

# A Holistic Approach to Aging Gracefully: Ayurveda Hospital Models for Geriatric Care

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## ABSTRACT

**BACKGROUND:** The rapidly growing elderly population necessitates the development of holistic, affordable, and sustainable models of geriatric care. Ayurveda, with its emphasis on *Rasayana Chikitsa*, lifestyle regulation, and integrative therapies, offers a comprehensive framework for promoting healthy and graceful aging.

**AIMS:** This paper aims to highlight hospital-based models of geriatric care in Ayurveda that integrate preventive, promotive, curative, and rehabilitative approaches to improve quality of life in the elderly.

**METHODS:** A conceptual review of Ayurveda hospital-based care frameworks was undertaken. Key interventions included *Dinacharya* and *Ritucharya* for preventive health, *Rasayana* and *Medhya* therapies for physical and cognitive vitality, and *Panchakarma* for rejuvenation and detoxification. Supportive practices such as yoga, meditation, dietary counselling, and caregiver engagement were also integrated. Interdisciplinary collaboration among physicians, nurses, therapists, and attendants was emphasized to ensure continuity of care.

**RESULTS:** Ayurveda hospital models demonstrate potential to address common geriatric challenges such as degenerative disorders, metabolic syndromes, neurocognitive decline, and psychosocial stress. These interventions collectively enhance vitality, preserve dignity, and improve quality of life in elderly individuals by blending traditional healing with structured hospital care.

**CONCLUSION:** Ayurveda hospital-based frameworks represent effective prototypes of integrative geriatric care. By uniting classical Ayurvedic wisdom with modern healthcare delivery, they provide sustainable strategies for healthy aging and improved well-being in the elderly.

**Keywords:** Ayurveda, Geriatric Care, *Rasayana*, *Panchakarma*, Healthy Aging

## INTRODUCTION

Population ageing has emerged as one of the defining public health transitions of the twenty-first centu-

ry, and India sits at the centre of this shift. The number of Indians aged 60 years and above is projected to rise from approximately 149 million in 2022 to 347 million by 2050, by which time nearly one in every five citizens will belong to the elderly category and this cohort will outnumber children under 15 years of age. This demographic transformation is accompanied by a steep rise in chronic, degenerative, and multi-morbid conditions, including musculoskeletal disorders, neurocognitive decline, metabolic syndromes, and psychosocial distress, which together place an escalating burden on conventional health-care infrastructure that was never originally designed around the specific physiological and psychosocial needs of older adults.

In India, this challenge is further compounded by socio-economic vulnerability: a large proportion of older adults belong to the poorest wealth quintiles, a substantial share live without independent income, and geriatric care services remain concentrated in urban tertiary centres with an acute shortage of trained geriatricians and rehabilitation infrastructure. Although the National Programme for Health Care of the Elderly (NPHCE) was launched to address these gaps, its implementation continues to be constrained by systemic limitations, leaving considerable room for complementary, sustainable, and community-accessible models of care. Within this context, Ayurveda offers a distinct and time-tested vantage point. Classical Ayurvedic texts conceptualise *Jara* (ageing) as a natural, *Swabhavika* process that cannot be reversed but can be skilfully managed, and dedicate an entire clinical discipline, *Rasayana* or *Jarachikitsa*, to delaying degeneration, restoring tissue nourishment, and preserving functional independence in later life. Far from being merely a set of herbal formulations, Rasayana therapy is conceived as a structured methodology that, when administered under supervised, hospital-based conditions (*Kutipraveshika Rasayana*), can be more closely monitored, individualised, and integrated with allied therapeutic disciplines.

National policy has increasingly recognised this potential. The National AYUSH Mission has expanded the co-location of Ayurveda services across thousands of primary and community health centres and district hospitals nationwide, and dedicated geriatric initiatives such as Vayo Mitra reflect a deliberate policy intent to mainstream traditional medicine into elderly care. This direction is also consistent with global health discourse: the World Health Organization's Traditional Medicine Strategy explicitly encourages the integration of evidence-based traditional and complementary systems into national health frameworks. Yet despite this enabling policy environment, the literature offers comparatively little synthesis of what a dedicated Ayurveda hospital-based geriatric care model actually looks like in operational terms, how its constituent therapies (preventive, promotive, curative, and rehabilitative) are sequenced and integrated within a single care pathway, and how interdisciplinary teams of physicians, nurses, therapists, and caregivers might function together under such a model. Existing reviews have tended to focus narrowly on individual Rasayana drugs or isolated therapeutic procedures, rather than on the hospital as an integrated unit of geriatric care delivery. It is this gap that the present paper seeks to address, by consolidating the conceptual and clinical elements of Ayurveda hospital practice into a coherent, holistic model for geriatric care that is both classically grounded and operationally relevant to contemporary health-care planning.

## AIMS AND OBJECTIVES

### Aim

To critically examine and consolidate hospital-based models of geriatric care within Ayurveda that integrate preventive, promotive, curative, and rehabilitative dimensions, with a view to proposing a holi-

stic and clinically coherent framework for healthy and graceful ageing.

### Objectives

1. To analyse the epidemiological and policy context underlying the rising demand for structured geriatric care in India, and to identify the specific gaps that Ayurveda hospital-based models are positioned to address.
2. To describe and classify the key preventive interventions used in Ayurveda geriatric care, including *Dinacharya* and *Ritucharya*-based lifestyle regulation, in order to assess their role in maintaining baseline physiological resilience among elderly patients.
3. To evaluate the promotive and curative contribution of *Rasayana* and *Medhya* therapies to physical strength, immunity, and cognitive vitality in elderly patients presenting with degenerative and neurocognitive conditions.
4. To examine the role of *Panchakarma*-based rejuvenative and detoxification procedures, administered under supervised hospital settings, in the rehabilitative management of degenerative disorders, metabolic syndromes, and psychosocial stress in the elderly.
5. To assess the contribution of supportive practices, namely yoga, meditation, structured dietary counselling, and caregiver engagement, in reinforcing clinical outcomes and psychosocial well-being within the hospital care pathway.
6. To highlight the significance of interdisciplinary collaboration among physicians, nursing staff, therapists, and attendants in ensuring continuity, safety, and individualisation of care within the Ayurveda hospital model.
7. To propose a consolidated, replicable framework for Ayurveda hospital-based geriatric care that can inform future clinical practice, institutional planning, and integrative health policy.

### MATERIALS AND METHODS

This paper is structured as a conceptual and narrative review rather than a primary clinical study. Material was drawn from three streams: classical Ayurvedic compendia, namely the *Charaka Samhita*, *Sushruta Samhita*, and *Ashtanga Hridaya*, for foundational concepts of *Jara*, *Rasayana*, *Dinacharya*, and *Ritucharya*; peer-reviewed clinical and review literature indexed in PubMed Central, ResearchGate, and AYUSH-affiliated journals such as the Journal of Ayurveda and Integrated Medical Sciences, published largely between 2012 and 2026, covering *Rasayana* pharmacology, *Panchakarma* outcomes in degenerative joint disease, and yoga-based interventions in older adults; and national policy and demographic documents, including the UNFPA India Ageing Report (2023), the Longitudinal Ageing Study in India (LASI), and Ministry of AYUSH programme literature on the National AYUSH Mission and Vayo Mitra.

Search terms combining “Ayurveda,” “geriatric care,” “Rasayana,” “Panchakarma,” “Dinacharya,” “Medhya,” and “hospital model” were used across these sources. Articles were screened for relevance to hospital- or institution-based geriatric application; single-drug pharmacological studies were retained only where they illustrated a therapeutic principle relevant to the broader care model described here. The synthesised findings are organised below under four operational pillars introduced in the abstract, preventive, promotive, curative, and rehabilitative care, followed by an account of supportive practices and the interdisciplinary team structure needed to deliver them.

## DISCUSSION

### **Preventive Foundations: Dinacharya and Ritucharya in the Elderly**

The first pillar of the proposed hospital model rests on regulating daily and seasonal living, rather than waiting for disease to declare itself before intervening. Ayurveda holds that *Vata dosha*, the principle governing movement, nervous function, and elimination, becomes naturally more active with advancing age, and that an irregular routine accelerates the very degeneration it is meant to forestall. *Dinacharya* prescribes a structured sequence of waking, oral and sensory hygiene, oil massage (*Abhyanga*), measured physical activity, and regulated mealtimes, while *Ritucharya* adjusts diet and conduct to the six classical seasons so that the body is not caught unprepared by shifts in temperature and humidity.

Recent comparative literature has reframed these regimens in the language of contemporary preventive medicine, linking their rhythm-based structure to improved metabolic regulation, reduced low-grade inflammation, and more stable hormonal responses, while also calling for more rigorous clinical trials before firm conclusions can be drawn. Within a hospital setting, *Dinacharya* and *Ritucharya* need not remain abstract advice handed to a patient at discharge; they can instead be written into a daily ward schedule, supervised by nursing and therapy staff, and adjusted to each patient's constitution (*Prakriti*), strength (*Bala*), and existing disease burden. This is precisely the kind of individualised, supervised application that classical texts describe, but that outpatient counselling alone struggles to enforce consistently.

### **Promotive and Curative Care: Rasayana and Medhya Rasayana**

Where *Dinacharya* maintains baseline resilience, *Rasayana* therapy is intended to actively replenish what age has depleted. Classical Ayurveda treats ageing as an inevitable, natural (*Swabhavika*) process, but one in which the rate and severity of decline can be moderated through tissue-level nourishment, improved immunity, and adaptogenic support against stress. This is not merely a historical claim. A clinical trial combining integrated yoga with Ayurveda *Rasayana* in the form of *Brahmi ghrita* followed seventy-two older adults with mild cognitive impairment over eight weeks and found significant improvement in attention, learning, and working memory across all three intervention arms, with the combined yoga-plus-*Rasayana* group showing the strongest gains.

A separate controlled study of Guduchyadi *Medhya Rasayana* involving 138 patients aged 55 to 75 years with senile memory impairment reported measurable memory enhancement together with anti-stress and anxiolytic effects relative to controls. More recent open-label work on a proprietary *Medhya* formulation in patients aged 50 to 70 years with mild neurocognitive disorder similarly recorded improvement on standard cognitive rating scales over sixty days of supervised administration. Taken together, this body of evidence supports the inclusion of *Medhya Rasayana*, herbs and formulations such as *Mandukaparni*, *Shankhapushpi*, and *Brahmi* that are specifically directed at neural tissue, as a structured, monitored component of hospital-based geriatric protocols, rather than as an incidental herbal supplement left to the patient's own discretion.

### **Rehabilitative Care: Panchakarma in Degenerative and Metabolic Disease**

The third pillar addresses patients who have already crossed from risk into established disease, most commonly degenerative joint disorders that Ayurveda classifies under *Sandhigata Vata*, the classical correlate of osteoarthritis in the elderly. *Panchakarma*, the five-fold purification methodology, functions here not as a single procedure but as a calibrated sequence, typically combining *Abhyanga* (oil massage), *Swedana* (medicated fomentation), *Basti* (medicated enema), and joint-specific procedures such as *Janu*

*Basti* for the knee, intended to clear metabolic toxins (*Ama*), restore lubrication to the joint space, and slow the depletion of bone and marrow tissue (*Asthi* and *Majja Dhatu Kshaya*).

Documented hospital case material illustrates this concretely. A one-year prospective case report of Grade III knee osteoarthritis managed with a *Panchakarma* protocol of *Upanaha*, *Janu Basti*, *Panchatikta Basti*, and *Abhyanga-Patra Pinda Sweda* alongside structured knee exercises recorded sustained improvement in pain scores, range of motion, and quality-of-life measures across four quarterly assessments. A separate case series of sixteen patients with Grade 2 knee osteoarthritis undergoing a structured knee rejuvenation protocol reported consistent improvement at one-month and ninety-day follow-up. These remain small, hospital-level observations rather than large randomised trials, but they demonstrate that *Panchakarma* can be delivered as a monitored, sequenced inpatient or day-care protocol with measurable, trackable outcomes, which is exactly the operational form a geriatric hospital model requires.

### **Supportive Practices: Yoga, Meditation, Dietary Counselling, and Caregiver Engagement**

No single therapeutic procedure operates in isolation from a patient's daily psychological and social environment, which is why the proposed model treats yoga, meditation, structured diet, and caregiver involvement as integral rather than supplementary components of care. Population-level data from the Longitudinal Ageing Study in India associates regular yoga and meditation practice among older adults with stronger performance across multiple cognitive domains, even after adjusting for baseline status. Randomised trials conducted specifically in elderly home residents have shown that structured yoga intervention improves both cognitive function and sleep quality relative to controls, and a protocol-stage trial currently underway in central India is examining yoga against light exercise for well-being, mobility, and fall risk in physically inactive older adults.

These findings support embedding daily yoga and breath-work sessions, individualised dietary counselling aligned with *Ritucharya* principles, and structured family or caregiver orientation into the hospital's standard geriatric care pathway, rather than treating them as optional wellness add-ons offered only when time and staffing permit.

### **The Interdisciplinary Hospital Team**

None of the preceding pillars can function as a coherent model without a defined team structure. The Ayurveda hospital model proposed here positions the physician as the diagnostic and prescriptive anchor, responsible for *Prakriti* assessment and overall treatment sequencing; nursing staff and *Panchakarma* therapists as the operational backbone who supervise *Dinacharya* schedules, administer procedures, and monitor for adverse responses, particularly important given the comorbidity burden typical of patients in the eighth and ninth decades of life; yoga and rehabilitation therapists who deliver the supportive movement-based component; dietary counsellors who translate *Ritucharya* principles into ward-level meal planning; and trained attendants and family caregivers who extend continuity of care into the home after discharge.

This division of labour is consistent with national policy direction. India's National AYUSH Mission has already established co-located Ayurveda services across thousands of primary health centres, community health centres, and district hospitals, and dedicated initiatives such as Vayo Mitra reflect an explicit policy intent to mainstream this kind of team-based traditional care for the elderly, giving the present model both clinical precedent and an existing administrative pathway to scale.

### **Limitations**

This synthesis is conceptual rather than experimental, and the clinical studies cited vary considerably in

sample size, methodological rigour, and duration; several are small, single-centre, or non-randomised observations. The model presented here should accordingly be read as a framework intended to structure future controlled, multi-centre research and institutional practice, rather than as a substitute for it.

## CONCLUSION

The convergence of a rapidly ageing Indian population, a still-developing geriatric care infrastructure, and a growing, if uneven, base of clinical evidence for Ayurvedic interventions creates both an opportunity and an obligation to define what a hospital-based Ayurveda geriatric care model actually looks like in practice. By organising preventive lifestyle regulation, *Rasayana*-based promotive and curative therapy, *Panchakarma*-based rehabilitation, and supportive psychosocial practices under one interdisciplinary roof, Ayurveda hospitals are positioned to offer elderly patients a form of care that is simultaneously classically grounded, individualised, and operationally scalable within existing national health infrastructure. Realising this potential fully will require larger, better-controlled clinical trials and standardised reporting of hospital-level outcomes, but the conceptual and preliminary clinical foundation reviewed here suggests that such investment would be well placed.

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