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Comparative Gerontology: A Binational Study of Senior Well-Being

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ABSTRACT: The quality of life among older adults is influenced by a dynamic interplay of physical health, emotional well-being, social engagement, financial stability, and environmental context. While existing research often centers on single-country analyses, there remains a significant gap in comparative studies across regions with distinct cultural, social, and healthcare systems. This study addresses that gap through a method approach of systematic surveys and interviews, offering a cross-cultural comparison between senior populations in India and the United States. Responses were categorized into four overarching themes: (1) Social Engagement & Activities, (2) Family Roles & Environment, (3) Self-Care & Independence, and (4) Healthcare Access & Community Resources. Advanced statistical comparative methodologies were employed to examine thematic patterns, identify cross-cultural parallels, and highlight region-specific distinctions. Findings reveal that self-rated happiness and health levels are statistically comparable, averaging approximately 8 on a 10-point scale. However, deeper analysis uncovered notable differences in lifestyle patterns and support structures, shaped by factors unique to each region. This research contributes to the field of gerontology and cross-cultural health by providing direct comparative insights into aging experiences across diverse contexts. The implications are particularly relevant for policymakers, caregivers, healthcare practitioners, and technological innovators.

KEYWORDS: Behavioral and Social Sciences, Physiological Psychology, Gerontology, Sociology, Quality of Life, Integral Support System.

Introduction

Older adults are a growing population in society whose quality of life is deeply dependent on social engagement, environment, and healthcare. In fact, by 2030, 1 in 6 people in the world will be aged 60 years or over, and by 2050, the world's population of people aged 60 years or older will double.[1] The quality of life for older adults is shaped by an interplay of physical, emotional, social, financial, and environmental factors. Physical health factors include chronic conditions, physical mobility, pain management, nutrition, and access to healthcare. Mental and emotional well-being depends on cognitive health, depression/anxiety, sense of autonomy/ dignity, and sense of purpose. Social factors, such as family/friends, community engagements, opportunities for expression, and intergenerational relationships, can have a significant impact. Financial independence is a critical factor that includes income/savings, affordable housing, and access to benefits like pensions, social security, etc. A living environment that includes safety, accessibility, cleanliness, and comfort is equally important. This information is an anecdotal basis for which each factor for each theme was based.

While these factors collectively shape the experience of the older adults, they do not exist in isolation. Rather, they are embedded within broader societal and systemic frameworks that vary significantly across cultures and nations. How a society prioritizes elder care, allocates resources, and designs its healthcare and social support systems can dramatically influence how these individual factors manifest and interact. Yet, despite widespread recognition of the systemic nature of aging-related challenges, much of the existing research tends to focus on individual countries, leaving a gap in the lack of comparison between two different countries with different healthcare systems, cultural contexts, and social frameworks. For example, studies done in India document the quality of life of older adults between rural and urban areas.[2] Furthermore, in the US, a study has been done to determine the lifestyle difference between older adults with and without disabilities.[3] Furthermore, the existing cross-cultural research is either outdated or not addressing quality of life; respectively, this is seen in a study about the relationship between emotional support and subjective well-being of married older people published in 1995,[4] as well as a cross-cultural study that analyzes health behaviors tied to aging without specifically addressing its impact on elderly quality of life.[5] This leaves a notable gap in comparative studies across regions with differing cultural, social, and healthcare frameworks.

This research attempts to address this gap and presents a novel cross-cultural comparison pertaining to the quality of life in older people. It builds on the hypothesis that differing values, infrastructures, and policy models can illuminate alternative pathways and innovative solutions. It undertakes a comparative exploration of the lifestyle of older adults in two distinct contexts: the United States and India. By examining how each of these populations navigates the complex terrain of aging, this research aims to draw conclusions from the interplay of influencing factors and uncover strategies that may be adapted or reimagined to improve the quality of life for elders across diverse settings.

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Methods

To investigate the complex factors influencing the quality of life among older adults (those that this particular study defines as being 60+ in age), this research adopted a mixed-methods design that integrates both quantitative and qualitative approaches.

First, the focus is on the design and administration of a structured survey aimed at capturing the multifaceted dimensions of older adults' quality of life. The survey was carefully constructed to address five key domains: physical health, emotional well-being, social engagement, financial stability, and environmental conditions. With a thematic approach in mind, a survey was created and distributed in English and Marathi (an Indian language from the state of Maharashtra), depending on the respective location. While the core structure of the questionnaire remained consistent across both the United States and India, minor contextual adaptations were made to ensure cultural relevance and clarity for local participants. The survey consisted of 43 multiple-choice questions, enabling the collection of quantitative data across several categories, including demographic profiles, health routines, social interactions, living environments, self-reported happiness, and perceived health status. To ensure accessibility and appropriate inclusivity, the survey was administered in person, allowing participants above the age of 60 to engage directly with facilitators and clarify any uncertainties.

To complement the quantitative findings, in-depth interviews were conducted with a subset of survey participants. These interviews provided rich qualitative insights, enabling respondents to share personal narratives and reflect on life experiences within a thematic framework. Qualitative data from these interviews allowed for a clear interpretation of the survey results. Interview questions included themes of quality of life, professional career, hobbies, exercise routine, favorite time of day, proximity to children, social engagements, and healthcare plans. Note that the actual interviews in most cases deviated from these, depending on the conversation flow to include more specific responses related to a topic invoked from the questions. The interview transcripts were systematically analyzed using a thematic analysis, allowing for the identification of recurring patterns, emotional undercurrents, and culturally specific nuances.

Throughout the study, ethical standards were rigorously upheld. An Institutional Review Board (IRB) approval was obtained for this study. Furthermore, all participants were engaged under the principles of voluntary participation, informed consent, and strict confidentiality. These safeguards ensured that the research process honored the dignity, autonomy, and privacy of every individual involved.

Results

The study was conducted at the Gilbert Senior Center in Arizona, USA, and at Athashri Senior Living, a private residence in Pune, India. The focus was on urban locations for both countries to refrain from selection bias. Results include 48 responses from the USA and 72 responses from India. About 10 total interviews were conducted as part of the study. All respondents filled out all the questions.

Demographic observations:

Figure 1 shows the age and gender distributions. In India, 72% of older people are 70 or older, while in India this proportion was 81%. Additionally, the gender distribution among older people indicates that in India's sample, 64% are female, and in the US sample, 79% are female. This demonstrates that most respondents are above the age of 70 for both countries, with a larger ratio of females over males. This imbalance represents a broader demographic trend showing more female longevity in older age groups.

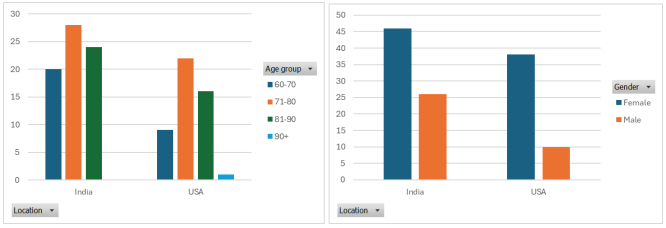


Figure 1: Age and Gender of the survey participants. The survey participants are predominantly female populations above the age of 70.

Figure 2 illustrates the marital and employment status of survey participants. Among female respondents in India, 50% did not engage in formal employment but identified as homemakers. In contrast, 100% of female participants in the United States reported being employed. The marital status distribution shows a statistically significant difference between the two countries: the majority of Indian women were either married or widowed, whereas in the U.S., most were divorced or widowed. The observed statistical difference in marital status between survey participants in India and the United States potentially reveals distinct cultural and generational patterns shaped by societal norms, historical context, and perceptions of relationships.

Figure 2: Marital and employment status of the survey participants. Older Indian women are often homemakers and married/widowed, while older women of the US are more often fully employed and divorced/widowed.

Analysis Approach:

Out of the 43 survey questions, 2 items required participants to provide quantitative self-ratings (on a scale of 1–10) for their levels of happiness and health. These numerical responses were analyzed using descriptive statistical methods, focusing on mean comparisons and variance assessments to summarize key trends. The Student t-test was used to compare numerical data across the two countries.

The remaining 41 questions were multiple-choice, generating categorical data. These were systematically organized into four overarching thematic categories: 1) Social Engagement

& activities, 2) Family Roles & Environment, 3) Self-care, and 4) Healthcare Access & Community Resources. The data was analyzed using countries as explanatory variables (x-axis) and choices as response variables (y-axis). The chi-square test was used as a statistical method to understand the relationship of the categorical data across the two countries and determine if the data is consistent with the assumed distribution.[6]

Findings/ Results

Self-rated levels of happiness and health:

Figure 3 shows the overall survey results for self-rated levels of health and happiness between the US and India. Both the indicators are on the higher side, averaging closer to 8 on a 1-10 scale. To scientifically assess potential differences in self-perceived happiness and health among older adults from the United States and India, a statistical analysis was conducted using a two-sample Student's t-test, a statistical method used in the testing of a hypothesis for comparison of mean values between groups, under the assumption of equal variances.[7] Prior to applying the t-test, an F-test of overall significance, which determines how well a regression line between two variables fits the given data points, was performed to evaluate the homogeneity of variances between the two groups.[8] The F-test results confirmed that the variance in responses across both geographies was statistically similar, thereby justifying the use of the equal-variance t-test model. Figure 3 illustrates the outcomes of the t-tests for both variables: self-rated happiness and self-rated health.

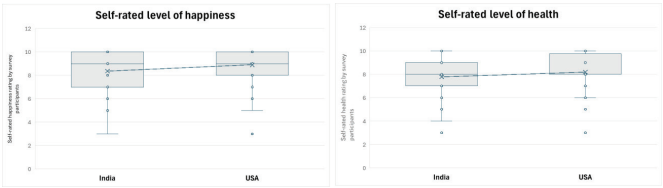


Figure 3: Self-rated happiness and health levels. Older adults in both the US and India rated their health and happiness highly (around 8/10) with no significant differences between countries.

Self-Rated Happiness: The left panel of Figure 4 focuses on the distribution of self-reported happiness scores. The computed p-value from the t-test is 0.078, which is above the conventional significance threshold of 0.05. Based on the sample sizes used, there is no statistically significant difference in perceived happiness between older adults in the United States and India. While the p-value is relatively close to the threshold, it still falls short of providing strong evidence to reject the null hypothesis. In practical terms, this implies that any observed difference in happiness ratings may be due to random variation rather than a true underlying disparity between the populations.

Self-Rated Health: The right panel of Figure 4 presents the analysis of self-reported health ratings. The resulting p-value is 0.21, which is substantially higher than 0.05. This reinforces the conclusion that there is no statistically significant difference in perceived health status between the two groups. The higher p-value indicates even weaker evidence against the null hypothesis; hence, the perception of health among older adults in both countries is statistically indistinguishable within the context of this study.

t-Test: Two-Sample Assuming Equal Variances

	India	Usa
Mean	8.361111111	8.895833333
Variance	2.881846635	2.222960993
Observations	72	48
Pooled Variance	2.619409134	
Hypothesized Mean Difference	0	
df	118	
t Stat	-1.773057452	
P(T<=t) one-tail	0.039396373	
t Critical one-tail	1.657869522	
P(T<=t) two-tail	0.078792746	Perception of happiness is same
t Critical two-tail	1.980272249	

F-Test Two-Sample for Variances

	Variable 1	Variable 2
Mean	8.361111111	8.895833333
Variance	2.881846635	2.222960993
Observations	72	48
df	71	47
F	1.296400002	
P(F<=f) one-tail	0.172545839	Equal variance
F Critical one-tail	1.57255337	

t-Test: Two-Sample Assuming Equal Variances

	Variable 1	Variable 2
Mean	7.777777778	8.1875
Variance	3.358372457	2.751329787
Observations	72	48
Pooled Variance	3.116584275	
Hypothesized Mean Difference	0	
df	118	
t Stat	-1.245507439	
P(T<=t) one-tail	0.107063935	
t Critical one-tail	1.657869522	
P(T<=t) two-tail	0.215412787	Perception of health is same
t Critical two-tail	1.980272249	

F-Test Two-Sample for Variances

	Variable 1	Variable 2
Mean	7.777777778	8.1875
Variance	3.358372457	2.751329787
Observations	72	48
df	71	47
F	1.220636098	
P(F<=f) one-tail	0.234996988	Equal variance
F Critical one-tail	1.57255337	

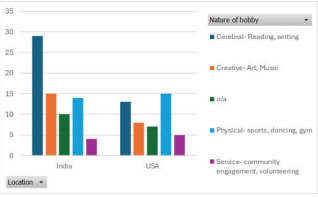
Figure 4: T-test for self-rated happiness and health levels. T-tests show no significant differences in the perception of happiness (p = 0.078) and the perception of health (p = 0.21) of older adults between the US and India.

There is insufficient evidence to show meaningful differences in self-rated happiness or health between older adults in the U.S. and India, based on the sample sizes and data analyzed. However, this initial analysis serves as a foundation for deeper inquiry. To find out further nuances in lifestyle and well-being, key influencing factors, such as access to healthcare, social support systems, cultural attitudes toward aging, and economic stability, that may shape the experiences of older adults in each country will continue to be examined.

The following sections highlight the four thematic categories that are utilized to summarize the survey findings.

Social Engagement and Activities: This category highlights how the older adults interact socially and what activities they engage in to stay active.

1) Engagement in leisure activities across cohorts: A high proportion of participants in both cohorts reported engaging in leisure activities, with prevalence rates of 85.4% among U.S. respondents and 86.1% among Indian respondents. To examine whether hobby preferences varied by country, a chi-square test was conducted. The resulting chi-square value of 0.37 indicates no statistically significant difference in hobby choices between the U.S. and India. As shown in Figure 5, across both groups, popular hobbies included cerebral pursuits such as reading and writing, physical activities like sports, dance, and gym workouts, and creative expressions including art and music. In contrast, service-oriented hobbies, such as volunteering, were reported less frequently in both locations. When it comes to the mode of entertainment, the two countries have similar inclinations, with television being the top mode (Figure 6).



Observed values	Cerebral	Creative	n/a	Physical	Service
India	29	15	10	14	4
USA	13	8	7	15	5

Expected Values	Cerebral	Creative	n/a	Physical	Service
India	25.200	13.800	10.200	17.400	5.400
USA	16.800	9.200	6.800	11.600	3.600

Chi Square values	0.573	0.104	0.004	0.664	0.383
Chi Square values	0.860	0.157	0.006	0.997	0.544

Chi Square stat	4.272
df	4
pvalue	0.3705024

Figure 5: a) Nature of hobbies b) Statistical analysis to derive the Chi-Square statistic. Leisure activities were common in both cohorts, with no significant differences between the hobbies of the older adults in the US and those of older adults in India.

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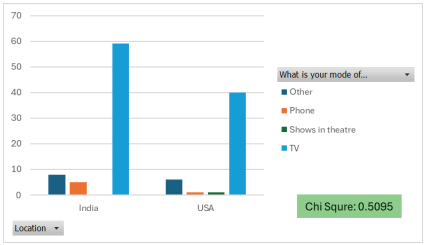

Figure 6: Mode of entertainment. Television emerged as the most common type of entertainment in both India and the US, reflecting similar entertainment preferences across cohorts.

2) Choice of social interaction methods: As shown in Figure 7, the survey reported no difference in the social media connectivity between the two cohorts. However, the choices of social media platforms were significantly different. While India favored WhatsApp as a media platform that favors direct and private conversations, the US favored Facebook, which is a broad and public platform. This was supported in findings from interviews, as many participants talked about their connectivity on WhatsApp in India, whereas in the US, WhatsApp was virtually unknown among the elderly population.

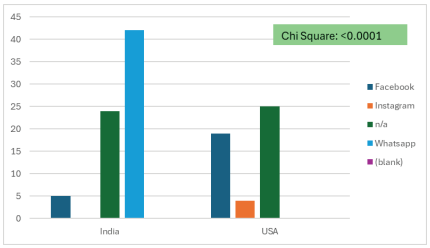

Figure 7: Preference for social media platform. While overall social media connectivity was similar across cohorts, Indians preferred WhatsApp for private conversations, whereas US participants favored Facebook for broader social interaction.

3) Impact of pandemic on social engagement: The survey also investigated the effects of the COVID-19 pandemic on participants' patterns of social interaction. Figure 8 shows the responses across different impact vectors. Analysis of responses from both cohorts revealed minimal change in the frequency or modality of in-person and online communication post-pandemic. Furthermore, participants from India demonstrated a comparatively higher propensity to report a full resumption of pre-pandemic lifestyle practices.

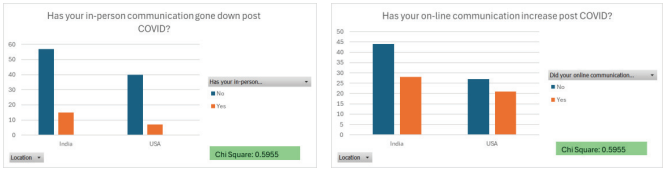

Figure 8: Impact of COVID-19 on lifestyle. Participants from both India and the US revealed minimal change in the frequency of in-person and online communication post-pandemic.

Family Structure and Roles: This category examines the composition of the family unit and explores the roles older adults occupy within familial interactions and responsibilities.

1. Residential arrangement: Residential arrangements differed considerably for the survey participants, as captured in Figure 9. In the U.S., 85.7% of older adults resided in privately owned dwellings, with 12.2% in institutional care facilities. In India, private ownership rates were at 56.9%, with 40.3% residing in senior living facilities. Note that there is a selection bias in the study. One part of the survey in India was done at a senior living facility, which is reflected in the composition fractions. Pre-pandemic living arrangements were relatively stable in both countries, and the majority remained in the same residence during the COVID-19 pandemic (>90% in both cohorts).

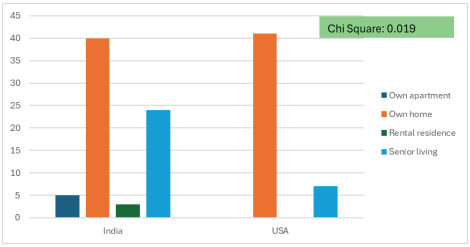

Figure 9: Primary residence details. Indian seniors more often resided in senior living facilities than seniors in the US; more seniors from the US lived in private homes than Indian seniors.

2. Family structure and proximity: Family structure and proximity revealed distinct patterns across the Indian and U.S. senior cohorts. Figure 10 shows the family sizes and current proximity to the children. The average number of children reported by Indian participants was 1.8, notably lower than the U.S. average of 2.5. This divergence reflects historical public health initiatives in India, such as the "Hum Do Hamare Do" ("We are Two, will have Two Children") campaign launched in 1967, which played a seminal role in promoting family planning and population stabilization (Government of India, 1967).[9] One Indian interviewee explicitly referenced this campaign when discussing the normative shift toward two-child families. Despite differences in family size, co-location within the same city was comparable across both cohorts. Yet Indian respondents tend to have more children away from their current home. This is likely due to the young population leaving the city or country to pursue studies in STEM and business fields, as noted in several interviews.

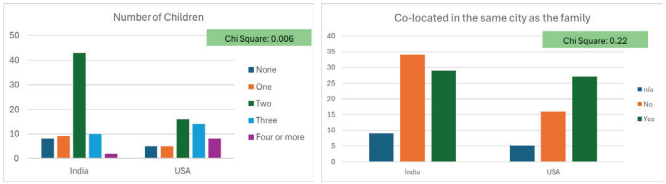

Figure 10: Family structure. Older adults in the US reported larger families on average compared to Indian seniors. Though older adults' proximity to children was similar across both cohorts, more Indian participants have children living away from them.

Self-care and independence: This category highlights how older adults engage in activities related to caring for their mental and physical health.

1) Diet: Figure 11 shows that dietary preferences reveal notable contrasts between the two cohorts. Approximately 70% of Indian respondents identified as vegetarians, while a similar proportion of U.S. respondents reported a non-vegetarian diet. Alcohol consumption patterns further underscore these cultural distinctions. Among Indian older adults, 80% reported

abstaining from alcohol, whereas 60% of U.S. older adults indicated regular or occasional consumption. >90% of respondents from both countries reported not smoking in both countries. Numerous interviewees in both India and the US stated that lifestyle choices among older adults are significantly shaped by their sociocultural conditioning and religious values, combined with implications for health behavior, social engagement, and community expectations.

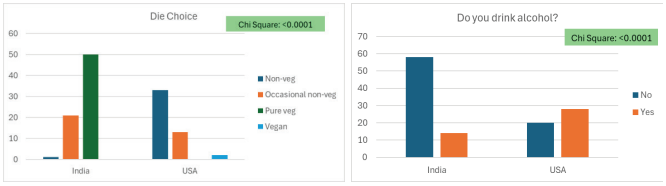

Figure 11: Diet choices. Indian participants were mostly vegetarian and abstained from alcohol, while US participants favored non-vegetarian diets with higher alcohol use.

2) Exercise: There was a marked difference in exercise frequency between the two cohorts. As shown in Figure 12, approximately 75% of respondents in India reported engaging in daily physical activity. In contrast, fewer than 40% of U.S. participants followed a daily routine, with many preferring to exercise a few times per week. Despite this variation in frequency, the type of exercise chosen was notably consistent across both groups, with walking emerging as the preferred form of physical activity.

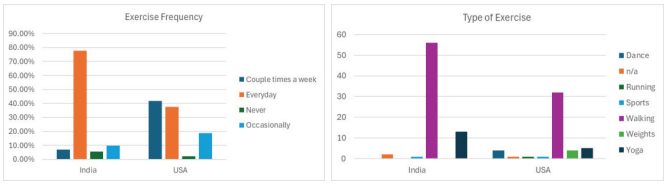

Figure 12: Exercise choices. Daily exercise was far more common among Indian seniors than US seniors, though walking was the preferred activity in both groups.

3) Mode of commute: Commuting practices reflected infrastructural disparities, with U.S. older adults utilizing personal vehicles and Indian older adults primarily relying on private feeder commute services like Uber™ and rickshaw, which are more economical modes of transportation. Figure 13 shows the preferred modes of commute between the two groups.

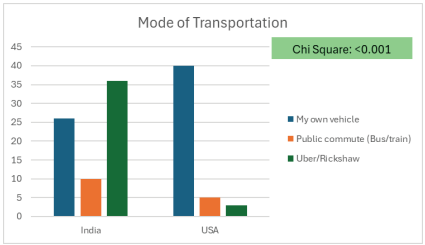

Figure 13: Mode of commute. US participants relied more on personal vehicles for commute, while Indian seniors favored services like Uber™ and rickshaws.

4) Independent living: Financial independence was also consistent across the two groups, with most older adults in both India and the U.S. reporting that they were financially self-sufficient. However, notable differences emerged in the domain of household support. In India, 58.3% of older adults reported employing domestic assistance for daily household tasks, whereas U.S. older adults were more likely to perform these tasks independently. This contrast reflects broader socio-cultural norms and labor market structures influencing elder care and domestic labor. For example, in interviews with seniors in India, elders had readily available domestic assistance in their household, whereas in the US, there were rarely any caretakers or maids present at their will. The comparison charts for both these elements are shown in Figure 14.

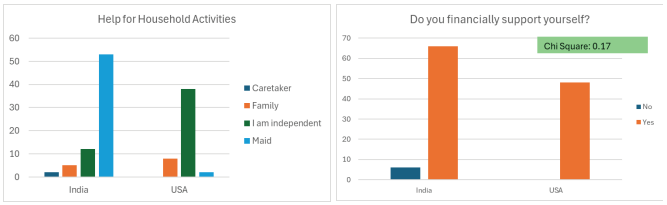

Figure 14: Factors affecting independent living. While financial independence was common among both cohorts, Indian participants relied on domestic help more than US seniors, who managed household tasks more independently.

Healthcare Access and Resources: This category highlights access to health care and resources.

1) Health insurance and expenses: Access to health insurance plays a vital role in the well-being of older adults. Survey results revealed that over 99% of U.S. respondents had access to health insurance, compared to approximately 57% of Indian participants (see Figure 15). The lower adoption rate in India stems from a blend of cultural and economic factors. Insights from interviews highlighted several reasons why many Indians opt out of purchasing health insurance:

- Perceived high premiums make insurance seem unaffordable.
- Limited awareness of the process and benefits, especially since health insurance is not mandatory.
- A cultural preference for out-of-pocket payments often relies on personal savings or family support.
- A low-cost government-sponsored health care system in India.

Among those who do have insurance, the survey explored whether their plans adequately cover medical expenses. In the U.S., 65% of respondents reported that their insurance covered most or all of their healthcare costs. In contrast, only 45% of Indian participants felt similarly. This disparity addresses the differences in coverage levels and plan choices available or selected in each country. As a result, more Indian participants are paying out of pocket for health-related expenses compared to the US.

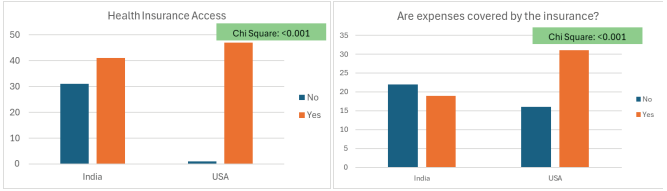

Figure 15: Health insurance and expenses. Nearly all US seniors had health insurance, versus only a little over half in India. Financial coverage was more comprehensive in the US, leaving many seniors to rely on out-of-pocket payments.

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2) Hospitalization: The survey explored respondents' awareness of pre-existing medical conditions. Approximately 65% of participants from India reported being unaware of any such conditions, whereas a similar proportion of U.S. respondents indicated that they did have pre-existing conditions (see Figure 16). Given the self-reported nature of the survey, it is difficult to verify the accuracy of these claims. Around 50% of respondents in both countries have experienced hospitalization within the past five years, with over 80% of these cases unrelated to COVID-19. In both cohorts, more than 70% of hospital stays lasted less than one week. When asked about family involvement during hospitalization, about 75% of Indian respondents reported receiving visits from family members, compared to roughly 50% of older adults in the U.S.

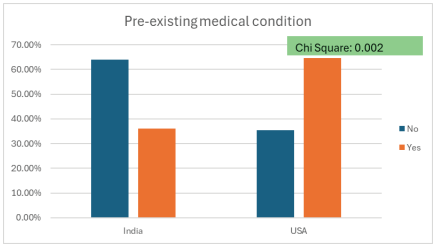

Figure 16: Awareness of pre-existing medical condition. Indian participants were less aware of pre-existing medical conditions compared to US participants. During hospitalization, family visitation was more common in India than in the US.

Discussion

The cross-cultural comparative study presented in this research paper demonstrates that despite distinct cultural, social, and healthcare contexts, older adults in India and the United States share similar overall self-perceptions of happiness and health, both averaging around 8 on a 10-point scale. This parity suggests that subjective well-being in older adulthood may be more strongly tied to intrinsic coping mechanisms, community ties, and perceived purpose than to the absolute availability of resources. However, beneath this surface similarity lie notable lifestyle differences with implications for health behaviors, social engagement, and care strategies.

Before moving on to the implications of these results, it is important to address potential limitations that could have been encountered. The biggest difference is that of the sample size. For the US, the sample size was n=48, while the sample size for India was n=72. This could skew comparative statistics, and this could make certain findings less reliable, due to the sample size not staying constant. The sampling bias also needs to be considered. For example, people were only selected from an upper-middle-class community in urban areas, and the data might not actually be completely representative of the broader elderly population. Across large and diverse countries like India and the US, there are bound to be limitations through sampling bias, resulting in a lesser generalizability of my results. Another limitation is self-reporting inaccuracies. For example, participants could have overestimated positive behaviors like exercise frequency or underestimated negative behaviors like alcohol use. Additionally, there were significantly more Indian older adults in the study who were in senior homes than American older adults, which could influence results on multiple fronts.

Socially, both cohorts maintain high engagement in leisure activities, favoring intellectually stimulating, creative, and physically active hobbies. Yet the nature of their social connections diverges in subtle but meaningful ways, as Indian older adults lean toward private, direct communication (WhatsApp). In comparison, U.S. older adults favor broader, more public networks (Facebook). This contrast may reflect differing cultural norms regarding privacy, self-expression, and intergenerational exchange. Additionally, pandemic-related disruptions were less enduring in India, where respondents more often reported returning to pre-pandemic social patterns, potentially indicating greater resilience or community integration. Family and living arrangements reveal sharper contrasts. U.S. older adults are more likely to live independently in private dwellings. In comparison, a larger proportion of Indian older adults reside in senior living facilities, a shift from traditional multi-generational cohabitation that may reflect evolving urbanization and lifestyle patterns. Interestingly, despite smaller family sizes in India, a likely legacy of public health campaigns, geographic proximity to children remains similar across countries, suggesting a persistent value placed on familial closeness in later life.

Self-care practices show cultural imprints: vegetarianism is predominant among Indian older adults, while non-vegetarian diets and higher alcohol consumption are common in the U.S. Indian older adults exercise daily at notably higher rates. However, walking is the preferred activity for both groups. Domestic assistance is also more prevalent in India, reflecting both cultural acceptance of household help and the affordability of labor markets, whereas U.S. older adults maintain greater independence in household management. Healthcare access and utilization mark a clear systemic divide. Nearly universal health insurance coverage in the U.S. contrasts sharply with partial adoption in India. Barriers in India include perceived affordability, lack of awareness, and cultural preference for out-of-pocket payments.

Figure 17: Spider charts showing the comparison of different factors across the four themes. There are similar patterns in family structure and social engagement between older adults' lifestyles in India and the US. However, there are differences between independence and healthcare access factors between the two cohorts.

Spider charts in Figure 17 show a high-level picture of how the different factors differ between the two countries across the four themes studied. While family structure and social engagement themes are comparable for the two countries, self-care/independence and healthcare themes have significant differences.

Conclusion

The findings in this research paper address the stated gap by comparing the lifestyles of older adults in India and the US, highlighting critical systems in each country that can be improved based on cultural background. Deep analysis underscores that successful aging is a multifactorial phenomenon, shaped as much by cultural values, social structures, and personal agency as by formal healthcare systems. For policymakers, the data highlights the need for context-specific interventions: in India, expanding affordable, comprehensible health insurance products and integrating preventive health education could address current coverage gaps; in the U.S., community-based aging models and structured opportunities for interpersonal connection could boost social engagement among independently living older adults. Caregivers and healthcare providers in both settings can benefit from culturally informed approaches that respect dietary norms, exercise preferences, and communication styles, thereby aligning interventions with older adults' lived experiences. Moreover, technology developers can create inclusive elder-care tech, such as simple health apps, telemedicine, and social connectivity tools, to support aging in place in both India and the U.S.

By learning from each other's strengths through family-based support in India and community/institutional support in the U.S., both countries can innovate policies and services that ensure older adults not only live longer but also live with a high quality of life.

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