ORIGINAL ARTICLE

Rethinking successful aging concepts: Insights from a culturally grounded model among older adults in Odisha, India

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ABSTRACT

Despite the widespread use of the biomedical model of successful aging, it overlooks the cultural and lived experiences of older adults in low- and middle-income countries, such as India. Therefore, this cross-sectional study aims to empirically test a culturally grounded model of successful aging in India. Using a multistage stratified sampling with a structured interview schedule, this study used 600 older adults aged 60 years and above from Odisha, India. We used a dichotomous measure of successful aging, which includes 1) being free from disability, 2) having high cognitive function, 3) being engaged in physical activity, 4) experiencing social engagement, and 5) having a positive attitude towards physical health. Descriptive statistics and correlation analysis were carried out to present the initial results. An association between successful aging and explanatory variables was carried out by multivariable logistic regression. One in five older adults fulfilled the requirements for successful aging with rural disadvantage. Being highly educated (AOR: 8.47; 95% CI: 2.89-24.82), having higher wealth (AOR: 4.86; 95% CI: 1.14-20.68), and living with a spouse only (AOR: 8.51; 95% CI: 1.91-37.98) had higher odds of successful aging. Positive psychology towards physical health had a strong positive correlation with successful aging ($r = 0.68$, $p<0.001$), whereas disability was found to have a significant negative correlation ($r = -0.61$, $p<0.001$). These findings highlight the inadequacy of universalist, biomedical definitions in capturing the lived experiences of Indian older adults, where education, familial roles, and wealth status were integral for successful aging. Policies should support family- and community-centered aging policies, including incentives for intergenerational co-residence and caregiving, which can foster stronger social support networks and improve overall well-being in later life. Additionally, there is a need for further qualitative studies to understand how older adults in rural Odisha define and perceive successful aging.

Keywords:
successful aging, health status, social support, aged, Odisha, India

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INTRODUCTION

Aging is an unavoidable biological phenomenon with significant societal, economic, and psychological consequences.[1] The World Population Prospects 2019 projected that the proportion of individuals aged 65 and older would rise from 9% in 2019 to 16% by 2050.[2] India is also experiencing a rapid demographic shift, with an anticipated 13% increase in the population aged 60 years and older from 2005 to 2050.[3] This aging trend significantly impacts the public health systems because of higher rates of non-communicable diseases (NCDs), chronic conditions, functional limitations, and mental health disorders among older adults.[4] As a result, India and other developing countries face challenges like a high burden of morbidity and disability, higher demand for healthcare facilities, and high health expenses, with concerns related to quality of life. Thus, understanding the process and quality of aging becomes relevant for many developing countries, including India.

The term successful aging, also referred to as the process of aging well, has received significant attention due to the increasing proportion of older adults worldwide. This concept aims to extend life while enhancing the quality of the added years.[5] However, defining "successful aging" is contentious and has changed over time, influenced by cultural, medical, and social values.[6] Among the most widely cited models is the biomedical model proposed by Rowe and Kahn, which defines successful aging as based on three main components: low likelihood of disease and disability, higher cognitive and physical functioning, and active engagement with life.[1] While this model provides a structured and measurable conceptualization, they have faced considerable criticism for their overly biomedical and individualistic orientation.[6]

In particular, the exclusion of older adults with chronic conditions from the category of "successful agers" has generated ethical debate.[7] In low- and middle-income countries like India, structural disparities, inadequate healthcare facilities, and cultural variables affect aging differently.[8,9] Despite having chronic health conditions, older adults have succeeded in maintaining social lives, strong spiritual connections, and a sense of purpose. Studies have shown that older adults often rate themselves as successful agers despite the presence of chronic health conditions.[7,10] Although chronic conditions are prevalent in older adults, the capacity for independent functioning, effective communication, and active participation in daily life, without substantial impairment from a disability, is of greater relevance and practicality.[11,12] This deviation between subjective valuations and objective measures highlights the inadequacies of the biomedical model of Rowe and Kahn.

Indeed, the strict application of biomedical model criteria fails to capture the complexity and multifaceted nature of aging, particularly in the context of India. The socio-cultural environment of India significantly differs from that of Western societies, where the Rowe and Kahn model was developed. In Indian society, aging is surrounded by familial and community structures.[13] In this context, older adults are often valued for their wisdom, caregiving responsibilities, and spiritual guidance.[14] Successful aging is not just a function of physical health or individual independence, but also of one's capacity to maintain integration within relational networks.[15]

Studies show that Indian older adults prioritize family and staying informed about their health status. These factors are often considered crucial to later life satisfaction and identity.[14] Indian older

adults live with family while maintaining emotional support and participating in family rituals and decision-making activities.[16] In India, successful aging promotes interdependence over independence. However, the Western model focuses on self-reliance and physical fitness, which may be culturally incongruent and normatively inappropriate for Indian older adults.[1] Furthermore, aging in India is closely linked to healthcare-seeking, lifestyle practices, and social responsibility.[17] In addition, physical activity is seen as both a personal health habit and a way to help other family members.[16]

Hence, redefining successful aging in India necessitates a departure from the universalist framework of Rowe and Kahn, and in favor of more inclusive and flexible definitions that reflect the diversity of aging experiences in India. An older adult with diabetes or arthritis who participates in community work, maintains strong family connections, practices meditation, and possesses knowledge about their physical health condition may not fulfill the Rowe and Kahn criteria; however, this individual could exemplify successful aging within the Indian sociocultural context.[7,18] The reliance on objective health metrics alone often overlooks the subjective experiences of older adults, who may derive meaning, fulfillment, and a sense of contribution in ways that exceed biomedical standards.[19] The term "successful aging," increasingly recognized by gerontologists, highlights the significance of purpose, legacy, and psychosocial engagement in determining life satisfaction in later years.[20]

Therefore, a culturally grounded model of successful aging in India should encompass being free from disability, having higher cognition, being physically active, having active social engagement, and possessing a comprehensive awareness of one's physical health conditions. This aspect is particularly significant in a nation where healthcare access and literacy vary across socioeconomic and regional divides.[17] Also, older adults with a positive mindset regarding health monitoring and maintenance are more inclined to adopt preventive measures, comply with treatments, and maintain overall well-being.[18] Hence, psychological orientation toward physical health is a crucial factor in successful ageing within the Indian context.[3] Therefore, this research paper aims to examine successful aging by proposing and testing an expanded culturally relevant model that captures the lived experiences of older adults within the Indian context. The proposed model integrates freedom from disability, higher cognitive function, engagement in physical activities, active social participation, and positive psychological tendencies towards one's own physical health, recognizing the multifaceted nature of aging and providing a comprehensive framework for assessing well-being in later life. This study hypothesized that individuals scoring higher on this integrated model will report significantly higher levels of successful aging in later life.

METHODS

Study design and participants

This study was conducted in the Indian state of Odisha, which was selected purposively for its demographic and socio-economic attributes relevant to aging research. Odisha was classified as an Empowered Action Group (EAG) state with a low human development index, socio-economic issues, poor health infrastructure, low literacy, and higher rural dependency, leading to poor quality of life among older adults.[21] Additionally, demographic transition towards an aging population, with the underdevelopment of the economy, creates a pressing context for exploring the determinants of successful aging in Odisha, India.

This cross-sectional study employed a multistage stratified sampling

method and included older adults aged 60 years and above, ensuring regional and socioeconomic representation. Odisha was divided into coastal, northern, and southern regions as per the National Sample Survey Organization (NSSO) and based on the Economic Development Index (EDI) and District Development Index (DDI), six districts were selected, two from each region, ensuring inclusion of both the best and the least-performing districts with a higher share of older adults. Best-performing districts of EDI and DDI were Cuttack, Sambalpur, and Ganjam, while the least-performing districts were Nayagarh, Bargarh, and Kalahandi for coastal, northern, and southern regions, respectively. According to Cochran's equation, when the population size is unknown, a minimum sample size of 385 should be used.[22] We collected 300 samples from rural areas and 300 samples from urban areas. For rural areas, one block is selected randomly from each district, five villages were chosen randomly from each block, and 10 respondents were interviewed from each village, totaling 50 rural samples per district. Similarly, in the urban areas, one Notified Area Council (NAC) or higher urban bodies was selected in each district, with five wards sampled per NAC and 10 respondents per ward, contributing another 50 urban samples per district. With a pre-tested schedule, we collected data regarding successful aging from 100 respondents (50 samples from rural and urban areas each) in each of the selected districts between December 2024 and June 2025.

Variable description

Dependent variable

Successful aging, which was coded as 0 for "No" and 1 for "Yes", was used as a dependent variable with a multidimensional approach based on a culturally grounded framework that reflects Indian socio-cultural values and aging realities. Older adults who were free from disability, had a solid cognitive function, did physical activity, had active social participation, and had a positive psychological tendency regarding their physical health were identified as successful agers. The factors in detail are as follows:

1. Free-form disability: Disability was measured through the Activities of Daily Living (ADL) and Instrumental ADL (IADL). ADL refers to regular self-care tasks, including dressing, walking, bathing, eating, bed mobility, toilet use, and IADL refers to cooking, shopping, use of telephone, self-medication, gardening, money management, and finding an address in an unfamiliar place. The capacity to perform such activities of ADL and IADL serves as an indicator of functional status with a score of 0-13, where each activity is coded as 1 if the respondent reports difficulty and 0 otherwise. Respondents were categorized as having no disability if they did not experience any difficulties (having a score of 0) while performing any of the above mentioned activities.[23]

2. High cognitive function: The abbreviated mental test score (AMTS) was used to assess the cognitive function of older adults. A score of 7 or more suggests high cognition.[24]

3. Physical activity: Respondents were said to be physically active if they performed any physical activity regularly, such as running/jogging, swimming, going to a health center or gym, cycling, or digging with a spade or shovel, heavy lifting, chopping, farm work, fast bicycling, or cycling with loads.

4. Social engagement: Older adults were classified as socially engaged if they participated at least once in a month in any of the following activities: " Eat outside of the house; going to the park/ beach; playing cards or indoor games; playing games/

sports/exercising/jogging/ yoga; visiting relatives/ friends; attending cultural performances/ shows/ Cinema; attending religious functions/ events such as bhajan/ Satsang/ prayer; attending political/ community/ organization group meetings; books/ newspapers/ magazines reading; watching television/ listening to the radio and use of a computer for e-mail/ net surfing."[23]

5. Psychological tendency toward physical health: This study used 10 sub-scales from the Health Orientation Scale (HOS) to measure psychological tendencies toward physical health, measured on a five-point Likert scale (range = 5-25). Each subscale contains five components, and a Cronbach's alpha value of >0.70 was used to assess the quality (Annexure I). A lower score corresponds to agreeing strongly with the psychological tendency measured by the HOS. Respondents scoring 10 or less on "Personal Health Consciousness, Health Esteem Confidence, Motivation to Avoid Unhealthiness, Motivation for Healthiness, Internal Health Control, and Health Status" were categorized as having positive psychological tendencies regarding their physical health. Similarly, a higher score of 11-25 on Health "Image Concern, Health Anxiety, External Health Control, and Health Expectations" was categorized as having positive psychological tendencies regarding their physical health.[25]

Explanatory variable

Socioeconomic and demographic characteristics: Age of older adults was categorized as 60-69, 70-79, and 80+. Sexes were coded as male and female. Education indicators were illiterate/below primary, up to primary, up to secondary, and secondary and above. Living arrangements were coded as living alone, with a spouse only, with a spouse and others, and without a spouse but with a child. Economic dependency was coded as fully dependent, not dependent, and partially dependent. Arranged by household, no insurance, and government sponsored were the categories for insurance.

Household factors: Rural and urban households were categorized. The wealth quintile was classified into five quintiles, from poorest to richest, and was calculated by using the formula "Total consumption expenditure/Household size". Schedule Caste (SC), Schedule Tribe (ST), Other Backward Classes (OBC), and others were castes. Recorded religions were Hindu, Islam, and Others.

Statistical approach

Frequency distribution for each variable, along with the components of successful aging, was displayed for descriptive statistics. The Pearson correlation test was used for successful aging and its components. Additionally, crude and adjusted odds ratios (OR) with 95% confidence intervals were obtained from a multivariable logistic regression model, which was used to examine successful aging and its determinants. The OR displays the variation in outcome probabilities associated with an additional unit in the predictor, while keeping all other variables constant. The regression model used was as follows:

$$Logit\left(\frac{p}{1-p}\right) = \propto + \beta_1(\text{Age}) + \beta_2(\text{Sex}) + \beta_3(\text{Education}) + \beta_4(\text{Wealth quintile}) + \beta_5(\text{Sector}) + \beta_6(\text{Religion}) + \beta_7(\text{Caste}) + \beta_8(\text{Living arrangements}) + \beta_9(\text{Economic dependency}) + \beta_{10}(\text{Insurance}) + \varepsilon$$

$$OR = e^{\beta i}$$

Where p is the probability of successful aging, $\beta_1, \beta_2, \beta_3$ ... are regression coefficients.

Ethical statement

The study obtained ethical clearance on 19/12/2024 from the Institute Ethics Committee of Centurion University of Technology and Management, Odisha, India (IEC ref. No: CUTM/IEC/627(A)/ 2024), following university guidelines for research involving human participants.

RESULTS

Sample characteristics

Table 1 shows that among 600 samples, six out of 10 were aged 60-69 years, and nearly five out of 10 were illiterate or had a below primary level of education, with a near-equal gender split. Nearly 97% follow Hinduism. Most live with family, and 86.2% were fully economically dependent. We observed that nearly seven out of 10 individuals reside with a spouse only or with any other family members. Government-sponsored insurance covers 80.8%, while 86.2% were fully economically dependent. The bivariate distribution of successful aging reveals that 19.5% of individuals met the criteria for successful aging, with higher rates observed in the 60–69 age group (28.5%) and among those who had secondary education or higher (52.3%). Physical activity (74%) and social engagement (98.5%) were the most common components, whereas positive psychology of physical health was the least common (33.8%). Male individuals (23%), urban dwellers (23.3%), individuals in the richest wealth group (27.7%), and individuals with partial economic dependency (52.9%) show higher rates of successful aging.

Table 1. Profile of older adults and percentage of characteristics of successful aging in Odisha, India, 2025

Variables	Components of Successful Aging (Row%)						
	Freq.	No Disability	Physical activity	High cognition	Social engagement	Positive psychology of physical health	Successful Aging
All (N)	600	236	444	417	591	203	117
Age							
60-69	354	52.54	94.07	74.58	99.44	40.4	28.53
70-79	140	30	65.71	72.14	99.29	29.29	9.29
80+	106	7.55	17.92	49.06	94.34	17.92	2.83
Sex							
Female	287	30.66	81.18	56.79	98.61	29.97	15.68
Male	313	47.28	67.41	81.15	98.4	37.38	23
Education							
Illiterate/below primary	282	13.12	63.48	43.97	96.81	20.92	4.26
Up to primary	116	37.93	74.14	82.76	100	39.66	20.69
Up to secondary	114	64.04	84.21	95.61	100	42.11	30.7
Secondary and above	88	93.18	94.32	100	100	56.82	52.27
Wealth Quintile							
Poorest	128	15.63	75	36.72	95.31	23.44	7.03
Poorer	128	29.69	76.56	72.66	98.44	35.16	16.41
Middle	121	47.11	77.69	80.99	100	37.19	23.14
Richer	104	51.92	69.23	77.88	100	35.58	25

Variables	Components of Successful Aging (Row%)						
	Freq.	No Disability	Physical activity	High cognition	Social engagement	Positive psychology of physical health	Successful Aging
Richest	119	56.3	70.59	82.35	99.16	38.66	27.73
Sector							
Rural	300	27	76	63.33	97.33	33	15.67
Urban	300	51.67	72	75.67	99.67	34.67	23.33
Religion							
Hinduism	577	39.17	73.66	69.67	98.61	33.62	19.06
Islam	13	53.85	76.92	92.31	100	46.15	30.77
others	10	30	90	30	90	30	30
Caste							
Other backward classes	232	41.81	74.14	78.02	98.71	32.76	19.4
Others	168	57.74	71.43	85.12	100	42.86	31.55
Schedule caste	129	23.26	69.77	51.94	96.12	25.58	10.85
Schedule tribe	71	16.9	87.32	36.62	98.59	30.99	7.04
Living arrangement							
Alone	14	14.29	78.57	7.14	85.71	7.14	7.14
With spouse and other members	383	52.48	81.72	81.98	99.48	41.25	26.37
With spouse only	56	46.43	82.14	75	96.43	35.71	23.21
Without a spouse but with children	147	4.76	50.34	40.82	97.96	16.33	1.36
Economic dependency							
Fully dependent	517	34.43	71.76	67.5	98.65	32.11	16.05
Not dependent	32	43.47	78.13	56.25	93.75	25	21.88
Partially dependent	51	86.27	94.12	98.04	100	56.86	52.94
Insurance							
Arranged by Household	5	80	80	100	100	40	20
No insurance	110	72.73	80	90.91	100	40	33.64
Govt-sponsored	485	31.34	72.58	64.33	98.14	32.37	16.29

Source: Author

Correlations between successful aging and its components

Table 2 presents the correlation matrix, indicating that successful aging had a strong positive correlation with physical activity, high cognition, and particularly psychological health ($r = 0.68$, $p<0.001$), while it was negatively correlated with disability ($r = -0.61$, $p<0.001$).

Table 2. Correlation between components of successful aging in Odisha, India, 2025

	Successful aging	Free from disability	Physical activity	High cognition	Social engagement	Psychology of physical health
Successful aging	-					
Free from disability	-0.61(<0.001)	-				
Physical activity	0.29(<0.001)	-0.31(<0.001)	-			
High cognition	0.32(<0.001)	-0.47(<0.001)	0.25(<0.001)	-		
Social engagement	0.06(0.13)	-0.09(0.01)	0.20(<0.001)	0.18(<0.001)	-	
Psychology of physical health	0.68(<0.001)	-0.32(<0.001)	0.21(<0.001)	0.34(<0.001)	0.08(0.03)	-

Source: Author
Note: p-values are in parentheses

Multivariable logistic regression estimates of successful aging

Table 3 shows the crude odds ratio (COR) and adjusted odds ratio (AOR) of multivariable regression estimated for successful aging among older adults in India. Individuals with growing age exhibit diminished odds [Age: 80+, AOR: 0.19; 95% CI: (0.05-0.70)], whereas higher education levels, specifically secondary education and above [AOR: 8.47; 95% CI: (2.89- 24.82)], significantly enhance the likelihood of successful aging. Individuals in the richest quintiles [AOR: 4.86; 95% CI: (1.14-20.68)] and those residing with a spouse and others [AOR: 14.73; 95% CI: (0.77-280.46)] or with a spouse alone [AOR: 8.51; 95% CI: (1.91-37.98)] exhibit significantly higher odds.

Table 3. Multivariable logistic regression estimates of successful aging among older adults in Odisha, India, 2025

Variables	COR	P>z	95% CI	AOR	P>z	95% CI
Age						
60-69	Ref					
70-79	0.26	<0.001	0.14-0.47	0.32	<0.001	0.16-0.68
80+	0.07	<0.001	0.02-0.24	0.19	0.01	0.05-0.70
Sex						
Female	Ref					
Male	1.61	0.02	1.06-2.43	1.08	0.80	0.61-1.90
Education						
Illiterate/below primary	Ref					
Up to primary	5.87	<0.001	2.82-12.21	4.13	<0.001	1.72-9.89
Up to secondary	9.97	<0.001	4.94-20.11	5.06	<0.001	2.04-12.53
Secondary and above	24.64	<0.001	12.07-50.31	8.47	<0.001	2.89-24.82

Variables	COR	P>z	95% CI	AOR	P>z	95% CI
Wealth quintile						
Poorest	Ref					
Poorer	2.60	0.02	1.14-5.91	2.28	0.15	0.74-7.07
Middle	3.98	<0.001	1.79-8.85	2.80	0.07	0.91-8.62
Richer	4.41	<0.001	1.96-9.91	3.81	0.07	0.88-16.45
Richest	5.07	<0.001	2.31-11.15	4.86	0.03	1.14-20.68
Sector						
Rural	Ref					
Urban	1.64	0.02	1.09-2.47	0.50	0.13	0.20-1.23
Religion						
Hinduism	0.55	0.39	0.14-2.16	0.04	<0.001	0.00-0.36
Islam	1.04	0.97	0.17-6.23	0.02	<0.001	0.00-0.29
others	Ref					
Caste						
Other backward classes	Ref					
Others	0.52	0.01	0.33-0.83	0.61	0.11	0.33-1.13
Schedule caste	0.26	<0.001	0.14-0.50	0.67	0.38	0.28-1.64
Schedule tribe	0.16	<0.001	0.06-0.43	0.23	0.08	0.04-1.21
Living arrangement						
Alone	Ref					
With spouse and other members	5.58	0.17	0.47-65.71	14.73	0.07	0.77-280.46
With spouse only	25.97	<0.001	6.32-106.76	8.51	0.01	1.91-37.98
Without a spouse but with children	21.92	<0.001	4.76-100.93	12.24	<0.001	2.20-67.95
Economic dependency						
Fully dependent	Ref					
Not dependent	0.68	0.39	0.29-1.63	0.79	0.70	0.25-2.55
Partially dependent	4.02	0.01	1.47-10.95	1.37	0.63	0.38-4.96
Insurance						
Arranged by Household	Ref					
No insurance	0.49	0.53	0.05-4.57	0.22	0.21	0.02-2.30
Govt-sponsored	0.38	<0.001	0.24-0.61	1.03	0.93	0.55-1.92

Source: Author
Note: Ref: Reference, COR: Crude odds ratio, AOR: Adjusted odds ratio, CI: Confidence interval

DISCUSSION

This empirical research presents a culturally contextualized model grounded in the Indian socio-cultural context, contributing to the discourse on successful aging. Using primary data from Odisha, India, this study demonstrates the necessity to characterize successful aging beyond Rowe and Kahn's biomedical frameworks. This study found that only 19.5% of the sampled older adults met the criteria for successful aging, which included being free from disability, having high cognition, engaging in physical activity, maintaining social engagement, and exhibiting positive psychological tendencies towards physical health. Due to the different definitions that

have been operationalized in multiple studies, comparing current findings to previous studies is difficult. For example, an Indian study excludes cognitive and physical activity from the Rowe and Kahn model, and adds life satisfaction with being free from depression, finding 27.2% to be successful agers.[3] Similarly, another Chinese study found 13.2% of older adults to be successful agers using a different active involvement metric, and a Malaysian study reported 13.8% of successful agers, defined as lack of chronic conditions and difficulty in functioning, and adequate psycho-cognitive function.[26,27]

The process of aging involves a decline in cognitive abilities, which can affect an individual's capacity to participate actively in life and sustain independence.[28] Similarly, social engagement is essential for successful aging. However, retirement, disability, and peer loss reduce social networks with age. Psychology of a positive view on aging can slow physical and cognitive decline. Maintaining a sense of purpose and positive aging expectations helps older adults see themselves as successfully aging.[18] Nevertheless, our analysis found lower odds with growing age.

As documented in prior research, educational activities are associated with enhanced cognitive activities, increased physical activity, improved social connections, and fostering of positive psychology in older adults, all of which contribute to successful aging.[29,30] This study also observed education as a prime factor for successful aging. This highlights the importance of education in enhancing health literacy, promoting healthy behaviors, and fostering psychological resilience, which are critical for managing aging-related challenges.

Higher wealth helps in preventing and managing disabilities by providing access to healthcare, rehabilitation, and adaptive devices.[31] Also, higher wealth boosts physical activity among older adults, as with higher incomes, one can afford fitness centers, workout equipment, and safer outdoor spaces like parks and walking paths.[32] As successful aging necessitates social engagement, income facilitates participation in community programs and social events, which can enhance social relationships and reduce loneliness.[33] Higher income levels are associated with greater happiness and lower stress levels, contributing to a more positive psychological outlook on physical health.[32,34] In parallel with this, the present study also found a positive relation between higher wealth and successful aging.

We also found that older Indians living with a spouse alone or with family exhibit higher rates of successful aging. These findings reflect that co-residence with family gives older adults a sense of meaning, emotional comfort, and practical help, emphasizing the value of family and social support in the Indian context.[35,36] This aligns with international studies, as living with a spouse and others reduces the risk of disability by increasing social support.[37] However, co-residing with a spouse can not only reduce cognitive decline and frailty but also provide support in social and physical activities, which may offset loneliness and enhance emotional support, boosting mental health.[38–40]

Multiple studies found that rural residents face disadvantages in successful aging, which may explain the current scenario.[41,42] This is substantiated by the greater contribution of higher education and socioeconomic status, which are predictors of successful aging.[29,32] Furthermore, research shows that urban areas provide comprehensive healthcare services, including regular health screenings and specialized medical care, which are crucial for maintaining good health and preventing disease-related

disabilities.[43] However, studies in less-developed countries have also confirmed the rural-urban discrepancy in healthcare utilization, with rural residence of older people being negatively related to successful aging.[8,44] Despite this, urban older adults tend to be more active and have access to amenities that promote an active lifestyle.[45]

Furthermore, recognizing psychological tendencies related to physical health as a factor in successful aging represents a significant contribution of this paper. The study's application of the HOS demonstrates that individuals who considered themselves responsible for maintaining their health were more likely to report improved health outcomes. This psychological orientation serves as a mediator between knowledge and behavior, impacting the degree to which older adults follow health practices and accommodate physical limitations. However, the limitations of this study should be mentioned. First, it has a cross-sectional nature, with a limited sample size. Secondly, reliance on self-reported measures and limited generalizability beyond Odisha, because of cultural, linguistic, and infrastructural diversity.

RECOMMENDATION

This study adds to the literature on the interplay between the psychology of physical health and experiencing successful aging. We tried to redefine successful aging within the Indian context and found that one in five older adults was a successful ager, with education, wealth, and living arrangement being found to be significant contributors. Our multifaceted approach, which incorporates a culturally grounded model, revealed Indian-specific aspects of successful aging, such as interdependence, familial support, and social activities. This study emphasizes the strengthening of healthcare infrastructure through accessible geriatric care, preventive check-ups, and rehabilitation. At the same time, supporting family- and community-centered aging policies, including incentives for intergenerational co-residence and caregiving, can foster stronger social support networks and improve overall well-being in later life.

In addition, the rural disadvantage in successful aging was found. Further studies must be conducted to find out the reasons for such differences, and what factors create differences among rural-urban individuals to be successful agers. Future studies should also adopt longitudinal designs, include institutionalized older adults, and explore qualitative insights to deepen understanding.

AUTHORS' CONTRIBUTIONS

AND: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Resources, Software, Validation, Visualization, and Writing – original draft. SMP: Conceptualization, Project administration, Supervision, and Writing - review & editing. AD: Conceptualization, Methodology, Project administration, Software, Supervision, and Writing – review & editing.

ETHICAL CONSIDERATION

The study obtained ethical clearance on 19/12/2024 from the Institute Ethics Committee of Centurion University of Technology and Management, Odisha, India (IEC ref. No: CUTM/IEC/627(A)/ 2024), following university guidelines for research involving human participants.

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CONFLICTS OF INTEREST

There is “no conflict of interest” between the authors of the paper.

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