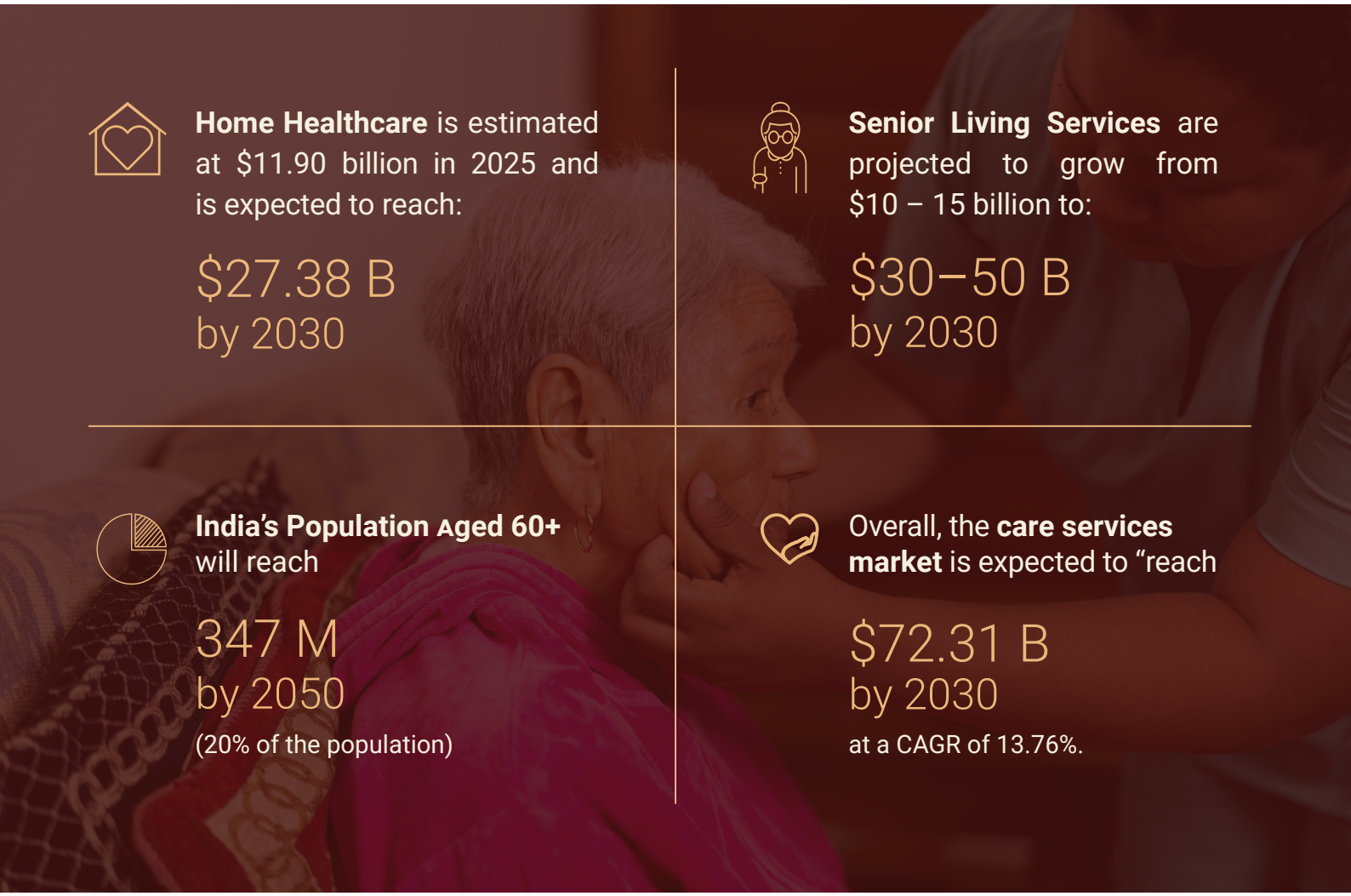
The Care Sector Market—What We See and What We Don't See

India's paid care economy is scaling rapidly, yet most of its activity remains outside formal measurement. Home healthcare "is estimated at USD 11.90 billion in 2025 and expected to reach USD 27.38 billion by 2030," senior living services are projected to grow from "USD 10–15 billion to USD 30–50 billion," and India's population aged 60+ will reach "347 million by 2050 (20% of the population)." Overall, the care services market is expected to "reach USD 72.31 billion by 2030 at a CAGR of 13.76%."[3]



Home Healthcare is estimated at $11.90 billion in 2025 and is expected to reach:

$27.38 B
by 2030

Senior Living Services are projected to grow from $10 – 15 billion to:

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India's Population Aged 60+ will reach

347 M
by 2050
(20% of the population)

Overall, the **care services market** is expected to "reach

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But these numbers reflect only what the formal market can see. UNFPA notes that senior care services remain "highly fragmented with the majority delivered by small, informal providers," and Oxfam India observes that care work is "overwhelmingly informal, with low levels of regulation and weak systems of worker protection." Large portions of the workforce are hired directly by households or operate through micro-agencies that never enter tax, labour, or enterprise datasets.

The result is a clear disconnect: a sector growing at double-digit rates but largely absent from national accounts. This invisibility limits India's ability to plan for workforce needs, design long-term care insurance, or build a structured service ecosystem. Until care work is counted, the sector cannot become the organised, investable industry India now requires.

Ripple effects of accounting for care work in the formal economy

Bringing paid care work into the formal economy does more than correct a statistical gap — it unlocks the ability to plan, finance and scale the services India increasingly depends on. Countries that measure care properly treat it as economic infrastructure, not an afterthought. In the United States, labour projections openly reflect this priority: the Bureau of Labor Statistics notes that "employment of home health and personal care aides is projected to grow 17% from 2024 to 2034, much faster than the average, with about 765,800 openings each year."[4] Accurate measurement allows governments to anticipate workforce shortages, expand training pipelines and prepare for long-term demand.

Insurance-led care systems show the same pattern. Japan's Long-Term Care Insurance (LTCI) exists because the state first established a formal needs-assessment process — users must "acquire a certification of needed long-term care or support to receive care services."[5] South Korea reached similar outcomes; academic evaluations find that LTCI "has enhanced the conditions of eldercare workers and created employment opportunities"[6] and even "created a new employment category of paid family care workers."[7] In both countries, financing models were possible only because demand was visible, quantified and institutionally recognized.

The statistical backbone for this visibility is often a satellite account. As the UN System of National Accounts explains, satellite accounts allow countries to "record production, consumption and capital formation of specific activities without overburdening the central system." Many nations use them for tourism, health and long-term care. For India, a satellite account for paid care services would finally capture the gross value added, employment and enterprise activity that currently remain outside tax, labour or enterprise records. In doing so, it would give India what it currently lacks: a reliable foundation on which to build financing mechanisms, skill pathways and long-term care infrastructure for a sector that is already central to daily life.

The demographic curve: Ageing, rising NCDs, childcare demand and urban migration

India's demographic transition is reshaping the very foundation of care demand. The UNFPA Ageing Report describes a profound structural shift: "the number of elderly population is expected to reach 347 million by 2050, constituting 20.8% of the total population." NITI Aayog's Senior Care Reforms in India echoes this trajectory, projecting that the "60+ population will nearly double from 138 million in 2021 to 235 million in 2031."[8] This is not a distant future, it is an imminent reality that places sustained pressure on assisted living, home-based recovery, post-hospitalization support and day-to-day eldercare.

At the same time, India is facing an epidemiological transition that pushes care needs beyond hospitals and into homes. The OECD's comparative review notes that non-communicable diseases account for "nearly 60% of all deaths in India,"[9] converting what were once episodic medical needs into long-term care requirements:

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physiotherapy, rehabilitation, palliative support, and daily living assistance. JLL reports that India's senior living sector is set to "skyrocket over 300 percent by 2030," particularly in cities outside the metros where service gaps are widest.

Childcare follows the same pattern at the other end of the course. As more households depend on dual incomes, structured early childcare becomes economically essential. The ILO notes that increased investment in care could "create almost 300 million jobs globally by 2035," a significant share of which lie in early childhood and home-based care underscoring how childcare is as labor-intensive, and as infrastructure-heavy, as eldercare.

Urban migration amplifies these pressures further. Movement from Tier 2 and Tier 3 cities into metros erodes traditional family-based support systems, leaving households with no choice but to rely on paid care for children, older adults and individuals recovering from illness. Care needs that were once informal and absorbed within extended families now translate directly into paid service demand.

Ageing, chronic disease, childcare needs and urban migration are converting private household pressures into sustained market demand, requiring trained workers, regulated enterprises and scalable service models. The demographic curve is not just a social transition; it is one of the strongest economic drivers of India's paid care sector.

The untapped potential of the care economy as a triple dividend: economic growth, gender equality, and human capital development

The paid care economy yields a three-part dividend: direct output and jobs, increased labour supply through reliable care services, and durable gains in skills and health that raise productivity over the course of life.

a. **Economic growth and jobs:** Global evidence indicates that scaled investment in organised care services converts directly into employment and output. The ILO estimates that investing in care **"could generate up to 299 million jobs by 2035."**[10] International Labour Organization for India, mainstreaming paid care as a service industry aligns with this jobs-to-growth channel.

b. **Labour supply and gender equality:** When childcare, eldercare and long-term care are available and affordable, more working-age adults can enter and remain in paid work. A World Bank review finds that studies examining access to institutional childcare **"impacts mothers' labor market engagement in lower- and middle-income countries."**[11] World Bank Macroeconomic modeling points to material upside: McKinsey estimated that closing key gender gaps **"could add Rs 46 lakh crore ($700 billion) to India's GDP in 2025,"**[12] with most gains coming from higher female participation. The Economic Times. In short, a reliable paid care infrastructure functions as a labour-market enabler.

c. **Human capital and productivity:** Care services preserve and extend the productive lifespan of the population. The OECD highlights that long-term care systems are essential for ageing societies because they **"support people to maintain independence, quality of life and productivity for as long as possible."** The World Health Organization similarly notes that rehabilitation and community-based care **"enable people to return to work and education more quickly, improving overall economic productivity."** In this sense, paid care is a form of human-capital maintenance—protecting the economy from productivity losses associated with illness, dependency, or premature exit from the labour force.

While care work has traditionally been low-paid due to informality and invisibility, evidence from organised care services, certified roles, and platform-based delivery shows that **formal care jobs offer higher and more predictable incomes than informal domestic work and comparable low-skill service occupations,** with clear pathways for wage progression through training and certification.

What This Study Seeks to Understand?

Understanding these structural pressures is only the first step; the next is to study the sector with enough clarity and depth to know what must be built, and how. To design the sector India now needs, this study takes an evidence-led approach to understanding its workforce, enterprises, and service ecosystem. The objectives are fourfold:

Quantify and qualify the care economy's economic footprint

To map the sector's role in India's growth trajectory by analyzing market size, labor absorption patterns, enterprise structures, and service demand across home healthcare, rehabilitation, senior living, wellness and other paid care segments.

Understand worker experiences across the skill spectrum

To document the challenges, aspirations and working conditions of care workers at all skill levels from entry-level aides to mid-level technicians to specialized practitioners with attention to wages, stability, mobility, training access and workplace norms.

Compare formal and informal care work

To examine differences in employment arrangements, job security, regulatory compliance, benefits access, and quality assurance across formal enterprises, care agencies and unregulated intermediaries that dominate service delivery.

Identify policy pathways for sectoral formalisation and growth

To propose actionable mechanisms for workforce certification, enterprise regulation, financing and insurance models, and quality standards, alongside institutional coordination needed to build the care economy as a structured, scalable sector.

Who This Study Listens To?

To capture this diversity, the study uses thirteen occupational personas that together reflect the core of India's paid care sector. They range from entry-level home-care aides, childcare assistants and elder companions to mid-level rehabilitative and wellness practitioners, to advanced clinical roles such as certified nursing assistants, counselors and palliative-care workers. We also include care-agency owners and aggregators whose managerial and entrepreneurial decisions shape how services are delivered.

Studying this full spectrum allows us to understand the sector as it actually functions which are distributed, varied, deeply human, and evolving rather than as a narrow category of formal healthcare roles.

Entry-level / low-skill (short training, often informal)

The jobs of domestic workers, both live-in and live-out helps, elder sitters or companions, and beauty assistants may be classified as "low skilled," but they are, in practice, the backbone of the care ecosystem. They enable millions of households to balance employment and family responsibilities, and without their labour, national productivity would suffer.

"Domestic help" covers a wide spectrum of roles and constitutes one of the largest informal workforces in India, dominated by women. Because these jobs exist across both urban and rural environments, the estimated number of people engaged in domestic services is ~43.9 million[13], with most working in multiple households. Rapid urbanisation and the rise of nuclear families have concentrated this workforce in metropolitan cities, where the average salary is around ₹5,000 per month[14].

"Live-out" helps carry the burden of day-to-day household routines so that families, especially women, can pursue paid work. These workers usually support one family full-time and often handle responsibilities beyond basic chores — including meal planning, grocery shopping, and overall home management. There are currently approximately 2 million workers in this category earning an average monthly wage of ₹15,000.

"Live-in" helps have even more complex responsibilities, supporting home maintenance, childcare, and eldercare round the clock. Demand for this workforce has risen sharply in urban India as more women enter the formal labour market. A survey estimates ~35,000 workers in this category, earning an average of ₹20,000 per month.

The overall domestic work market, including part-time, live-in, and live-out helps is increasing at a 10 – 11% CAGR[15]. Currently, the industry stands at ~$29.66 billion and is estimated to reach ~$48.95 billion by 2030.

~$48.95 Billion

is the expected reach of the domestic work market by 2030 from ~$29.66 billion currently. This market, including part-time, live-in, and live-out helps, is increasing at a 10 – 11% CAGR

Increasing youth migration to Tier-1 cities and abroad has left many elderly without family support, fueling growth in the elder sitter and companion workforce. Their role typically includes assistance with activities of daily living, medication and diet management, and light mobility exercises such as walking and passive joint movements. India has approximately 149 million people aged 60+, of whom 75% live in rural areas[16]. A NITI Aayog study indicates that 24% of the elderly require assistance, translating to a need for ~11,62,000 elder sitters / companions[17]. Working usually with a single family for about 8 hours daily, they earn around ₹11,000 per month. Given rising demand, this segment is expanding at a 7–9% CAGR and is expected to reach $2.41 billion by 2030.

$2.41 Billion

is the expected reach of the domestic help segment by 2030. Driven by rising demand, the market is expanding at a CAGR of 7–9%.

"Beauty assistants" form a fast-growing segment of India's care workforce, offering personal grooming and wellness services that directly support individual dignity, confidence, and social presence. Many operate door-to-door through informal networks or gig platforms, bringing accessible services into homes and saving clients' time. Rising incomes in Tier-1 and Tier-2 cities have driven rapid demand growth. Although their work is often undervalued, it requires skill, hygiene awareness, and strong client trust. This ~$9.29 billion informal industry employs ~8.6 million workers[18] and is projected to grow at an 8.5% CAGR, reaching ~$13.9 billion by 2030.

~$13.9 Billion

is the expected reach of the beauty assistants segment by 2030. This ~$9.29 billion informal industry employs ~8.6 million workers and is projected to grow at an 8.5% CAGR

India's "Group 1" Care Workforce: Spectrum of Roles and Growth

Domestic Workforce (Largest informal workforce)

Wide spectrum, urban and rural. Dominated by women.

~43.9 M	~₹5,000	Often work in multiple households
People engaged in domestic services	Average salary per month	

Overall Domestic Work Market (Part-time, Live-in, Live-out)

~$29.66 B Current — CAGR: 10 –11% — **~$48.95 B** 2030 Estimate

Live-Out and Live-In Help (Specialized support)

Live-Out Help: Full-time support, household routines, home management.

Live-In Help: Round the clock, complex responsibilities, childcare, eldercare.

~2 Million	~₹15,000	~35,000	~₹20,000
Workers	Average wage per month	Workers	Average wage per month

Demand driven by women entering formal labour market

Elder Sitters / Companions (Rising demand)

Assistance with daily living medication, mobility. Driven by youth migration.

Market Growth

Current — CAGR: 7 – 9% — **$2.41 B** 2030 Estimate

~149 M	~11,62,000	24%	~₹11,000
Elderly population (60+). (75% rural)	Need for sitters	Elderly requiring assistance	Average wage per month (approx. 8 hours daily)

Beauty Assistants (Fast-growing segment)

Personal grooming, wellness, door-to-door/ gig platforms. Skilled, builds trust.

Demand growth driven by rising incomes in Tier-1 and Tier-2 cities

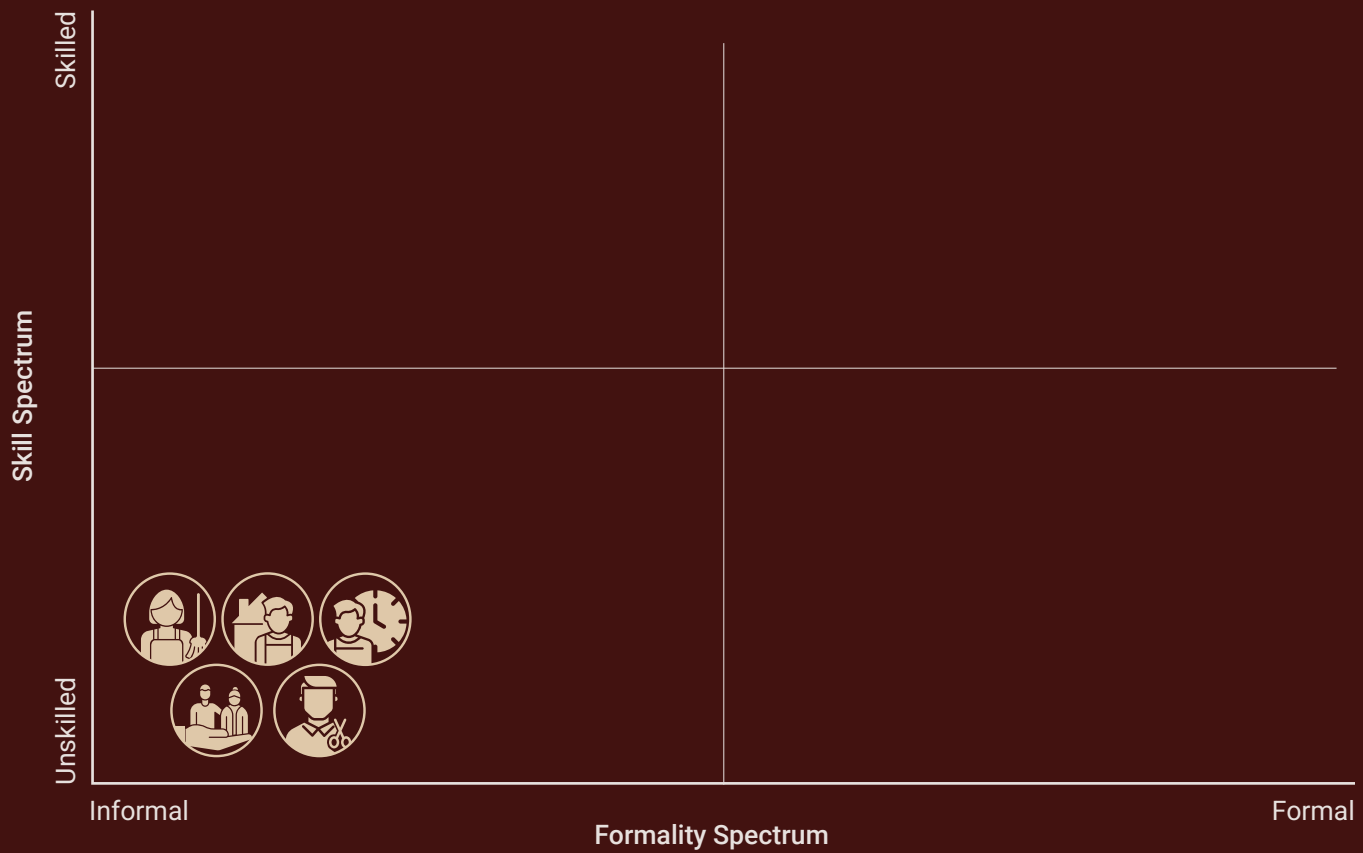
~9.29 B	~8.6 M
Informal Industry Size	Workforce

Market Growth

Current — CAGR: 8.5% — **~$13.9 B** 2030 Estimate

Current Framework for the "Group 1" Care Workforce

The framework analyses the care-giving landscape and plots it on the axes of skill and formalisation



Domestic Help

Live-In Full Time help

Live-Out Full Time help

Beauty Assistant

Eldercare Sitter

> I need regulated wages and social security to ensure my daughter has the stable future I was denied.

Pushpa Rani

Age: 35 years

Gender: Female

Location: Multiple houses

Type of work: Domestic Help

Employment type: Self-employed

Hours of work: 11-12 hrs

Income stability: Inconsistent

Pushpa, a domestic worker, is employed across three households. She faces financial instability and food insecurity due to irregular pay. She lacks documents. Operating without social security or sick leave, she reports that illness results in immediate wage deductions and medical debt. She advocates for structural labour rights, specifically regulated wages, pensions, and medical aid, aiming to secure social mobility for her daughter.

PERSONA

> I give a full day to one home but return exhausted with no energy left for my own family. I fear that what will happen if the single salary I depend on disappears.

Sarita Verma

Age: 40 years

Gender: Female

Location: Single Household

Type of work: Domestic Help/ Housekeeper

Employment type: Hired by one family

Hours of work: 11–12 hrs (Early morning to late night)

Income stability: Partially stable but insecure

Sarita works full-time in one household, handling cooking, cleaning, grocery management, and daily upkeep. Although she does not live at her employer's home, her work hours often extend late into the night. Her working hours are undefined, sometimes spanning from 6:00 AM to past 9:00 PM. Returning home late makes her evenings difficult, leaving little energy for her own family. She hopes for fixed work hours, safer travel arrangements, and some financial security so that dependence on a single employer does not put her at risk.

PERSONA

> I need clear legal boundaries for working hours, as living in the current situation forces me to be on call 24/7. I have no personal freedom and limited family connection.

Radha Gupta

Age: 30 years

Gender: Female

Location: Single Household

Type of work: Domestic Help/ Housekeeper

Employment type: Hired by one family

Hours of work: No defined period of rest.

Income stability: Partially stable but insecure

Radha lives in her employer's home and provides round-the-clock care for a toddler. She manages feeding, hygiene, sleep routines, and travel support. Because she stays at the workplace, she rarely gets uninterrupted rest and must respond even at night. Her personal space is limited, and she misses regular contact with her own child. The lack of defined "off-duty" hours makes her feel constantly on call. She wants clear work boundaries, privacy, and recognition that live-in workers also need personal time and dignity.

PERSONA

> I carry out the toughest salon work yet remain a ‘helper’ because my talent is unrecognized without a certificate.

Kavita Narayan

Age: 24 years

Gender: Female

Location: A Beauty Salon

Type of work: Beauty Assistant

Employment type: Hired by the Salon Owner

Hours of work: 8-10 hrs

Income stability: Partially stable but insecure

Kavita works in a salon, handling tasks like waxing, scrubbing, and preparing clients for treatments. She often deals with strong chemicals and long hours, which cause fatigue and discomfort. Despite learning hair and styling techniques through observation, she cannot advance because she lacks a formal certificate. Senior stylists earn significantly more for shorter tasks, while she remains in a support role. She hopes for practical training opportunities, safety measures in the workplace, and a recognised qualification that allows her to grow as a professional stylist.

PERSONA

> I care for those in ailing, but when my patient dies, my job ends too. I don't get rest, respect, or protection for my own aging body.

Suresh Kumar

Age: 35 years

Gender: Male

Location: Single Household

Type of work: Eldercare Sitters

Employment type: Hired by the Household through an agency

Hours of work: No defined period of rest.

Income stability: Partially stable but insecure

Suresh works as an Eldercare Sitter, supporting elderly clients with daily activities, safety, and companionship. His tasks include lifting, feeding, and monitoring medication. The work is physically tiring, and he has no insurance to manage his own health issues. When a client passes away, his job ends immediately, leaving him without income. Long shifts and constant responsibility give him little rest. He wishes for better pay that reflects the medical complexity of his work, mechanical tools to prevent injury, and a small financial buffer after each assignment.

PERSONA

Challenges Faced and Aspirations Ahead: Insights into the Care Workforce (Group I)

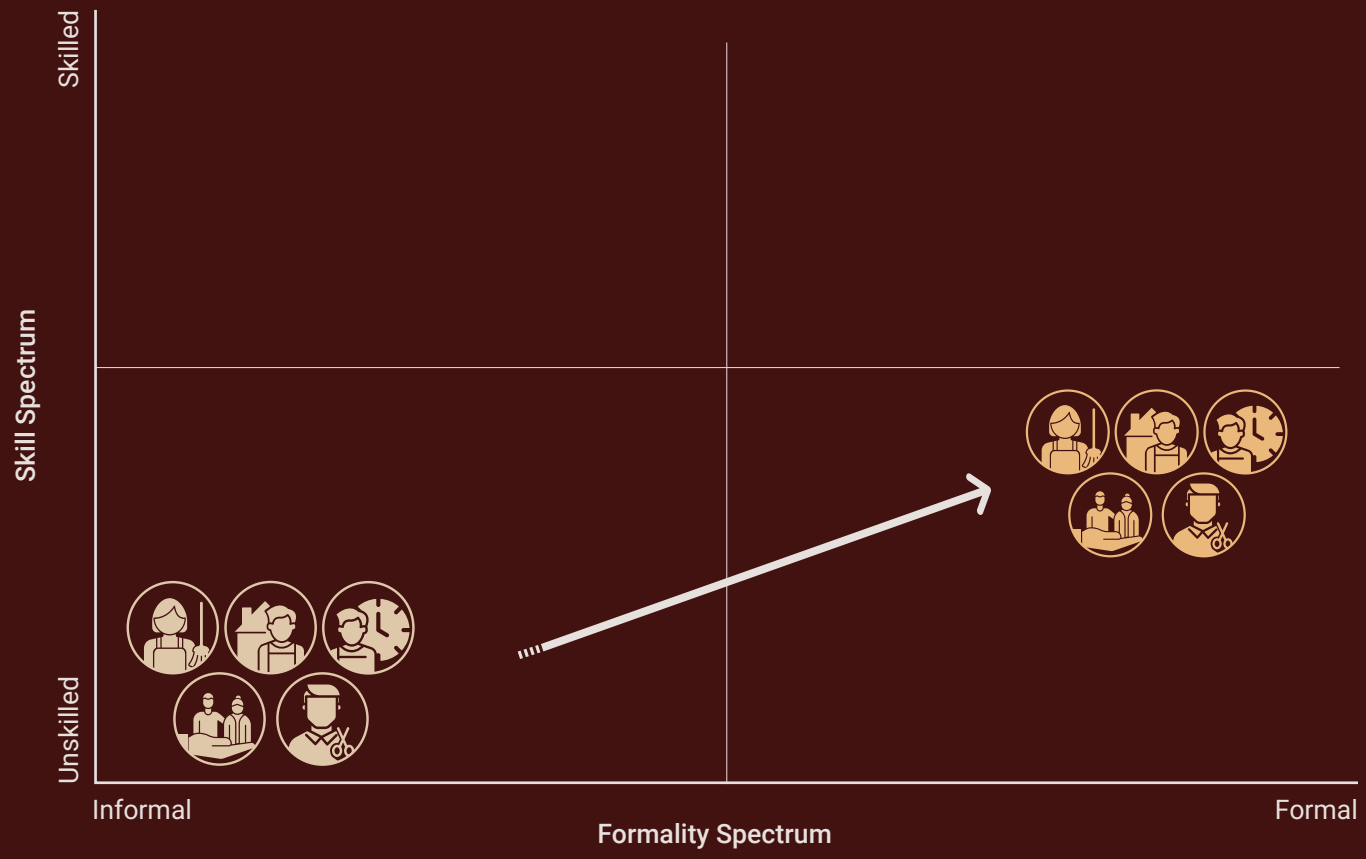




Domestic Help	Live-out Help	Live-in Help	Beauty Assistant	Eldercare Sitter
Employment Type				
Self-employed (Multi-household)	Hired by Household	Hired by Household	Hired by Salon	Agency Hired
Hours of Work				
11–12 hrs (Fragmented)	11–12 hrs (Undefined "full time")	24/7 Availability	8–10 hrs	24/7 Availability
Income Stability				
Inconsistent	Partially Stable (High risk)	Partially Stable	Partially Stable	Partially Stable
Wages / Payment				
Cash/Direct (Delayed)	Monthly Salary	Monthly Salary + Room/Board	Low Salary (Manual rate)	Flat Rate (Low)
Key Challenges				
• No employment documents • No Safety Net: No Health or Old Age benefit • No Savings: Borrowing for emergencies	• Dependency on a single employer • Safety Risk: Late-night and Early Morning Commute • No Time for own family	• Privacy: No personal space • Separation from own Family • No uninterrupted rest	• Health Hazard: Exposure to harsh chemicals • Paid for labour, not for skill • No Certificate to prove skill	• Physically Tiring • Job Ends instantly on death • Privacy: No personal space
Aspirations				
• Regulated wages • Old age safety net and Health Benefits • Children's education	• Fixed work hours • Safety Net • Energy for own family	• Defined rest hours • More time for own child and family • Identity beyond work	• Skill certification • Payment as per Skill and Experience • Formal training	• Formal recognition • Pension/Health benefits • Respect for duty

Targeted Framework for the "Group 1" Care Workforce

The framework analyses the caregiving landscape post policy-intervention for skilling and formalisation



Domestic Help

Live-In Full Time help

Live-Out Full Time help

Beauty Assistant

Eldercare Sitter

Semi-Skilled / Mid-Level (structured training, certification pathways)

This segment of the care workforce has grown alongside India's shift towards the demand for more professionalised services at home and increasing accessibility of facility-based care. Workers such as Early Childhood Care and Education (ECCE) workers, rehabilitation aides, senior living facility staff, special needs care workers, and beauticians and wellness technicians typically undergo structured training or certification and create a buffer between informal and formal workforce. They help prevent illness, support recovery, improve quality of life and offer families affordable alternatives to hospital-based care. Their contribution is increasingly visible in urban and peri-urban India: as more women join the workforce and as the population ages, the demand for trained childcare, eldercare and rehabilitation support is rising.

There is a rapid increase in the demand for "Early Childhood Care and Education (ECCE)" workers in creches and pre-primary and primary schools, especially in the urban settings. ECCE workers are not to be confused with teachers as they are the support staff that play an essential role in early childhood development in a more holistic manner. They support nutrition, hygiene, stimulation and safety during the most formative years of life, which in turn improves long-term learning outcomes. These necessities are fulfilled in the rural areas by *Anganwadi Workers*. At present, there are only about 3.7 million ECCE workers[19] catering to a population of 187 million children below the age of 14 years.[20] As a full-time employee, an ECCE worker can earn Rs 15,000 per month on an average. The pre-school/childcare market is growing at a 9.5% CAGR[21], which will increase the value of ECCE workers from ~$7.58 billion currently to ~$11.8 billion in 2030.

~$11.8 Billion

is the expected increase in the pre-school/childcare market by 2030 from ~$7.58 billion currently. This market is increasing at 9.5% CAGR

"Rehab aides" provide hands-on support that helps people recover from injuries, surgeries and chronic conditions outside the hospital setting. They make physiotherapy and occupational therapy more accessible and affordable, enabling patients to regain function faster and resume work and daily life. By shifting rehabilitation into homes and communities, they help reduce hospital load and accelerate return to productivity. Usually attached to a qualified physio/occupational therapist, the approximate population of rehab aides in the country is 45,000[22], catering to a population of ~411 million Indians living with a condition that would benefit from rehabilitation in a given year.[23] The average monthly income of rehab aides can be around Rs 25,000, given that they under technical training through diploma courses from formal institutions. The market for rehab work is increasing at a 15.5% CAGR as the awareness and need for physical therapy increases. This will bring the value of rehab aide work to ~$0.31 billion by 2030.

~$0.31 Billion

is the expected value of rehab aide work by 2030, as the market for rehab work is increasing at a 15.5% CAGR

As India's aging population grows, "Senior Living Facility staff" are filling a widening care gap. They provide daily living support, companionship and health monitoring, administration of routine medication and first aid for older adults who may not have family caregivers. Their presence reduces avoidable hospital visits and helps elders maintain dignity and safety, a vital function in a country undergoing a rapid demographic transition. Currently, India has fewer than 1,200 licensed and operational facilities for eldercare, which only cater to about 97,000 senior people.[24] This brings the number of qualified staff to around 16,160. The percentage of elderly population in the country is projected to double to over 20% of total population by 2050[25] and the senior living market is growing at a 27% CAGR[26], due to increasing urban migration. The market for facility staff will reach ~$0.17 billion by 2030.

~$0.17 Billion

is the expected reach of senior living market by 2030, as the market is growing at a 27% CAGR.

The percentage of elderly population in the country is projected to **double to over 20% of total population by 2050**

Families caring for children or adults with disabilities rely on trained support workers who understand developmental needs, behavioral strategies and assistive routines. The "Special Needs" caregivers enable greater independence and inclusion for people with disabilities, while freeing family members to maintain stable employment. Their work has both emotional and economic impact, improving quality of life and strengthening social participation. As per the 2011 Census, there are approximately 26.8 million people with disabilities in India. Estimates from a 2018 National Sample Survey (NSS) indicated that around 62% of PWDs used the services of a caregiver. According to the NSS survey, 0.60% hired home-based caregivers and 0.36% opted for institutional caregivers.[27] There is a huge demand for special needs caregivers however, most of them depend on family members as the total pool of professionals is only around 181,000. Given their higher technical training and majorly formalised setting, the average monthly income is Rs 22,000.[28] Due to lack of awareness, the market for Special Needs caregivers is ~$0.73 billion currently but is expected to grow at a 15% CAGR to reach ~$1.47 billion by 2030.

~$1.47 Billion

is the expected growth of Special Needs caregivers market by 2030 from ~$0.73 billion currently. This market is expected to grow at a 15% CAGR.

The “Beauty and Wellness” workforce is central to India’s booming personal care market, offering affordable beauty and wellness services both at home and in neighborhood salons. Their work supports confidence, social participation and mental well-being, while also creating one of the most accessible employment pathways for young women from lower-income backgrounds. As platform-based home services expand across cities, these workers represent a rapidly professionalising segment of the care economy. This is a major employer, especially for women, with approximately 3.4 million workers with an average salary of Rs 18,000. The beauty services market is increasing at a compound annual growth rate of 8.5%[29], bringing the value of the workforce to ~$12.5 billion by 2030.

~$12.5 Billion

is the expected value of the workforce of the beauty services market by 2030, as the result of the increasing compound annual growth rate of 8.5%

India's "Group 2" Care Workforce: Spectrum of Roles and Growth

Childcare Assistant (Early childhood development Support)

Workers in creches and pre-primary and primary schools, especially in the urban settings. These necessities are fulfilled in the rural areas by Anganwadi Workers

3.7 M	~187 M	~₹15,000
ECCE workers	Children supported	Average salary per month

Pre-School / Childcare Market

~$7.58 B Current — CAGR: 9.5% — **~11.8 B** 2030 Estimate

Rehab Aide (Attached to physio / occupational therapist)

Provide hands-on support to recover from injuries, surgeries and chronic conditions outside the hospital setting.

~45,000	~411 M	~₹25,000
Rehab aides in the country	Indians with a condition catered	Average wage per month

Rehab Aide Work Market

Current — CAGR: 15.5% — **~$0.31 B** 2030 Estimate

Senior Living Facility Staff (Filling a widening care gap)

Provide daily living support, companionship, and health monitoring, administration of routine medication and first aid for older adults

<1,200	97,000	16,160
Operational facilities in India	Senior people catered	Qualified staff

Senior Living Facility Staff Market

Current — CAGR: 27% — **~$0.17 B** 2030 Estimate

Special Needs Caregivers (Trained support workers)

Enable greater independence and inclusion for people with disabilities

62%	181,000	~₹22,000
PWDs used caregiver services	Pool of Professionals	Average wage per month

Special Needs Caregivers Market

~0.73 B Current — CAGR: 15% — **~$1.47 B** 2030 Estimate

Beauty and Wellness Technicians (India's booming personal care market)

Offers affordable beauty and wellness services both at home and in neighborhood salons

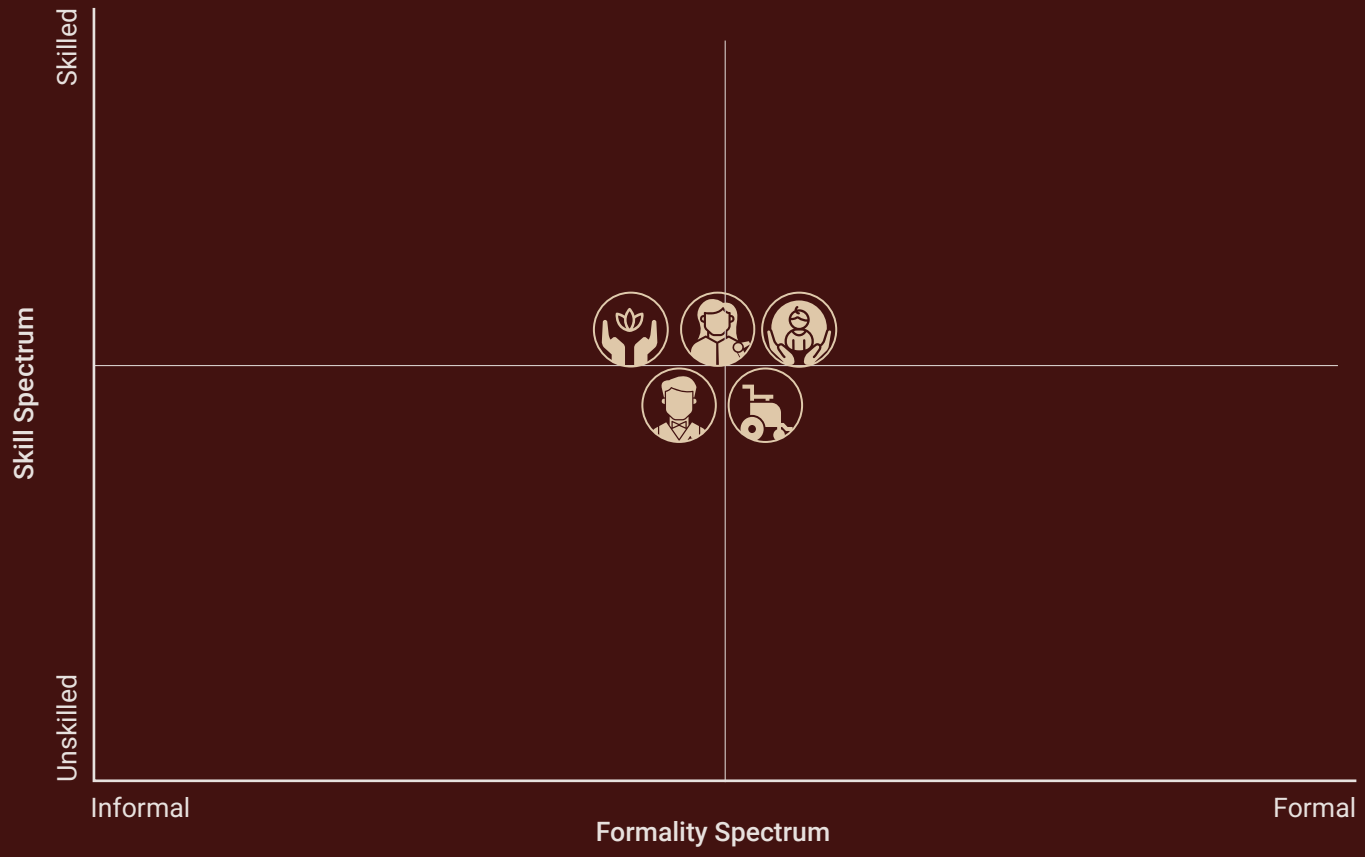
This is a major employer for women with low income background	~3.4 M	~₹18,000
	Workers	Average wage per month

Beauty Services Market

Current — CAGR: 8.5% — **~$12.5 B** 2030 Estimate

Current Framework for the “Group 2” Care Workforce

The framework analyses the care-giving landscape and plots it on the axes of skill and formalisation



Childcare Assistant

Rehab Aides

Special Needs Workers

Senior Living Facility Staff

Beauty and Wellness Tech

> I raise other people's children while my own wait for me, yet my love and labour vanish the moment the child grows up.

Neha Gupta

Age: 27 years

Gender: Female

Location: Playschool

Type of work: Childcare Assistant

Employment type: Hired by the play school

Income stability: Partially stable but insecure

Neha works as a Childcare Assistant in a playschool and also takes babysitting jobs on short notice. She spends her day caring for young children, helping them play, learn, and stay safe. While she grows close to the children, she knows her job ends once they start school. She has no job security or benefits, and illness can affect her pay. The emotional connection makes leaving difficult, and she often misses time with her own children. She hopes childcare workers are recognised as caregivers and given more stable support and protection.

PERSONA

> I heal others through heavy labour, yet remain unprotected, underpaid, and unseen as anything more than strong hands.

Manoj

Age: 33 years

Gender: Male

Location: A Rehabilitation Center

Type of work: Rehabilitation Aide Assistant

Employment type: Hired by the physiotherapist

Income stability: Partially stable but insecure

Manoj assists patients recovering from surgery by providing exercises, transfers, and physical training. His work involves lifting and supporting patients, which often strains his body. Although agencies charge high fees, he receives only a small share. If a patient slips or an accident occurs, he is usually blamed despite having no insurance or legal protection. He feels his skills are not seen as medical expertise. He hopes for proper training, safety equipment, transparent pay, and recognition that his role requires specialised physical and technical knowledge.

PERSONA

> I care for fifteen elders at once, racing against call bells while my own body breaks without support.

Arjun Singh

Age: 45 years

Gender: Male

Location: Senior Living Facility (Old Age Home)

Type of work: Senior Living Facility Assistant

Employment type: Hired by the facility.

Hours of work: 11–12 hrs

Income stability: Stable but not secure

Arjun works in a senior living facility, beginning early in the morning and supporting many residents at once. His tasks include bathing, feeding, lifting, and responding to constant call-bell requests. The workload is heavy, and he often feels rushed, even though some residents need slow, careful attention. He fears self-injuries due to frequent lifting and has no health benefits. With many residents depending on him, he feels stretched and unable to give each person the care they deserve. He hopes for safer equipment, smaller groups, and better support for his physical well-being. Having worked at the same place for the last 15 years, he feels stagnant with no career growth.

PERSONA

> I manage complex behavioral crises daily, yet my skill remains invisible because I lack a formal certificate.

Anjali Pradhan

Age: 26 years

Gender: Female

Location: Single Household

Type of work: Special Needs Assistant

Employment type: Freelancer

Hours of work: 8–10hrs

Income stability: Inconsistent

Anjali works as a shadow teacher and Special Needs Assistant for children with special needs. She helps them manage sensory challenges, behavior, and learning activities, often spending long hours supporting one child. Her schedule is unstable due to cancellations and constant travel. Although she demonstrates patience and observation skills, her work is often considered unskilled because she lacks formal certification. She wants structured training, recognition of her ability to understand children's needs, and a more straightforward career path that values her contribution beyond basic caregiving.

PERSONA

> I'm trusted with machines that can burn skin, but never given the training that could protect both my clients and my job.

Vedant Pathak

Age: 29 years

Gender: Male

Location: Wellness Clinic

Type of work: Wellness Technician

Employment type: Hired by Center

Hours of work: 10 hrs

Income stability: Partially Stable but insecure

Vedant operates machines and performs basic wellness treatments like massages, reflexology, and laser procedures. Though he handles expensive equipment, he received very little formal training and worries about accidental harm to clients. He has learned many techniques through experience but lacks certificates to prove his skill. His shifts often stretch late into the evening, and he feels limited in career growth. He hopes for proper technical education, safer protocols, and a recognised qualification that allows him to advance from manual tasks to a more specialised role.

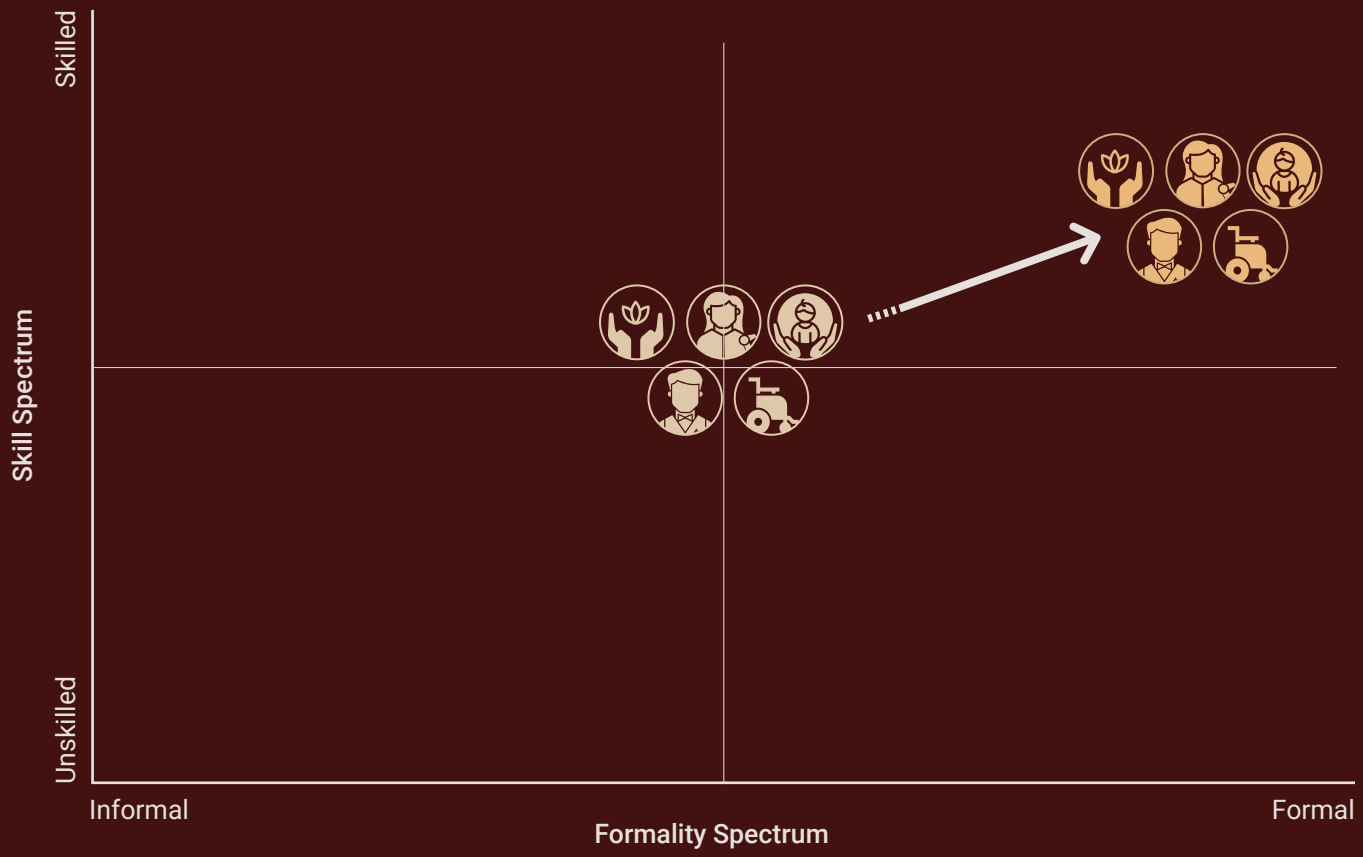
PERSONA

Challenges Faced and Aspirations Ahead: Insights into the Care Workforce (Group 2)

Childcare Assistant	Rehab Aide	Special Needs Asst	Beauty and Wellness Tech
Employment Type			
Hired by school / shifts	Agency / freelance	Freelance / shadow teacher	Hired by clinic
Hours of Work			
Shift-based / flexible	Varies (travels to homes)	Erratic	Fixed clinic hours
Income Stability			
Partially Stable	Unstable	Unstable	Partially Stable
Wages / Payment			
Hourly/shift wages	Commission (agency skims)	Hourly / session based	Monthly salary
Key Challenges			
• The job ends when the child grows • Blamed for minor accidents • No health benefits: pay cut if sick	• Physical toll: moving immobile bodies • Liability: blamed for falls	• Emotional toll • Risk physical harms / scratches / bites	• Use of Tools/Equipment without Training • Liability: Fear of burns/ injury to patient
Aspirations			
• Recognition as caregiver • Future security / pension • Severance pay	• Safety gear / insurance • Respect • Fixed salary	• Certification (paper) • Professional respect • Career growth	• Technical certification • Scientific knowledge • Expert status

Targeted Framework for the “Group 2” Care Workforce

The framework analyses the caregiving landscape post policy-intervention for skilling and formalisation



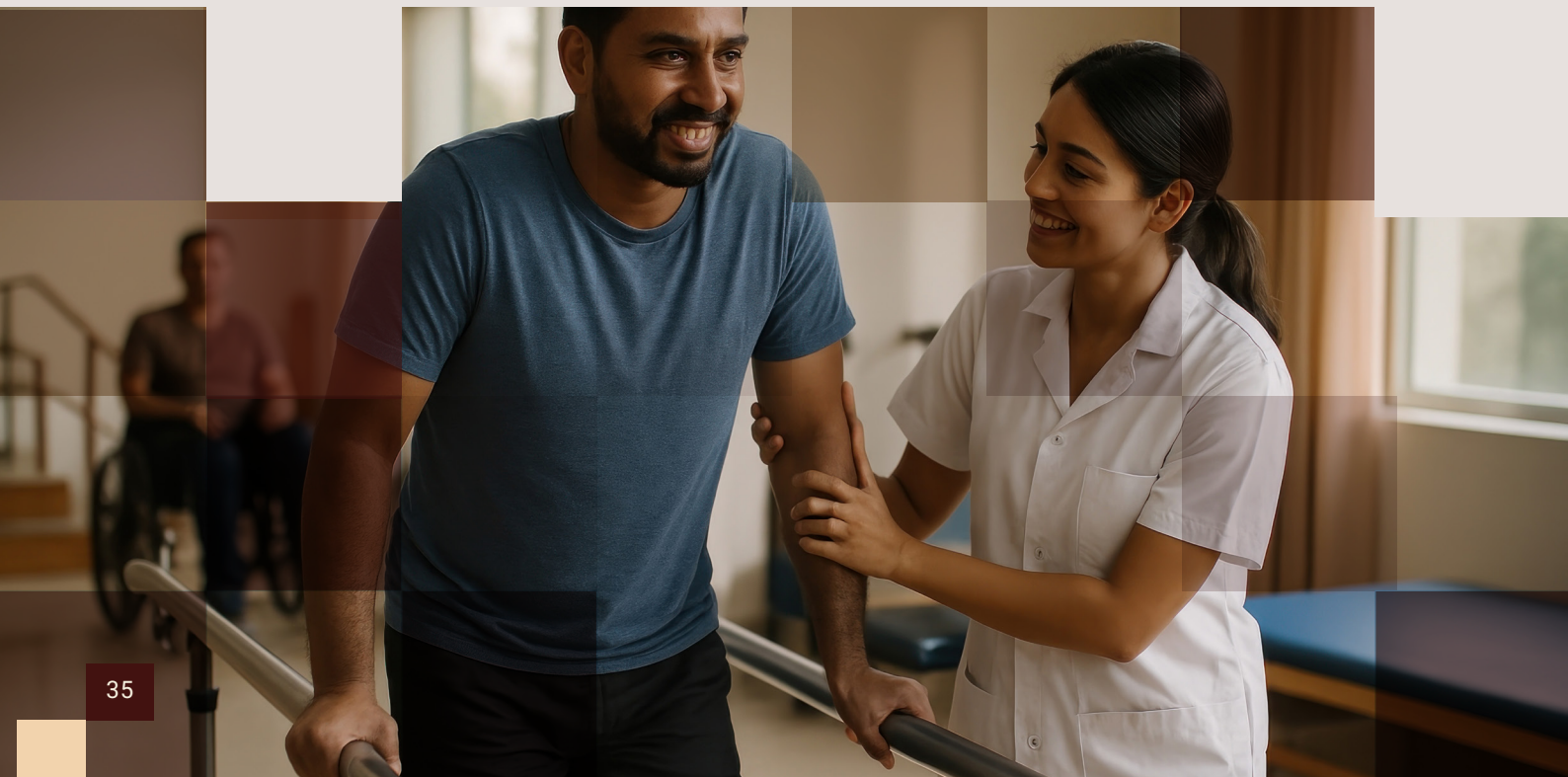
Childcare Assistant

Rehab Aides

Special Needs Workers

Senior Living Facility Staff

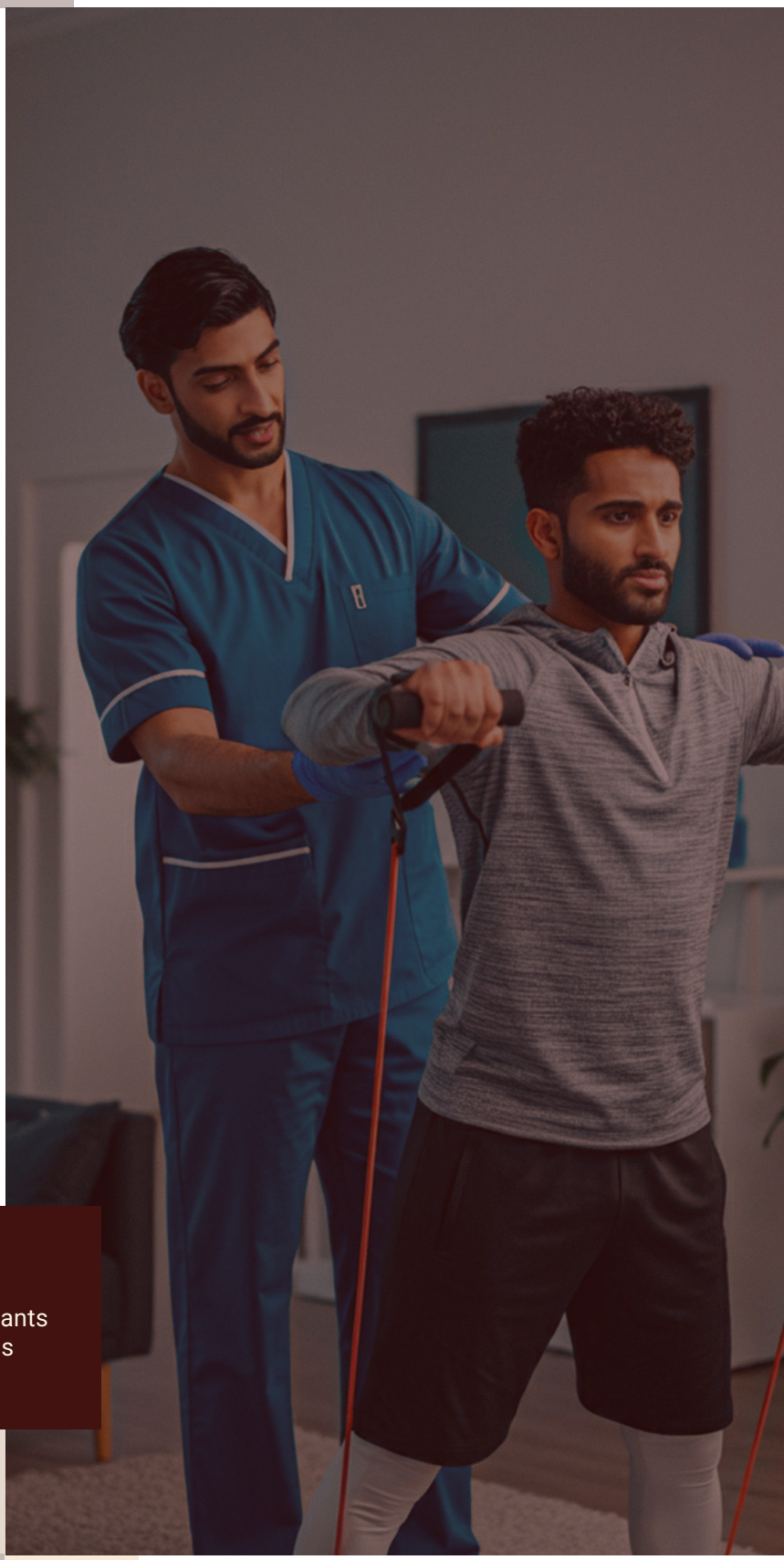
Beauty and Wellness Tech



Skilled / Advanced (formal certifications, degrees, licenses)

This advanced tier includes certified nursing assistants, counselors, community therapists and palliative care workers, all formally trained to handle complex or sensitive care needs. They work in homes and facilities to manage chronic illness, recovery and emotional well-being, reducing pressure on hospitals and helping families maintain safety and dignity. As India ages and mental health needs rise, their role is becoming essential.

"Certified Nursing Assistants" deliver essential clinical support such as monitoring vitals, assisting mobility, ensuring hygiene and helping with medication routines. They are often the ones who spend the most time with patients, noticing changes early and preventing complications. Their work enables smoother recovery at home or in long-term facilities, reducing the need for constant hospital attention and easing the physical and emotional load on families. CNAs are registered under the Rehabilitation Council of India and currently stand at 892,829 licensed professionals.[30] With the highest visibility and recognition, the current market value of the CNAs is ~$107.44 billion, growing at a CAGR of 10.2% to reach ~$175 billion by 2030.



~$175 Billion

is the expected reach of the certified nursing assistants market by 2030 from ~$107.44 billion currently. This market is growing at a CAGR of 10.2%.

"Counselors and community therapists" provide structured emotional and behavioral support for children, adolescents and adults dealing with stress, trauma, learning difficulties, addictions or mental health challenges. By improving coping skills, daily functioning and participation in school or work, they play a growing role in India's shift toward preventive mental health care, especially as stigma declines and demand accelerates. Recent data shows that there are fewer than 13,000 specialised counselors/community therapists in the registered system.[31] Given that the Indian mental health market is growing at a CAGR of 28.16%[32], the market for counselors/community therapists is estimated to reach ~$0.55 billion by 2030.

~$0.55 Billion

is the estimated reach of the counselors and community therapists market by 2030. The Indian mental health market is growing at a CAGR of 28.16%

"Palliative Care Assistants or Hospice Workers" support individuals with terminal illnesses with end-of-life care. The main aspects of their job also include providing comfort to the patient and their families and guide them through difficult decisions. Formally trained in administering medication, first aid, physical therapy, nutrition and mental health counseling, these professionals protect the caregiver from burnout from constant hospital visits and care and give a dignified life to the patients. As of November 2022, India had 847 palliative care centers, of which 526 (62.1%) were active, translating to about 4 centers per 10 million population. Since, only 477 centers had at least one healthcare worker.[33] The total number of professionals in this field are approximately only 1,700, earning an average wage of Rs 16,000 per month. The palliative care industry is growing at a CAGR of 11.1% and the market value of the human resource in the industry is estimated to be ~$7 million by 2030.

~$7 Million

is the estimated reach of the palliative care assistants market by 2030. This market is increasing at 11.1% CAGR

India's "Group 3" Care Workforce: Spectrum of Roles and Growth

Certified Nursing Assistants (Highest visibility and recognition)

Deliver essential clinical support and helping with medication routines

892,829	CNAs are registered under the Rehabilitation Council of India	**Certified Nursing Assistants Market**
Licensed professionals		~$107.44 B (Current) — CAGR: 10.2% — ~$175 B (2030 Estimate)

Counselors and Community Therapists (Specialized support)

Provide structured emotional and behavioral support for children, adolescents and adults dealing with stress, trauma, learning difficulties, addictions or mental health challenges.

<13,000	They play a growing role in India's shift toward preventive mental health care	**Counselors/Community Therapists Market**
Specialised counselors/ community therapists		Current — CAGR: 28.16% — ~$0.55 B (2030 Estimate)

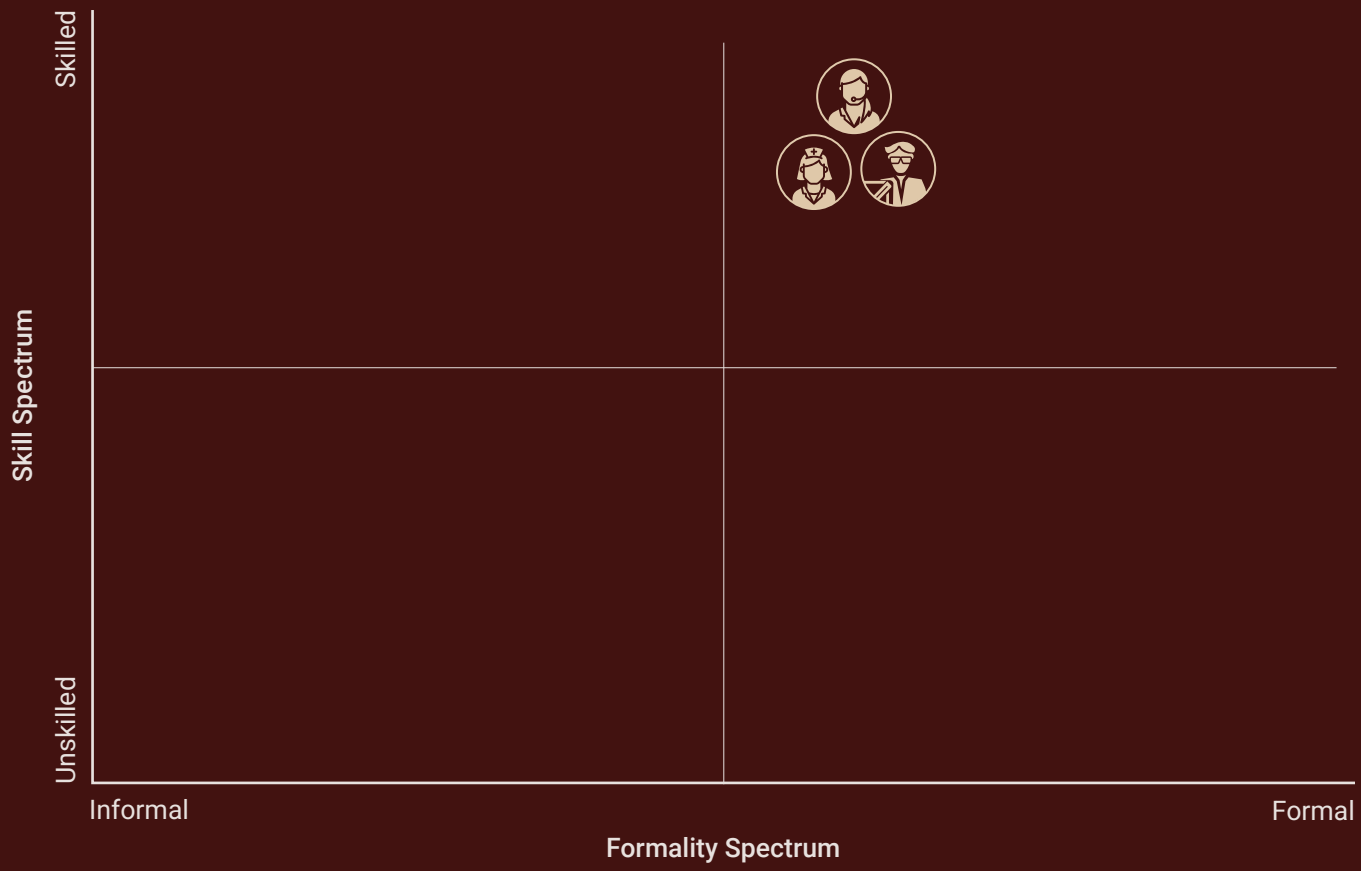
Palliative Care Assistants or Hospice Workers (Formally trained support)

Support individuals with terminal illnesses with end-of-life care

62.1%	1,700	₹16,000	**Palliative Care Market**
Active palliative care centers	Total number of professionals	Average wages per month	Current — CAGR: 11.1% — ~$7.00 M (2030 Estimate)

Current Framework for the “Group 3” Care Workforce

The framework analyses the care-giving landscape and plots it on the axes of skill and formalisation



Certified Nursing Assistant

Counselor

Palliative Assistant

> I do the hardest medical work but stay stuck at the bottom because the ladder to real nursing is locked to me.

Sunita

Age: 38 years

Gender: Female

Location: Nursing Home

Type of work: Certified Nursing Assistant

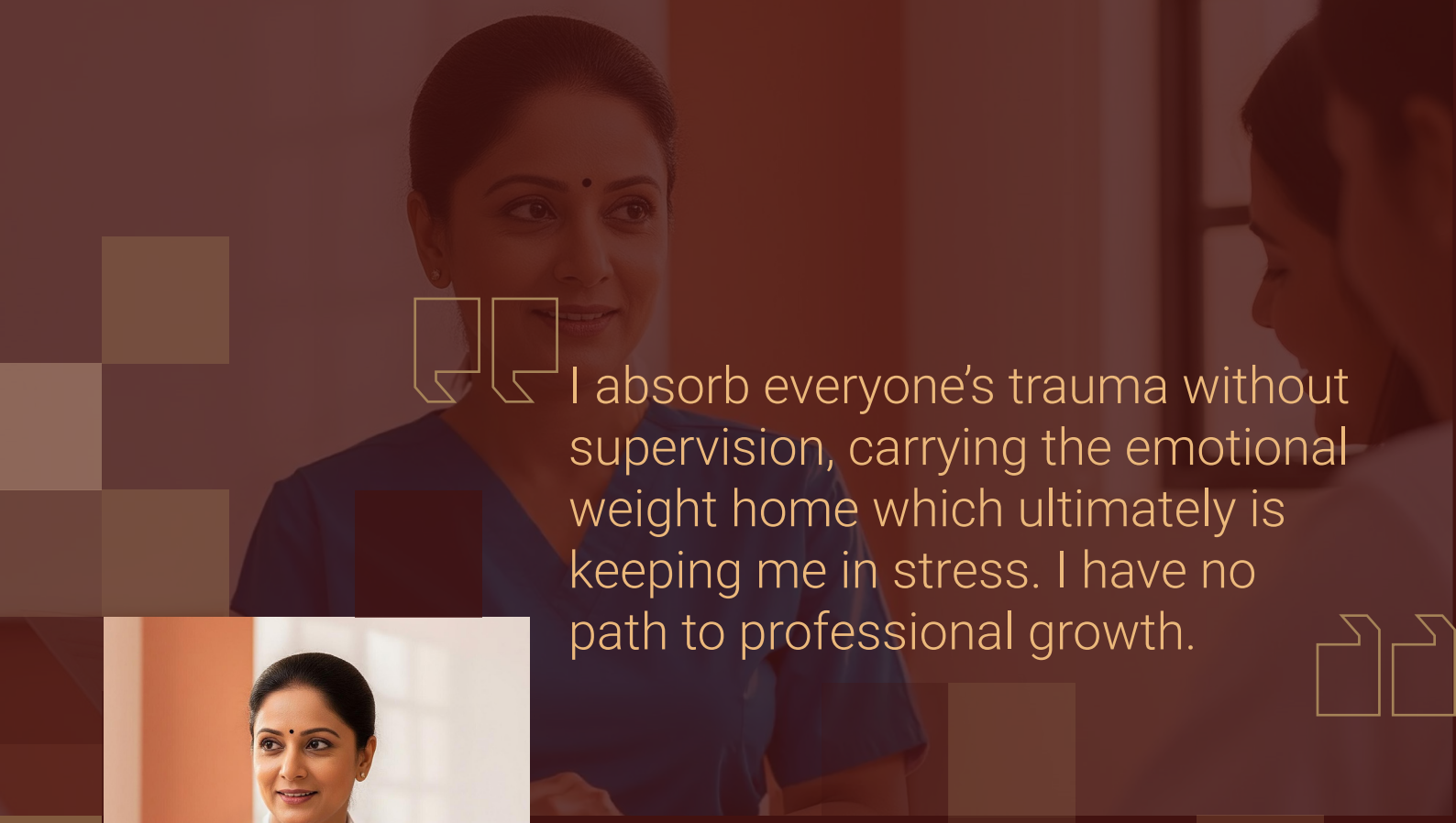
Employment type: Hired by the Nursing Home

Hours of work: 8–10 hrs (shift duty)

Income stability: Partially Stable but insecure

Sunita is a certified Nursing Assistant who monitors vitals, manages hygiene care, handles bedsores, and supports patients. Although she has formal training, her work is often treated as low-status, and her salary does not reflect the medical tasks she performs. She works long hours doing physically demanding care while more senior staff focus on administrative tasks. With limited opportunities for advancement, she feels stuck. She hopes for a pathway to study further, earn higher qualifications, and eventually move into a staff nurse role.

PERSONA



> I absorb everyone's trauma without supervision, carrying the emotional weight home which ultimately is keeping me in stress. I have no path to professional growth.

Priyal Bhatia

Age: 31 years

Gender: Female

Location: Community healthcare center

Type of work: Counselor / Therapist

Employment type: Hired by the NGO

Income stability: Partially Stable but insecure

Priyal works as a community counselor, supporting survivors of violence, addiction, and trauma. She manages unpredictable walk-in cases and handles emotionally intense conversations throughout the day. Without senior supervision, she often carries the emotional weight home, leading to stress and burnout. Although she wants to help more effectively, she lacks formal clinical training and structured support. She hopes for mentorship, short certifications in counseling methods, and opportunities to build a long-term career in mental health without compromising her own well-being.

PERSONA

> I sit with the dying, offering comfort families cannot, but my expertise in end-of-life care is treated as unskilled labour.

Ahmed Shareef

Age: 42 years

Gender: Male

Location: As a Care Home

Type of work: Palliative Care Assistant

Employment type: Hired through an agency

Income stability: Partially Stable but insecure

Ahmed supports patients during end-of-life care, helping with hygiene, pain comfort, and companionship. His assignments end immediately when the patient passes away, creating sudden income gaps. His work requires sensitive understanding of physical and emotional needs, yet it is often viewed as simple “watching.” He has many practical skills but no certification to validate them. Constant exposure to death is emotionally draining. He hopes for short formal training, recognition as a palliative care professional, and structured support to manage the emotional demands of the role

PERSONA

Challenges Faced and Aspirations Ahead: Insights into the Care Workforce (Group 3)



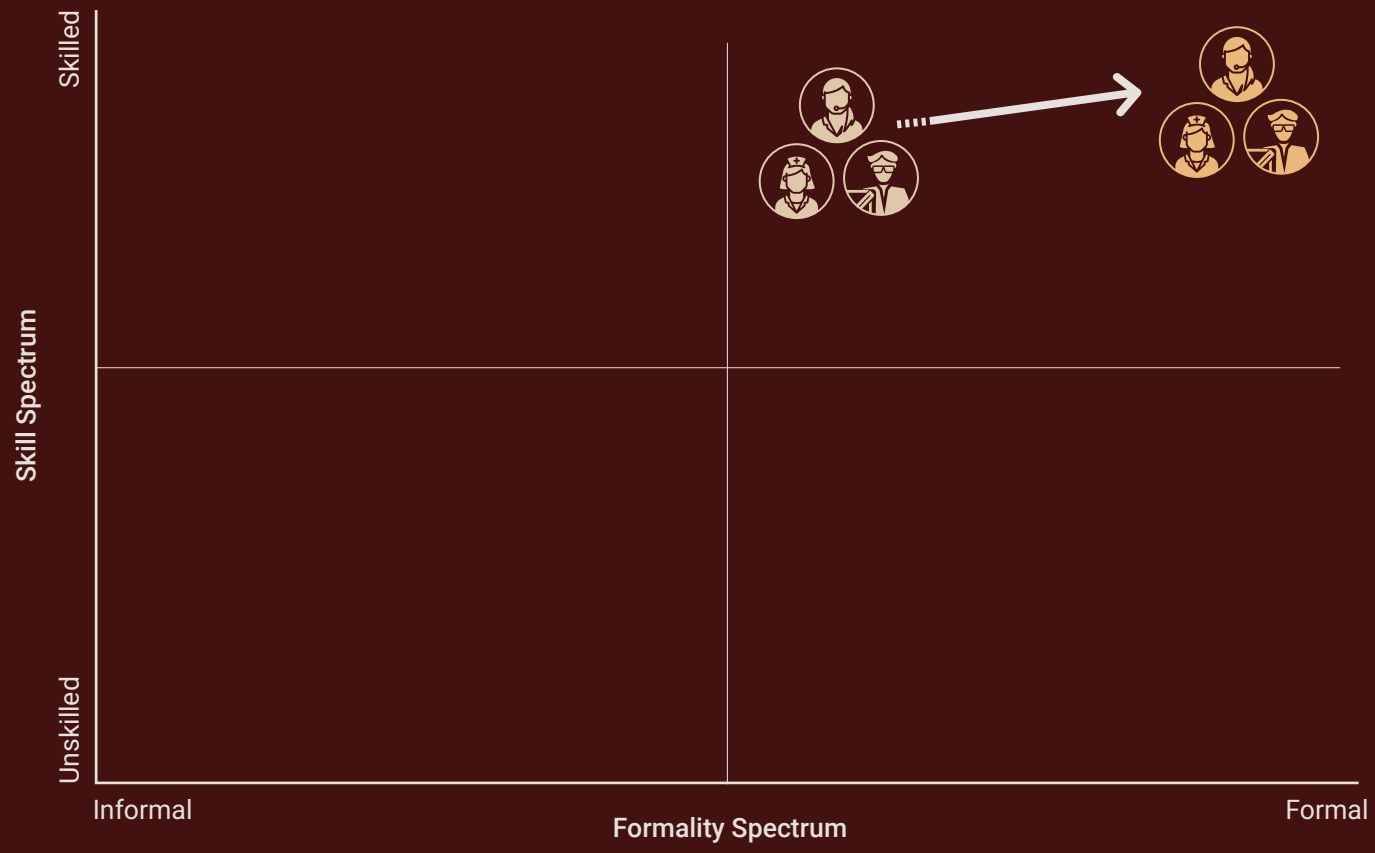
Certified Nursing Assistant	Counselor	Palliative Assistant
Employment Type		
Hospital Employee	NGO / Community Center	Live-in
Hours of Work		
Shift work	Erratic / Unpredictable	Undefined
Income Stability		
Stable	Unstable	Unstable
Wages / Payment		
Salaried	Salary / Stipend	Salaried

Key Challenges		
• Certified but practically treated as maid in uniform • Burden of work but not paid adequately • No ladder for career progression	• Emotional Trauma: "Dustbin" for others' pain • Lack of proper Supervision and training • No support for career progression	• Emotional toll • No Respect • No ladder for career progression

Aspirations		
• Course design to accommodate experience and skill • Dignity/Respect • Career progression	• Study sponsorship • Clinical supervision • Professional identity	• Professional identity • Career progression • Medical training

Targeted Framework for the "Group 3" Care Workforce

The framework analyses the caregiving landscape post policy-intervention for skilling and formalisation



Certified Nursing Assistant

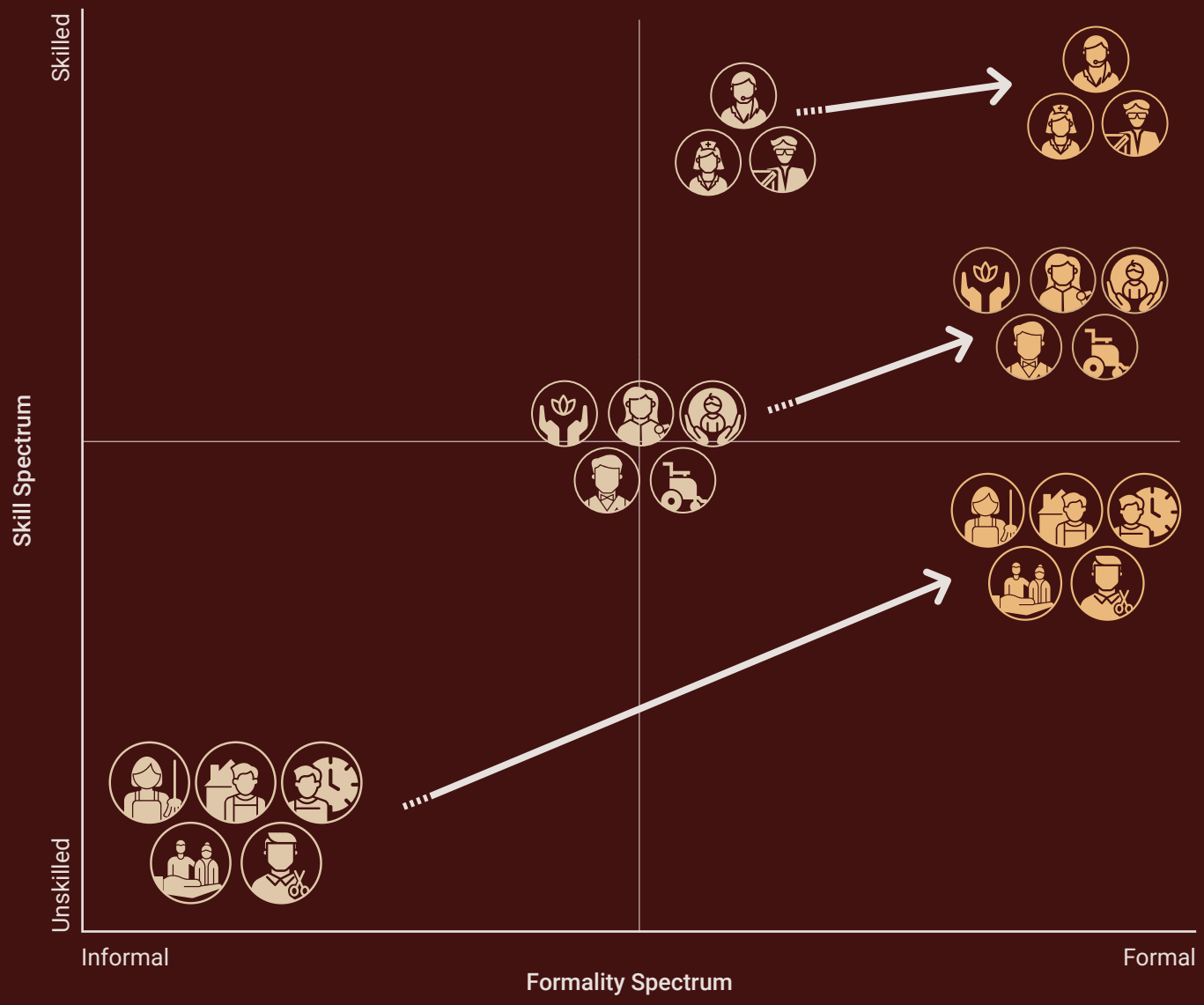
Counselor

Palliative Assistant

The Consolidated Targeted Framework

Targeted Framework for the Care Workforce

The framework analyses the caregiving landscape post policy-intervention for skilling and formalisation



- Domestic Help
- Live-In Full Time help
- Live-Out Full Time help
- Beauty Assistant
- Eldercare Sitter
- Childcare Assistant
- Rehab Aides
- Special Needs Workers
- Senior Living Facility Staff
- Beauty and Wellness Tech
- Certified Nursing Assistant
- Counselor
- Palliative Assistant

The Care Services Industry

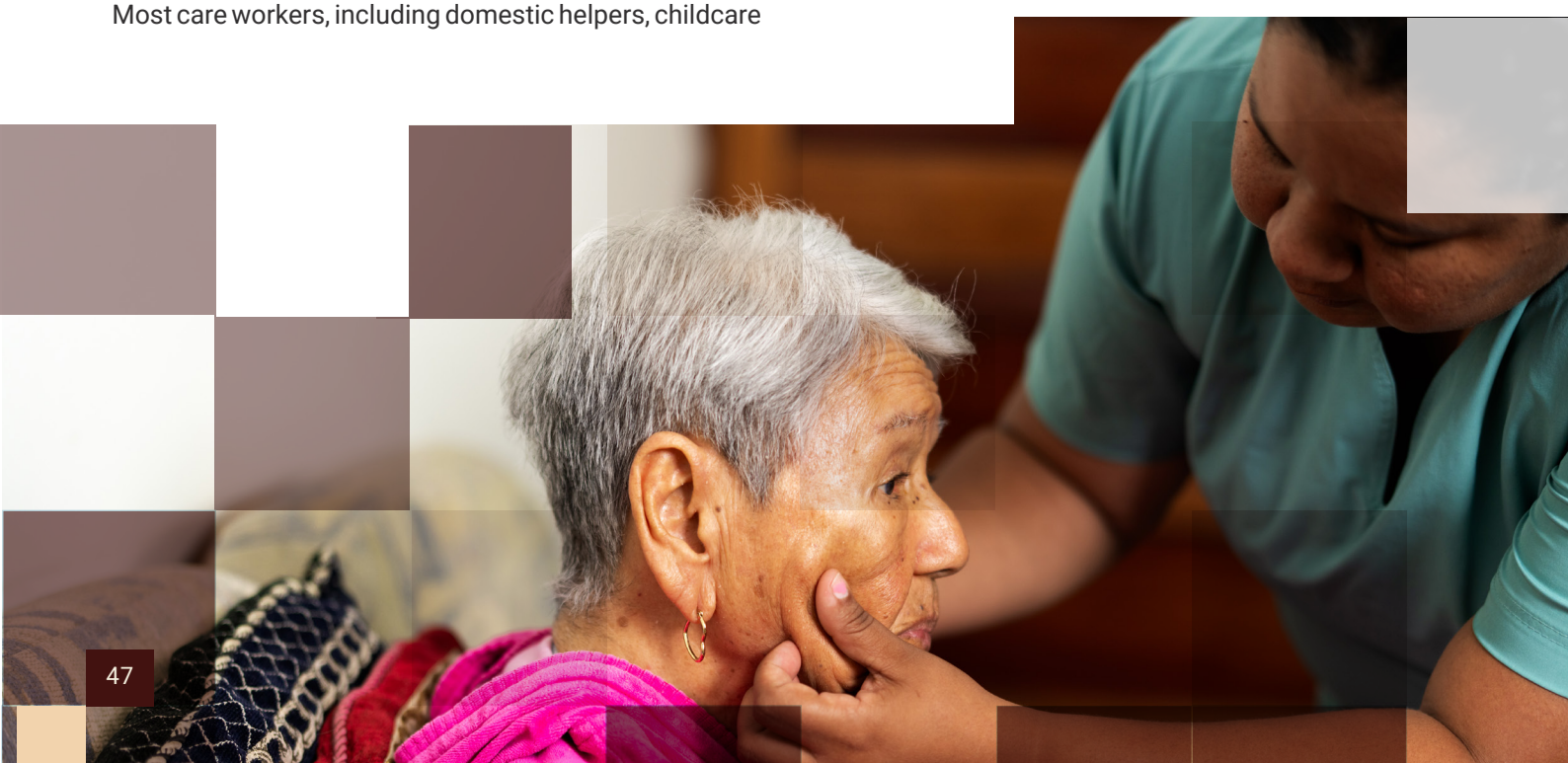
In the past decade, the private sector has successfully attempted to bring care services in a structure that formalises the workforce and makes them more accessible to a larger population. India's private care economy is diverse and fast growing, covering everything from domestic work to beauty services to mental health support, through platforms, startups and training ecosystems. Companies such as Urban Company, Portea, Care24 and several smaller regional platforms have professionalised segments of domestic work, beauty and wellness, and home-based nursing and rehabilitation. Urban Company's recent public listing achieved a valuation of $3 billion on debut, which shows strong investor confidence in platform-based care services.[34] The broader home- and personal-care market, including housekeeping, beauty, childcare and eldercare services, has also expanded significantly as dual-income households rely on outsourced care.

Gaps in policy and governance

Despite rapid growth, the private care-services industry remains constrained by policy fragmentation and weak labour protections. Care roles are not clearly classified within India's occupational frameworks, limiting standardisation of training, certification and wages. Most care workers, including domestic helpers, childcare assistants, beauty technicians, eldercare providers, and disability-support aides, remain outside formal labour regulation, with limited access to minimum wages, maternity benefits, health insurance, grievance redressal or safe-work environments. Similarly, the aggregators and platforms operate in a largely unregulated manner with arbitrary performance rating systems, unequal job allocations and irregular payouts. Additionally, the care facilities and platforms do not follow a unified quality-assurance regime and worker and patient safety frameworks, background-verification norms, and data-privacy protections are inconsistently applied.

Challenges in operations

Care agencies face challenges in maintaining quality, scaling workforce, and sustaining worker satisfaction. They struggle with high turnover, low job stability, and the absence of clear career ladders for care workers. Absence of policy framework to address these issues makes it a difficult entrepreneurship venture, even with an increasing demand in the market. Establishing standardized operational norms for care agencies will also enable them to expand beyond tier I and metro cities and cater to the underserved rural and per-urban areas.



Prof. Sanjay Zodpey

President, Public Health Foundation of India

This report makes a compelling case for recognising the care economy as a cornerstone of India's public health and human capital strategy. As the country's health needs increasingly extend beyond hospitals into homes and communities, improving health outcomes at scale will depend on how seriously we invest in the care workforce. This means building robust skilling and certification pathways, creating opportunities for career progression, and ensuring quality across home-based care, rehabilitation, mental health, and wellness services. Integrating care work into formal health and skilling systems is therefore not just about employment—it is about strengthening population health, ensuring dignity for workers, and building a resilient workforce that can support India's long-term development.

EXPERTS

Recommendations and the Way Forward

India's care economy is at a turning point. Demand for childcare, eldercare, disability support, and long-term care keeps rising, while families still carry most of the burden and the workforce stays largely informal. At the same time, new platforms, community models, and women-led enterprises show how care can grow into a structured economic sector. To move in that direction, the country needs a clearer way to organise its efforts. The NURTURE framework offers that structure by linking national mission design, skills, regulation, technology, social protection, demand creation, and enterprise growth into one cohesive agenda. It helps translate scattered initiatives into a systemic plan that strengthens services, protects workers, and expands access for households.

Dr. Meenakshi Hembram

Additional Director (HQ) and Head of Office, DGHS, Government of NCT of New Delhi

Women are at the heart of India's care economy. From homes and communities to health and care facilities, it is largely women who provide the care that keeps families healthy and economies functioning. Yet this work remains poorly paid, informal, and without adequate protection. There is a clear need for action to ensure fair wages, formalisation of care roles, and full access to social security, health insurance, and other national welfare schemes. Addressing this cannot sit within one department alone. A dedicated committee with cross-departmental representation, bringing together health, labour, skilling, women and child development, and social protection, would help provide the coordination needed to recognize care work, protect women workers, and build a stronger, more equitable care system.

EXPERTS

1. **A National Care Services Mission** could bring together ministries whose mandates already touch care, without creating new institutional silos. **Labour** could focus on workforce formalisation through wages, contracts, and social security; **Women and Child Development** on childcare and ECCE integration; **Health** on eldercare, long-term care, rehabilitation, and ABDM linkages; **Social Justice** on disability and senior care; **Skill Development and Entrepreneurship** on modular training and recognition of prior learning; and **Urban Affairs** on enabling care infrastructure through planning and incentives. **A dedicated Union Budget allocation for caregivers and care services could provide the financial anchor for this coordination**, supporting skilling, quality assurance, digital systems, and service expansion, with complementary support from Finance, IT, and Rural Development for financing, platforms, and community-based care models.

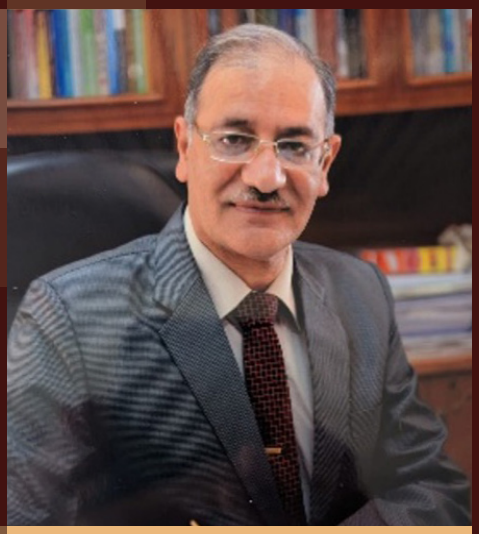
2. **Skilling and regulation** could evolve together to professionalise care work without disrupting existing livelihoods. **Standardised skilling pathways under Skill India,** built around modular courses and recognition of prior learning, could allow childcare, eldercare, homecare, and rehabilitation workers to formalise their skills incrementally, while tiered career ladders and periodic refresher training improve service quality and create wage progression over time. Linking trained workers into Anganwadi and ECCE systems through modular pathways could strengthen public service delivery while expanding formal employment. In parallel, minimum wages, written contracts, and regulated working hours could provide a predictable foundation for care work, supported by safety requirements, background verification, and clear protocols to prevent harassment in home-based and institutional settings. Quality monitoring, anchored through **State Care Coordination Cells** and supported by public–private partnerships, could help enforce standards while allowing diverse providers and platforms to operate within a common regulatory framework.

3. **Technology** could serve as enabling infrastructure for the care economy by improving transparency and access without displacing human services. **A national digital backbone** linking worker IDs, job matching, payments, verification, and skilling records could reduce informality, while support for worker-centric platforms may help care services scale safely. **Integration with ABDM** could enable tele-rehabilitation and remote monitoring for long-term care, complemented by digital literacy support and hybrid online–offline models to ensure inclusion and rural outreach.

4. Care work remains unstable not because demand is weak, but because workers carry most of the risk themselves. Extending **social protection** to this workforce would shift that balance. Basic wage enforcement, health insurance, pensions, and provident funds can turn irregular work into predictable livelihoods, while portable benefits tied to a care worker ID allow mobility without loss of protection. Simple income buffers, paid leave, and access to childcare and primary healthcare recognise the reality of care work as physically and emotionally demanding and help retain workers in a sector that households increasingly rely on.

5. Demand is the real constraint in the care economy, not supply. Households need affordable, reliable services before providers can invest and scale. Expanding childcare in Tier-2 and Tier-3 cities through **smart subsidies, vouchers, and tax incentive**s would unlock both women's workforce participation and a large, local employment market. Strengthening ECCE and Anganwadi systems with trained care workers creates an immediate, publicly anchored demand base. On the eldercare side, India is sitting on a major infrastructure gap. **Assisted living, rehabilitation day-care, and dementia centers** remain scarce outside metros, even as need accelerates. **Targeted incentives** and the introduction of long-term care insurance can convert this unmet need into a viable service market, reducing household risk while offering predictable revenues for providers. Once demand is visible, capital follows.

6. **Public–private partnerships and CSR funding** can de-risk early investments in training and community care infrastructure, while access to low-cost credit enables enterprises to build and operate care facilities at scale. Incentives for hiring certified workers raise quality and formalisation, and support for women-led and community-based enterprises ensures that growth remains broad-based rather than concentrated. For policymakers, this is about turning demographic pressure into jobs. For industry, it is about entering a sector where demand is structural, labour is local, and growth is built into the next two decades.



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The care economy is no longer a peripheral socio-economic issue; it is emerging as one of India's most important sources of employment and economic value. It has immense potentials to create further opportunities on these fronts, by way of opportunity creation as well as monetization of work. As healthcare needs are rising, the population is aging, and family structures are changing, the care services are turning out to be a large, lasting and locally rooted job market that also supports wider productivity and gender inclusion across the economy. This potential, however, will remain under-realised unless caregivers are recognised and strengthened as skilled workers, paid fairly, and included into the formal economy. Investing towards formalisation and upskilling can elevate incomes and dignity for care-providers while increasing efficiency, service quality, care infrastructure and the overall economic contribution of the sector, thus, creating a well-defined and sustainable growth pathway for care economy in India.

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Nurture Pillar	Mapped Recommendations
 **National Mission and Governance**	• Establish a National Care Services Mission with cross-ministerial alignment and national targets. • Set up state-level Care Coordination Cells for quality monitoring, grievance redressal, and ecosystem-building. • Advance the Domestic Workers Bill and create unified governance for formalisation. • Launch national/state helplines and grievance systems for safe workplaces. • Lead public campaigns to shift social norms and elevate care as skilled, professional work.
 **Upskilling and Certification**	• Standardise skilling pathways under Skill India with modular courses and RPL for childcare, eldercare, homecare, and rehab roles. • Create tiered career ladders and annual refresher modules on safety, communication, disability, dementia, and infection control. • Integrate trained care workers into Anganwadi and ECCE systems through modular pathways.
 **Regulation and Quality Assurance**	• Enforce minimum wages, written contracts, and regulated working hours for domestic and care workers. • Introduce safety requirements, mandatory background verification, and zero-tolerance protocols for harassment. • Standardise background checks for both caregivers and clients. • Strengthen quality monitoring through Care Coordination Cells and PPPs.
 **Technology and Platforms**	• Build a national digital infrastructure with digital IDs, job-matching, payments, verification, and skilling linkages. • Support start-ups building safe, transparent platforms for care work. • Integrate services with ABDM for secure data exchange, tele-rehab, and remote monitoring. • Establish digital literacy kiosks and offline assistance for workers. • Promote hybrid online–offline care delivery models, including rural outreach.
 **Universal Social Protection**	• Guarantee minimum wage enforcement, social security coverage, pensions, provident funds, and health insurance. • Create portable benefits linked to a national care worker ID. • Offer matched emergency savings and protection against income volatility. • Institutionalise paid leave, flexible schedules, and mental health support for workers. • Provide childcare support and primary healthcare access for care workers.
 **Real Demand Creation (Childcare, Eldercare)**	• Expand affordable childcare in Tier-2 and Tier-3 cities through subsidies, vouchers, and tax rebates. • Strengthen public ECCE and Anganwadi systems with trained care workers. • Incentivise eldercare and long-term care infrastructure: assisted living, rehab day-care, dementia centers. • Introduce long-term care insurance to reduce catastrophic household expenditure.
 **Enterprise Growth and Women-Led Models**	• Expand PPPs and CSR partnerships to finance training, community daycare, elder hubs, and care infrastructure. • Provide low-interest credit to enterprises building eldercare and disability-care facilities. • Incentivise households and agencies to hire certified workers and support formal agencies, cooperatives, and SHGs. • Back community-based and women-led care enterprises to scale through access to credit, digital tools, and market linkages.

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India's care economy is a vital sector that addresses long-term health needs and provides extensive employment opportunities. With around 36 million workers, it includes home healthcare, counselling, palliative care, rehabilitation, mental health, and daily support services. The care workforce is essential for critical health conditions like HIV, especially as more people now live longer. This is due to advancements in ART Medication, strengthened care and support services, and ongoing community- and home-based support that promote treatment adherence, manage comorbidities, and address stigma, mental health issues, and family caregiving burdens. However, much of this care workforce remains informal, under-skilled, and invisible in economic planning. Integrating this care workforce into a strengthened care economy can improve health outcomes, ease pressure on the system, provide dignified jobs, and establish care as a key public health and economic infrastructure. Through targeted investments in skills, certification, and formalization, the care economy has the potential to create quality jobs and become a crucial part of India's development economy

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Conclusion

India's care economy can no longer be seen as a peripheral social function. It is a labour-intensive and steadily expanding sector that underpins how families work, how the population ages, and how people manage care needs across their lives. This report shows clearly that the way the system operates today, fragmented, informal, and largely outside policy planning, is already out of step with the demand on the ground. Care workers across skill levels carry essential responsibilities with limited protection, mobility, or recognition. At the same time, the growth of private agencies, platforms, and new enterprises shows that care services can be organised, professionalised, and expanded when the right conditions exist.

The economic case is difficult to ignore. With deliberate formalisation and investment, India's care economy has the potential to grow into a **$300 billion sector and support over 60 million jobs by 2030.** These numbers reflect real and rising demand for childcare, eldercare, disability support, rehabilitation, mental health services, and wellness. This demand already exists and continues to grow, driven by demographic change and shifting household structures. Few sectors offer this scale of job creation with such low capital requirements and such wide geographic reach.

The **NURTURE framework** provides a way to move from scattered efforts to a more coherent approach. By bringing together governance, skilling, regulation, technology, social protection, demand creation, and enterprise development, it outlines how care can be built as a functioning sector rather than a collection of isolated programs.

The next phase will depend on intent and follow-through. The Union Budget offers an important moment to recognise care as economic infrastructure and to back that recognition with resources. As India works towards the goal of Viksit Bharat, strengthening the care economy is not an optional add-on. It is central to creating jobs, supporting families, and sustaining growth over the long term. The opportunity is clear. What remains is the willingness to act on it.

With deliberate formalisation and investment, India's care economy has the potential to grow into a **$300 billion sector and support over 60 million jobs by 2030.**

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