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Research Paper

The Silent Suffering: Reimagining Psychosocial Palliative Care for Indian Elderly Cancer Patients

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ABSTRACT

The unprecedented growth of the worldwide ageing population is significantly influencing the epidemiology and management of cancer, with individuals aged 60 and above representing a growing proportion of cancer incidence and mortality both globally and within India. The convergence with rising cancer rates presents multifaceted clinical, psychosocial, and policy-related challenges. Psychosocial palliative care plays a pivotal role in alleviating the complex suffering of elderly cancer patients. Despite policy efforts and innovative care models, access to comprehensive palliative services in India remains limited and disproportionately concentrated in urban centers, reaching fewer than 2% of those in need. Systemic barriers such as stringent regulations, inadequate healthcare workforce, societal stigma, age-related discrimination, and cultural hesitations continue to hinder timely referrals, open communication, and the delivery of effective psychosocial support. The community-led palliative care initiative in Kerala exemplifies a transformative model rooted in grassroots participation, volunteerism, and public health integration, offering a scalable blueprint for other regions. Nonetheless, stark disparities persist across rural-urban divides, socioeconomic groups, and state health infrastructures, highlighting the urgent need for context-specific and adaptable interventions. This review consolidates current literature on the psychosocial dimensions of palliative care for elderly cancer patients in India, critically analyzing systemic, cultural, and infrastructural impediments while spotlighting avenues for innovation and policy advancement. Through this examination, it seeks to inform stakeholders: researchers, clinicians, and policymakers, on the development of culturally appropriate, age-responsive, and sustainable models that uphold dignity, autonomy, and holistic care in the evolving landscape of geriatric oncology in India.

Keywords: *Elderly, Cancer patients, Palliative care, Psychosocial needs, India, Geriatric oncology, Health disparities*

The global population is aging at an unprecedented rate, with the number of individuals aged 60 and above expected to reach 2.1 billion by 2050, accounting for 22% of the world's population (United Nations, 2019). This demographic shift is accompanied by a rise in non-communicable diseases, particularly cancer, which

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disproportionately affects older adults. According to the Global Cancer Observatory (GLOBOCAN, 2020), individuals aged 65 and above account for nearly 60% of all new cancer cases and 70% of cancer-related deaths worldwide. Age is a significant risk factor for cancer due to cumulative DNA damage, reduced immune surveillance, and prolonged exposure to carcinogens (DePinho, 2000). Common malignancies among the elderly include prostate, breast, lung, and colorectal cancers, which require long-term, complex care (Siegel et al., 2021). In India, the burden is escalating, with 1.4 million new cancer cases annually, of which 40% occur in individuals above 60 years (National Cancer Registry Programme, 2022). The Indian elderly population is projected to rise from 8.6% (2021) to 19.5% by 2050 (Ministry of Statistics and Programme Implementation, 2021), necessitating urgent attention to geriatric oncology care. Despite advancements in cancer treatment, elderly patients often face delayed diagnoses, undertreatment, and exclusion from clinical trials due to comorbidities and age-related vulnerabilities (Hurria et al., 2016). This underscores the need for age-sensitive cancer care models that integrate palliative care to address both survival and quality of life (QoL) (Mohile et al., 2018).

The Complex, Multidimensional Needs of Elderly Cancer Patients: Elderly cancer patients experience physical, psychological, social, and spiritual distress, necessitating a holistic care approach. Physically, they suffer from pain, fatigue, malnutrition, and treatment-related toxicities (Extermann et al., 2012). Psychologically, depression and anxiety are prevalent, with 25-30% of elderly cancer patients in India reporting clinically significant distress (Hurria et al., 2009). Socially, isolation, financial strain, and caregiver burden exacerbate suffering, particularly in low-resource settings (Nagy et al., 2024). Indian studies highlight cultural and systemic barriers, such as lack of awareness, stigma around cancer, and limited access to palliative care (Rajagopal & Venkateswaran, 2014). A study in Kerala found that only 18% of elderly cancer patients received adequate pain management (Sadhu et al., 2010). Additionally, family dynamics play a crucial role, with many elderly patients relying on informal caregivers who lack training (Dhiliwal et al., 2022).

Defining Palliative Care and Its Emerging Role: The World Health Organization (WHO, 2020) defines palliative care as: *"An approach that improves the quality of life of patients and their families facing life-threatening illness through prevention and relief of suffering by early identification, assessment, and treatment of pain and other problems—physical, psychosocial, and spiritual."* Palliative care is not limited to end-of-life care but should be integrated early into cancer treatment (Temel et al., 2010). Studies show that early palliative care improves symptom control, reduces depression, and enhances survival in some cases (Bakitas et al., 2015). In India, however, only 1-2% of cancer patients receive palliative care, primarily due to limited infrastructure, policy gaps, and lack of trained professionals (Rajagopal, 2016). Emerging models, such as community-based palliative care (Needs Assessment Study, 2021) and tele-palliative care (Cheung et al., 2021), show promise in bridging gaps.

Purpose of the Review: This comprehensive review aims to critically examine the current status, multifaceted benefits, persistent challenges, and critical research gaps in the provision of psychosocial palliative care for elderly cancer patients within the unique context of India. As the country undergoes a rapid demographic transition, with its population aged 60+ projected to nearly double to 19.5% by 2050 (Ministry of Statistics and Programme Implementation, 2021), and cancer incidence among this group rising alarmingly (40% of India's 1.4 million annual cases; Sathishkumar et al., 2022), the integration of holistic palliative care becomes a pressing public health priority. The purpose extends beyond mere documentation; it seeks to synthesize fragmented evidence on how psychosocial dimensions—encompassing mental health, social support, spiritual needs, and caregiver burdens—are addressed (or neglected) in existing palliative frameworks for the elderly. By systematically analyzing challenges such as workforce shortages (only 1 palliative care physician per 8,000 patients; Ghoshal et al., 2022), cultural barriers (stigma around cancer and mental health; Pandey et al., 2020), policy fragmentation (inconsistent integration into national health programs), and urban-rural disparities in access (Rajagopal, 2016), this review will identify actionable solutions. Furthermore, it will evaluate the potential of emerging models like community-led initiatives (Kerala's Neighbourhood Network in Palliative Care) and telehealth interventions (Cheung et al., 2021) to bridge gaps. The ultimate goal is to provide evidence-based recommendations for policymakers, clinicians, and researchers to develop culturally congruent, scalable, and sustainable psychosocial palliative care strategies. This is not merely an academic exercise; it addresses an urgent equity issue where elderly cancer patients in India—particularly in resource-limited settings—remain vulnerable to preventable suffering due to systemic neglect (Nagy et al., 2024). By mapping the landscape and proposing a roadmap for integration, this review seeks to catalyze reforms that prioritize dignity, quality of life, and psychosocial well-being for India's aging cancer population at a critical juncture in its healthcare evolution.

Prevalence of Cancer and Cancer Care in the Elderly: A Focus on India and Global Comparison

Globally, cancer incidence and mortality are increasingly concentrated among older adults. According to GLOBOCAN 2020 estimates, over 50% of new cancer cases and 70% of cancer deaths occurred in adults aged 60 and above (Sung et al., 2021). A detailed analysis by Pilleron et al. (2021) revealed that older adults (≥60 years) accounted for approximately 11.3 million cases and 7.5 million cancer-related deaths in 2020. Projections estimate an alarming 75–83% increase in elderly cancer burden by 2040 (Pilleron et al., 2021). The World Health Organization (2020) recognizes this trend and has called for global interventions targeting the aging population through its "Decade of Healthy Ageing" initiative. The most common cancers in older adults globally include lung, breast, prostate, and colorectal cancers (Sung et al., 2021). Lung cancer remains the leading cause of cancer-related deaths among elderly men, while breast cancer leads among older women (Ferlay et al., 2020). Colorectal cancer is prevalent in both sexes, with prostate cancer being particularly common in older males (Pilleron et al., 2021).

In India, demographic aging is contributing to an increasing cancer burden. The elderly population (≥60 years) is expected to grow from 8.6% in 2011 to 19.5% by 2050 (Verma et al., 2019). Concurrently, India's total cancer cases are projected to rise from 1.39 million in 2020 to 1.57 million by 2040 (Sathishkumar et al., 2022). Data from Population-Based Cancer Registries indicate that 35–45% of cancer cases occur in those aged 60 and above (ICMR-NCDIR, 2021; Mathur et al., 2020). A multicentric study by Sansar et al., 2024 across 17 Indian cancer center showed that 36% of all patients were elderly. Head and neck cancers (19.6%) were most common, followed by breast (11%), genitourinary (10.9%), and lung cancers (10.7%) in this population. This pattern differs from global trends due to India's high burden of tobacco-related cancers (Pak et al., 2021). Globally, geriatric oncology is becoming an established sub-specialty. Guidelines by ASCO and SIOG emphasize the importance of comprehensive geriatric assessment (GA) for treatment decisions (Mohile et al., 2018; Soto-Perez-de-Celis et al., 2017). In countries like France and Spain, national cancer care pathways include elderly-specific protocols (Rached et al., 2023). However, in India, this field remains underdeveloped. Apart from Tata Memorial

Hospital, very few centers have dedicated geriatric oncology units (Noronha et al., 2023). An Indian survey by Choudhury et al. (2021) found that only 10% of oncologists routinely used GA tools; over 50% relied solely on clinical judgment. Furthermore, awareness of international geriatric oncology guidelines is limited—44% of practitioners were unaware of ASCO recommendations (Choudhury et al., 2021). This results in undertreatment, overtreatment, and suboptimal outcomes for older cancer patients (Tiwari et al., 2015). Clinical trials in India also marginalize the elderly. A review by Noronha et al., 2024 found that only 23% of Indian trial participants were ≥60, although elderly patients constitute over 30% of cancer cases. Age-related exclusion criteria and comorbidities often prevent elderly participation.

India also lacks age-specific cancer care protocols. Current national frameworks do not account for geriatric-specific variables like frailty, polypharmacy, or cognitive function (Noronha et al., 2023). Experts emphasize the urgent need for guidelines tailored to older Indian patients, including validated GA tools like SCOPE-C, which are now being adapted for local use (Banerjee et al., 2019). In conclusion, while global health systems are evolving toward geriatric-focused oncology, India lags in implementing elderly-centered cancer care. With its aging population and rising cancer rates, India must urgently develop age-appropriate guidelines, training programs, and inclusive research practices to address the growing burden in this vulnerable group.

Understanding Palliative Care in Elderly Cancer Patients

Elderly cancer patients present with complex and distinctive palliative care needs that span physical, psychological, social, and existential domains, requiring a holistic, multidisciplinary approach (Alexander, 2015). Early integration of palliative care with oncological treatments is shown to improve outcomes, as evidence suggests that such integration optimizes symptom control, enhances quality of life, and supports patient autonomy (Sanders et al., 2024); this is particularly relevant in elderly populations, where multimorbidity, frailty, dependency, and cognitive impairments often complicate cancer management (Castelo-Loureiro et al., 2023).

A significant psychological burden among elderly cancer patients includes high rates of depression, anxiety, and existential distress (Ann-Yi & Bruera, 2022). These issues may be intensified by fears surrounding loss of independence and the meaning of illness and dying in old age (Wong & Yu, 2021). Indian studies have highlighted that spirituality and existential well-being are profoundly linked to the quality of life in advanced cancer, underscoring the regional importance of addressing spiritual needs (Kandasamy et al., 2011). Identifying and appropriately managing psychological symptoms require routine screening and collaborative care models (Block, 2017). Social and familial concerns further shape palliative needs: many older adults face increased dependency due to decreasing physical function, often resulting in heightened risk of social isolation (Castelo-Loureiro et al., 2023). Family caregivers, central in India's sociocultural context, experience substantial psychological distress, with reports indicating that 66–96% of caregivers face significant anxiety, depression, or burden (Oechsle, 2019). A lack of structured support for caregivers in resource-limited settings exacerbates these challenges (Chandra et al., 2023). Barriers to effective palliative utilization among elderly cancer patients arise from misperceptions—such as seeing palliative care as only for the terminally ill—as well as logistical, financial, and cultural challenges, particularly in India (Parajuli et al., 2020). Comprehensive reviews identify gaps in awareness, training for health professionals, and infrastructural limitations, all of which hinder timely referrals and consistent palliative involvement (Getie et al., 2025).

In India, systematic reviews estimate a substantial unmet need, with a prevalence of 6.21 individuals per 1,000 requiring palliative care, yet services remain underutilized (Chandra et al., 2023). In terms of direct care, symptom control remains paramount. Older adults with cancer commonly endure complex, multifactorial symptoms—such as pain, fatigue, dyspnea, anorexia, and insomnia—that require careful, often non-pharmacologic, tailored interventions to minimize side effects from polypharmacy (Alexander, 2015). Psychological and existential issues must be integrated into care through skilled counseling, psycho-oncology, and spiritual support (Wong & Yu, 2021; Ann-Yi & Bruera, 2022).

Research from both high- and low-resource settings supports the value of early palliative involvement, ideally initiated at diagnosis of advanced disease, to facilitate advance care planning, symptom anticipation, and psychosocial adaptation (Sanders et al., 2024). Indian and global literature highlights the pivotal role of community-based, multidisciplinary, and family-inclusive palliative models (Chandra et al., 2023); such strategies are associated with better symptom relief, less aggressive end-of-life interventions, and more dignified dying (Walbaum et al., 2024). Overall, the core goals of palliative care in elderly cancer patients are symptom control, enhanced quality of life, maintenance of dignity, and facilitation of a dignified death (World Health Organization, 2020). Preserving dignity is particularly salient; interventions that respect patient preferences, foster communication, and attend to spiritual needs are essential (Wong & Yu, 2021; Block, 2017). Early, holistic palliative approaches, especially in India, close gaps in care, reduce caregiver burden, and align care with patients' values and cultural context (Kandasamy et al., 2011; Chandra et al., 2023).

Palliative Care in India: The Kerala Model

India faces a severe shortage of palliative care services, with only 1-2% of the estimated 7-10 million people needing such care actually receiving it (McDermott et al., 2008). This gap is especially critical for elderly cancer patients who often struggle with complex physical and emotional needs that go unaddressed (Web et al., 2021). In this challenging landscape, Kerala's innovative approach to palliative care - particularly through its Neighbourhood Network in Palliative Care (NNPC) - has emerged as a groundbreaking example of how community-based solutions can transform end-of-life care. What started as a local initiative in Kozhikode in 1993 has grown into a globally recognized model that demonstrates the power of combining community participation with primary healthcare systems. This examination explores how the Kerala Model developed, how it works, what it has achieved, and the difficulties in applying it elsewhere in India.

The development of palliative care in India faced major obstacles from the beginning. The Narcotic Drugs and Psychotropic Substances Act of 1985, while meant to prevent drug abuse, created so many restrictions that it became extremely difficult for doctors to prescribe pain-relieving medications like morphine (Rajagopal & Joranson, 2007). At the same time, palliative services were only available in a few major cancer centers located in big cities, leaving most of India's rural population without access to proper care (Rajagopal, 2016). Medical schools paid little attention to teaching palliative care, and cultural taboos about discussing death and illness made it harder for families to seek help (Sadhu et al., 2010). It wasn't until 2012 that India finally created a national policy for palliative care, despite the urgent need being clear for many years. In response to these challenges, Dr. M.R. Rajagopal and Suresh Kumar developed the NNPC in Kerala in 1993. Their revolutionary idea was that communities themselves could provide most basic palliative care with proper training, while saving medical professionals for more complex cases (Kumar, 2004). This community-based approach reduced dependence on overcrowded hospitals and made care more accessible to people in their own homes. The NNPC works through local groups of 10-20 volunteers who serve about 1,000 households in their area. These volunteers receive 15-30 hours of training to learn how to assess patients' needs, provide basic care, recognize when professional help is needed, and offer emotional support (Sallnow et al., 2010; Woitha et al., 2015). They visit patients regularly at home, often identifying people who need help through word-of-mouth in the community or referrals from local health centers. The volunteers work closely with nurses and doctors who hold regular community clinics to examine patients and adjust treatments as needed. More serious cases are referred to specialized care through an organized system. All these efforts are coordinated at the district and state levels to maintain quality standards across Kerala.

What makes the Kerala Model particularly successful is how it pays for itself locally. Volunteer groups raise money through small monthly donations from households (typically ₹10-100), community fundraising events, and support from local businesses and places of worship (Kumar, 2020). People also contribute goods and services like food, medical supplies, and transportation. This local support system creates strong community involvement while reducing the need for outside funding. A major breakthrough came in 2008 when Kerala's government made palliative care part of its official health policy. This decision integrated palliative services into the existing network of local health centers, which became responsible for storing medicines, hosting clinics, and supporting volunteers (Government of Kerala, 2008). Health workers received special training in pain management, and nurses learned to serve as links between volunteers and doctors. Most importantly, Kerala changed its rules to make morphine more easily available through local health centers, solving one of the biggest obstacles to pain relief in India (Rajagopal, 2016). The results have been remarkable. Today, over 80% of people needing palliative care in Kerala can access services, compared to less than 2% nationwide (McDermott et al., 2008). More than 15,000 trained volunteers work across all districts, supported by medical professionals. The easy availability of pain medication through local health centers has dramatically reduced suffering (Valleth et al., 2018). The system operates very cost-effectively thanks to volunteer labor and local fundraising (Sallnow et al., 2010). Beyond physical care, volunteers provide crucial emotional support, help resolve family conflicts, and arrange spiritual care when requested (Woitha et al., 2015). Perhaps most importantly, the program has helped change social attitudes, making discussions about death and serious illness more open and reducing stigma.

However, Kerala's success story can't be easily copied in other parts of India because of important differences. Kerala benefits from having one of India's highest literacy rates (94%) and a strong tradition of community organizing, both of which help in training volunteers and getting people involved. Its network of local health centers works relatively well compared to other states. Many parts of India struggle with weaker healthcare systems, less effective local government, and communities that aren't as well organized. The local fundraising that works in Kerala might not succeed in poorer areas with greater economic inequality. India's strict national drug laws continue to limit access to pain medication in most states, and few have shown Kerala's willingness to change these rules. Keeping volunteers motivated and maintaining service quality across large areas presents another major challenge (Woitha et al., 2015). The model also works less well in big cities where people don't know their neighbors as well. The Kerala Model shows what's possible when communities take responsibility for caring for their most vulnerable members. Its combination of local volunteers, professional medical support, and government backing offers important lessons for improving palliative care everywhere. But other Indian states will need to adapt these ideas to fit their own circumstances rather than trying to copy Kerala exactly. Kerala has proven that better end-of-life care is achievable - now it's up to the rest of India to find their own ways to make it happen.

Benefits of Palliative Care in Elderly Cancer Patients in India

In India, palliative care plays a vital role in managing the diverse psychosocial issues that elderly cancer patients encounter, such as caretakers' stress, social isolation, and emotional discomfort. Indian studies have continually shown considerable improvements in psychological well-being among patients receiving palliative care, with reduced anxiety, sadness, and feelings of hopelessness (Asthana et al., 2019; Nayak et al., 2017). In addition to enhancing coping mechanisms and emotional resilience, these therapies improved patient autonomy and carers' capacity to provide continuous support (Singh, 2010; Sultana et al., 2021). In India, a key element of palliative care is home-based care. In rural and resource-constrained places, where access to institutional care may be restricted or culturally unacceptable it performs particularly well. By honouring local cultural norms and integrating care within well-known social networks, these community-oriented methods help to provide psychosocial support (Dhiliwal & Muckaden, 2015; Salins et al., 2024). Training community health professionals to provide structured psychosocial interventions has the ability to address access gaps and provide culturally competent care, according to Cartmell et al. (2022).

Beyond relieving symptoms, psychosocial advantages include improved communication between patients, relatives, and medical professionals. According to studies, patients who receive palliative care are more satisfied with the counselling and emotional support they receive, as well as the respect they receive for their choices about end-of-life care and decision-making (Nayak et al., 2017; Asthana et al., 2019). These factors are essential for preserving self-respect and minimising existential anxiety. Additionally, palliative care lessens the financial burden that cancer places on senior citizens and their families. By lowering hospital stays and medical costs, home-based care enables families to continue providing care while continuing to be able to access government assistance programs (Khosla et al., 2012; Rajagopal, 2015). According to Agrawal et al. (2025), in order to guarantee fair medical and psychosocial care for the diverse Indian population, critical medication lists must be expanded. Longitudinal data from Mumbai highlight that consistent, integrated palliative care strengthens family resilience, improves psychosocial wellbeing, and supports preferred death settings, such as dying at home (Dhiliwal & Muckaden, 2015; Salins et al., 2024).

Challenges to Palliative Care in India

Despite clear psychosocial benefits, palliative care services in India face systemic barriers that disproportionately affect elderly patients. Service provision is predominantly urban-centric, resulting in insufficient psychosocial assistance for the majority of older adults in rural areas and outskirts of cities (Immanuel et al., 2024). Workforce shortages and infrastructure limitations intensify this disparity, impeding the provision of consistent counselling, emotional care, and social engagement opportunities (Ghoshal et al., 2022; Salins et al., 2024). Regulatory challenges, including restrictive opioid policies, indirectly affect psychosocial care by restricting effective symptom relief and exacerbating patient suffering, potentially increasing anxiety and depression (Rajagopal & Joranson, 2007). Although policy amendments have enhanced availability, inconsistencies in enforcement continue to undermine comprehensive care approaches (Khosla et al., 2012). Cultural and familial perspectives on ageing, death, and cancer present additional complexities. The social stigma associated with cancer and death, along with traditions of family-centered decision-making, frequently interfere with open discussions regarding prognosis and palliative care needs, resulting in delays in referrals and psychosocial interventions (Singh & Harding, 2015; Sultana et al., 2021). Elderly patients often encounter ageism, which includes the neglect of their psychosocial issues and being excluded from comprehensive care planning (Immanuel et al., 2024). This leads to insufficient support for emotional and social vulnerabilities, including loneliness, caretaker stress, and reduced social participation (Agrawal et al., 2025).

Hospice care in India is in its early development phase, primarily located in urban areas, and exhibits significant variation in care standards (Shukla et al., 2022). Current policy frameworks inadequately address the psychosocial challenges associated with ageing. Palliative care is part of the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS); however, dedicated funding and nationwide implementation are inadequate (Nair et al., 2021). Kerala's community-driven model demonstrates effective integration of psychosocial care into palliative services; however, many states struggle to replicate these approaches (Rajagopal, 2015). Ageism exacerbates care delivery by resulting in diagnostic overshadowing and insufficient referrals for psychosocial assessment, which leaves numerous elderly patients without required psychological support or carer assistance (Agrawal et al., 2025; Immanuel et al., 2024). Addressing these barriers requires policy reform that includes geriatric-sensitive training for healthcare providers, public education to mitigate stigma, and investment in psychosocial research.

DISCUSSION

Although palliative care is formally acknowledged as a critical component of cancer management in India, the delivery of psychosocial palliative care for elderly cancer patients is notably fragmented and inadequate. The National Program for Palliative Care (NPPC) has established a national vision that emphasises the essential role of palliative services; yet, significant disparities in access and quality persist, particularly in rural and underserved areas (Rajagopal et al., 2019; Bhatnagar et al., 2022). While there are observable incremental improvements in infrastructure, palliative care models in India primarily emphasise curative approaches. The introduction of palliative services occurs later in the disease trajectory, which significantly compromises thorough management of symptoms and undermines the holistic well-being of elderly patients (Salins et al., 2021). The 2014 amendment to the Narcotic Drugs and Psychotropic Substances (NDPS) Act represents a significant development aimed at enhancing the availability of opioids for pain management. The continuing reluctance of healthcare providers, along with complex bureaucratic processes, persists in restricting the effective application of these reforms. Clinicians' hesitance to prescribe opioids frequently stems from concerns regarding legal scrutiny and ongoing stigmatisation, resulting in insufficient pain management and consequently worsening psychological distress in elderly patients (Rajagopal & Mishra, 2010). The regulatory developments, although essential, have not resulted in uniform or equitable access to pain relief nationwide, indicating a significant disparity between policy and implementation.

National policy frameworks often fail to address the complexities that emerge at the intersection of ageing and cancer. The recent publication of Elderly Palliative Care Guidelines by AIIMS Bhopal signifies advancement, as these guidelines aim to address the needs of older adults through recommendations including frailty screening and the organised participation of caretakers in care planning. However, there is a deficiency in a unified national strategy that is tailored for geriatric populations and flexible enough to accommodate various local circumstances (Bhatnagar & Garg, 2023). A persistent disconnect exists between national-level guidance and the capacity of decentralised health systems to implement these initiatives inclusively and sustainably. A significant methodological limitation in palliative care research in India is the prevalent absence of age-specific data collection and analysis. Many studies categorise adult cancer patients as a uniform group, neglecting to identify or address the specific psychosocial vulnerabilities of the elderly, such as social isolation, cognitive impairment, and existential distress (Asthana et al., 2019). This research gap has significant implications: interventions frequently lack the precise adaptation necessary to meet the distinct needs of older adults. Designing, evaluating, or scaling psychosocial interventions, including organised counselling or peer support programs, for elderly cancer patients is infrequent, resulting in the consistent neglect of their emotional and social needs (Chaturvedi et al., 2018).

To effectively support elderly cancer patients, palliative care must evolve beyond physical symptom control to embrace integrated age-sensitive models that address psychosocial well-being, which is also a lacking area in terms of research in psycho-oncology. There is an abundance of studies on psychosocial effects of cancer and the services available for the care of these issues. While the satisfaction rate after the teleconsultation is higher (73.9%) in patients (Adhikari et al., 2021), only 10 patients called for the counselling services from the total of 547 patients in total. This highlights a crucial gap: while digital health interventions like tele-palliative care are promising—especially during widespread disruptions such as the COVID-19 pandemic—issues of digital literacy, infrastructural access, and ongoing stigma continue to circumscribe their impact. Collaborations with non-governmental organizations (NGOs) and academic partners represent one of the most productive avenues for bridging these systemic gaps. Organizations such as Can Support, Pallium India, and Karunashraya have pioneered home-based palliative and hospice care with methodologies sensitive to the psychosocial and cultural needs of older patients. These NGOs have demonstrated the efficacy of integrating community health workers who are trained to provide both practical assistance and emotional support, thereby overcoming shortages in the formal healthcare workforce (Ghoshal et al., 2022; Agrawal et al., 2025). However, while these civil society initiatives highlight scalable models, their reach is limited, and they are highly dependent on regional leadership and variable funding.

The COVID-19 pandemic catalyzed a shift toward telehealth in palliative care, with observational studies demonstrating that telemedicine is not only feasible for elderly cancer patients but also acceptable as a means to sustain psychosocial engagement in situations where physical presence is not possible (Nair et al., 2021; Adhikari et al., 2021). Nonetheless, the effectiveness of such interventions is moderated by factors such as age-related technological challenges, cognitive or sensory impairments, and the privacy limitations of multigenerational households. As several studies note, while these interventions can enhance autonomy and access, they often require hybrid models combining in-person and digital support to ensure equitable and comprehensive care (Kirby et al., 2025). Integration of tele-palliative care with larger annual health programs also holds promise for bolstering ongoing psychosocial support, facilitating advanced care planning, and extending caregiver education—functions especially critical in resource-constrained or geographically isolated settings (Kirby et al., 2025). This approach, if systematically supported, can help address the acute shortage of specialist resources and enable ongoing, culturally attuned psychosocial engagement with elderly cancer patients.

In conclusion, although India's palliative care policy is developing to meet the needs of elderly cancer patients, significant obstacles remain in systematic execution, interdisciplinary integration, research practice, and social stigma. The future of equitable, age-sensitive psychosocial palliative care in India relies on coordinated policy advocacy, the expansion of effective community-based models, increased engagement from academic and civil society, and a strong commitment to research that categorises and dynamically addresses the psychosocial trajectories of older adults with cancer.

CONCLUSION

Prioritising elderly cancer patients in India's palliative care system is essential for effectively addressing their complex psychosocial needs. A strategy that integrates age-sensitive care models, policy advocacy, community empowerment, and telehealth expansion is likely to yield more compassionate, equitable, and sustainable care. Improving research and training in geriatric psychosocial oncology is essential for transitioning care from a fragmented approach to a holistic one, thereby ensuring dignity and quality of life for the ageing cancer population in India.

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