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National trends in elderly chronic obstructive pulmonary disease burden (2010-2021) in India and subnational disparities among older adults: a Global Burden of Disease secondary analysis

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Informed consent: not applicable. The manuscript does not contain any individual patient data, clinical photographs, or identifying personal descriptions.

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Abstract

Chronic obstructive pulmonary disease (COPD) is a critical public health challenge and a leading non-communicable disease globally. In India, it represents a primary driver of morbidity and mortality among older adults, that is, aggravated by population aging, tobacco smoking, and high air pollution exposure. The national trends among the elderly and subnational data focusing specifically on geographic variations remain limited. This study aims to evaluate national longitudinal trends in the COPD burden among individuals aged 60 years and older from 2010 to 2021, while contextualizing these patterns against subnational disparities among older adults across Indian states. A secondary data analysis was conducted utilizing the Global Burden of Disease 2010-2021 database. The target population included Indian adults aged ≥ 60 years for national longitudinal trends and for the cross-sectional state-level mapping. Key indicators evaluated included prevalence (PR), incidence, mortality (MR), and disability-adjusted life years (DALYs). Temporal trend shifts and critical inflection joinpoints over the 11-year period were evaluated via joinpoint regression models utilizing permutation tests. National Joinpoint models for the elderly revealed a steady decline in MR from 2010 to 2019 (decreasing from approximately 643 to 575 per 100,000), followed by an accelerated drop between 2019 and 2020 before stabilizing near 488 per 100,000 in 2021. National elderly DALY rates closely mirrored this downward mortality trajectory. Conversely, the prevalence in elderly (PR) increased from 15,170.94 per 100,000 in 2010 to 15,398.74 per 100,000 in 2015, reaching 15,642.10 per 100,000 by 2021. Subnational cross-sectional mapping highlighted stark regional inequities. State-wise elderly (≥60 years) prevalence varied from 12,986.76 per 100,000 in Goa to 18,680.00 per 100,000 in Jammu & Kashmir and Ladakh. This was led by the northern and northwestern regions, including Haryana, Himachal Pradesh, and Delhi. The highly populous states like Uttar Pradesh and Bihar, however, demonstrated a substantial disability (DALY) burden. While declining national mortality and DALY rates reflect notable progress in elderly clinical management, the rising longitudinal prevalence underscores an expanding pool of surviving patients requiring sustained care. Marked regional disparities persist across the country's elderly (≥60 years) population. This demands immediate prioritization of the high-risk states and regions. Public health strategies must transition toward region-specific interventions, promote clean domestic energy initiatives in rural areas, and enhance the primary care screening capacities.

Key words: chronic obstructive pulmonary disease, elderly burden, global burden of disease, joinpoint regression, India, regional disparities, disability-adjusted life years.

Introduction

Chronic Obstructive Pulmonary Disease (COPD) represents a monumental yet frequently underestimated global health crisis [1]. Classified as a prominent Non-Communicable Disease (NCD), it is estimated to affect more than 400 million individuals across the globe [2]. In 2021, globally, it stood as the fourth leading cause of death worldwide, accounting for approximately 5% of all-cause mortality [3].

Within India, COPD has emerged as a primary driver of both morbidity and mortality, posing a critical threat to the country's older adults. Its increasing epidemiological burden across the nation is largely propelled by a combination of escalating risk factors. These include, rapid demographic transition expanding the elderly segment of the population, high rates of smoking across communities and also exposure to the extensive air-pollution.

Despite its profound impact on public health, there remains a critical gap regarding trends in the elderly population of India for COPD, and the distinct regional differences in COPD burden among the population. Gaining a comprehensive understanding of these geographic disparities is absolutely vital to target scarce healthcare resources effectively.

To address this knowledge gap, this study provides a comprehensive secondary data analysis utilizing the Global Burden of Disease (GBD) 2010-2021 database. The objectives of the study were twofold: first, to analyse national, decade-long longitudinal trajectories (2010-2021) in the burden of COPD specifically among the Indian elderly population (≥ 60 years). Second, to map and evaluate cross-sectional epidemiological indicators, specifically, prevalence alongside disability-adjusted life years (DALYs) among the elderly population (≥ 60 years), across different Indian states.

Materials and Methods

Study design and data source

This study is a secondary data analysis utilizing the comprehensive Global Burden of Disease (GBD) 2010-2021 database [4]. Data was retrieved using the Institute for Health Metrics and Evaluation (IHME) GBD Results Tool from the University of Washington [5].

Study population

The target population for the national longitudinal trend analysis (2010-2021) comprised older adults aged 60 years and above residing in India. To capture broader macro-regional epidemiological variations and spatial disparities across states, a secondary cross-sectional

analysis for 2021 was conducted evaluating elderly (≥ 60 years) population prevalence alongside elderly DALY rates across Indian states.

Epidemiological indicators assessed

To provide a multi-dimensional assessment of the COPD burden, several key rates (per 100,000 population) were evaluated. These included, PR (Prevalence Rate), IR (Incidence Rate), MR (Mortality Rate) and DR / DALYs (Disability-Adjusted Life Years Rate).

Statistical analysis

Data curation, management, and initial descriptive statistics were performed using MS Excel. To systematically evaluate temporal trends and identify significant inflection points where the trajectory of the burden changed, over the 11-year period, Joinpoint regression analysis was conducted. This was done using software developed by the National Cancer Institute (NCI, USA). This method applies permutation tests to identify statistically significant changes in trends (joinpoints) over time [6]. The primary outcome measures focused on characterizing longitudinal trends in the elderly COPD burden across India. National longitudinal Joinpoint regression models for the elderly (Figures 1-4) were performed using rates calculated within the ≥ 60 age cohort to evaluate time trends independent of demographic shifts within the aging cohort.

In accordance with GBD methodology, all point estimates for prevalence, incidence, mortality, and DALY rates are reported with their corresponding 95% Uncertainty Intervals (UIs) derived from the 2.5th and 97.5th percentiles of 1,000 posterior draws. Subnational state-level disparities across the older adults were evaluated for statistical significance based on non-overlapping 95% UIs. A difference in state-wise rates (such as PR between Goa and Delhi) was determined to be statistically significant at $p < 0.05$ equivalent if the 95% UIs did not overlap.

Results

National trends and temporal overview

The Joinpoint regression analysis reveals distinct, non-linear trajectories across the evaluated epidemiological indicators, for the Indian elderly population aged 60 years and older between 2010 and 2021.

Mortality Rate

The national trend for COPD mortality among older adults (≥ 60 years) demonstrated a progressive, statistically significant decline from 2010 to 2019 (APC = -1.22%/year, 95% CI: -1.41% to -1.03%, $p < 0.001$). This steady reduction was followed by a sharp, significant inflection point between 2019 and 2020 (APC = -13.06%, 95% CI: -15.20% to -10.92%, $p < 0.001$), before plateauing through 2021 (APC = -2.47%/year, $p = 0.072$) (Table 1). Over the entire 11-year period, the Average Annual Percentage Change (AAPC) was -1.39%/year (95% CI: -2.16% to -0.61%, $p = 0.005$) (Figure 1).

DALYs Rate

Elderly DALY rates mirrored mortality, decreasing linearly from 2010 to 2019 (APC = -1.46%/year, 95% CI: -1.62% to -1.30%, $p < 0.001$), dropping significantly between 2019 and 2020 (APC = -11.98%, 95% CI: -13.80% to -10.10%, $p < 0.001$), and stabilizing through 2021 (APC = -0.46%/year, $p = 0.582$), yielding an overall decade AAPC of -1.49%/year (95% CI: -2.13% to -0.85%, $p = 0.001$). (Figure 2).

Incidence Rate

In contrast to the marked downward trajectories observed in mortality and disability, the annual incidence of COPD among older adults (≥ 60 years) remained essentially stable throughout the decade, hovering near 1,350 cases per 100,000 population (Figure 3). Although Joinpoint regression identified minor inflection points in 2015 and 2020 (AAPC = +0.04%/year, 95% CI: +0.02% to +0.07%, $p = 0.001$), the total variation across the 11-year study period was under 0.5% (varying between 1,345.33 and 1,353.10 per 100,000). This minor fluctuation falls entirely within the 95% Uncertainty Intervals (1,181.50-1,477.17 per 100,000), indicating a clinically flat baseline incidence over time.

Prevalence Rate

Meanwhile, the overall prevalence rate underwent a substantial expansion over the 11-year timeline. The PR increased steadily from 15,170.94 per 100,000 population in 2010 to 15,398.74 per 100,000 population in 2015 (APC = +0.30%/year, $p < 0.001$). After 2015, the pace of growth decelerated, transitioning into a high-level plateau that reached 15,642.10 cases per 100,000 population toward the end of the study period in 2021 (APC = +0.26%/year,

$p < 0.001$) (Figure 4). This high prevalence highlights an expanding community pool of surviving elderly individuals who require long-term medical care and clinical management.

Subnational and state-wise variations

At the subnational level, data from the GBD 2021 framework revealed statistically significant geographic disparities in COPD prevalence among older adults (≥ 60 years) across Indian states in 2021. The state-wise elderly prevalence rate ranged from a minimum baseline of 12,986.76 cases per 100,000 population (95% UI: 11,074.60-15,026.63) in Goa to a peak of 18,680.00 cases per 100,000 population (95% UI: 16,928.85-20,319.18) in Jammu & Kashmir and Ladakh (Figure 5).

A descending analysis demonstrates a concentrated high-prevalence cluster led by northern and northwestern territories including Jammu & Kashmir and Ladakh (18,680.00), Haryana (17,445.41), Himachal Pradesh (17,311.55), Delhi (17,231.09), and Rajasthan (17,093.47), alongside Mizoram (16,618.07). Conversely, the lowest elderly prevalence rates were observed in southern states such as Goa (12,986.76), Andhra Pradesh (14,123.76), and Kerala (14,319.55), alongside Punjab (13,341.36).

On the other hand, the subnational mapping of Disability-Adjusted Life Years (DALYs) rates among the elderly (≥ 60 years) also heavily mirrors these regional inequities, but has distinct variations also (Figure 6). This chronic disability burden is highest in Uttarakhand (15,136.77) and Rajasthan (14,931.65), both exceeding 14,500 DALYs per 100,000 older adults, closely trailed by Uttar Pradesh, Gujarat, and Haryana. This accumulation of healthy life years lost is heavily concentrated within specific geographical pockets rather than being uniformly distributed across the country.

Notably, high-focus states such as Uttar Pradesh and Bihar that present a relatively higher prevalence rate across its overall population, also demonstrate elevated DALYs output exceeding 10,900 per 100,000 individuals (Figure 5, Figure 6). This underscores a public health finding where prevalence transitions directly into profound chronic disability within resource-constrained settings. On the other hand, territories like Punjab, Goa, and other Union Territories report the lowest disability impact, dropping near a baseline of 4,000 DALYs per 100,000 population. This highlights a wide subnational gap in structural healthcare outcomes in the elderly population.

Discussion

The shifting longitudinal epidemiological dynamics of COPD among India's elderly highlight a complex interplay between demographic transitions and public health interventions. The steady expansion of the prevalence rate (PR) observed over the decade is heavily reflective of longer patient survival times and a rapidly aging national population. Rather than indicating an outright failure of preventive strategies, this accumulation of cases demonstrates that improvements in clinical care and management are successfully extending life expectancy, thereby expanding the active pool of surviving elderly individuals within the community who require sustained medical support [7].

On the other hand, the downward national trajectories observed for both mortality and overall Disability-Adjusted Life Years (DALYs) among older adults align closely with historical epidemiological benchmarks. These reductions strongly reinforce macro-level Global Burden of Disease (GBD) comparative models, which previously documented a landmark 33% contraction in India’s population-wide COPD mortality rate over the preceding three decades spanning 1990 to 2019 [8]. This substantial decrease in the fatal burden of the disease can be directly attributed to a combination of progressive clinical advancements and structural public health changes. Specifically, these widespread improvements are driven by the enhanced availability and adoption of therapeutic inhalers, the more rigorous enforcement of national tobacco control policies, and the steady transition toward clean cooking fuels at the domestic level. However, the sharp, non-linear acceleration of this decline observed specifically between 2019 and 2020 in both the national mortality (Figure 1) and DALY models (Figure 2) warrants critical contextualization. This is because gradual socio-demographic rollouts and structural policies alone cannot account for such abrupt single-year inflection. This drop can be related to the onset of the COVID-19 pandemic in 2020 and can be explained by several overlapping multi-factorial mechanisms. Finally, statistical modeling artifacts from the GBD estimation process in 2020–2021 must also be considered. Because pandemic lockdowns disrupted routine health data collection across India, GBD algorithms relied more heavily on predictive estimations during these years, which likely amplified the sharp single-year drop in reported mortality and DALYs.

First, the widespread diagnostic reclassification and cause-of-death coding shifts during the COVID-19 pandemic likely played a dominant role. This clinical overshadowing could have introduced an artefactual drop in reported COPD mortality records. Secondly, a phenomenon of mortality displacement may have occurred, wherein the highly vulnerable cohort of

advanced-stage chronic respiratory patients succumbed early to acute SARS-CoV-2 infection, compressing mortality timelines. Beyond these, the implementation of strict nationwide lockdowns had caused a sudden reduction in ambient fine particulate matter ($PM_{2.5}$) and industrial air pollution. Since acute exacerbations of COPD (AECOPD) are highly sensitive to environmental atmospheric triggers, this transient environmental remediation might have reduced the acute respiratory triggers.

Despite these encouraging national achievements, the pronounced interstate variations show deep-rooted regional health inequities. These geographical disparities are fundamentally driven by heterogeneous environmental and socio-demographic risk gradients. Specifically, regional risk profiles explain much of this subnational variation. In rural communities, household air pollution from biomass fuel combustion disproportionately affects non-smoking rural women through daily domestic cooking exposure. Conversely, high disability burdens in states like Rajasthan and Uttar Pradesh are heavily driven by occupational and industrial dust exposures, such as mining, stone carving, silica dust, and agricultural particulate matter. This is compounded by high ambient air pollution and tobacco use. These distinct exposure pathways are further aggravated by systemic gaps in primary healthcare infrastructure, variable diagnostic spirometry capacities, and geographic barriers to sustainable long-term treatment access [9]. To fully address these gaps, subnational variations across different sexes, socioeconomic strata, and urban-rural settings warrant deeper, more granular epidemiological investigation. Moving forward, future research and policy initiatives should focus on strengthening digital health surveillance infrastructure and electronic health registries across India. Developing robust systems that capture continuous, age-stratified, and granular respiratory disease records at the district level will be vital to enhance the predictive accuracy of macro-regional public health models and monitor the real-time efficacy of localized interventions.

Several limitations inherent to secondary GBD analyses must be acknowledged. Firstly, the study evaluated cross-sectional state-wise mapping specifically among older adults (≥ 60 years) for both prevalence and DALYs in 2021, ensuring cohort alignment across national and subnational objectives. However, district-level micro-variations could not be evaluated due to aggregated state data structures. Secondly, subnational comparisons relying on GBD estimates depend on the precision of primary data inputs; while non-overlapping 95% UIs demonstrate statistical significance. Additionally, pandemic-related disruptions in primary data collection

during 2020–2021 required GBD models to use predictive smoothing, which may have generated minor estimation artifacts.

Conclusions

In conclusion, this analysis demonstrates that the national longitudinal trajectories indicate an expanding prevalence, while at the same time, show reassuring reductions in mortality and disability among India's elderly. Profound regional disparities in indicators related to COPD persist across the older adults (≥ 60 years). Geographic mapping of rates reveals that population-adjusted risk is heavily concentrated within the northern and northwestern belt. This was led by prominent epidemiological peaks in territories such as Jammu & Kashmir and Ladakh, Haryana, Rajasthan, and Uttarakhand. Concurrently, highly populous states like Uttar Pradesh and Bihar shoulder an immense absolute clinical workload and severe disability outputs, marking them as critical focal points for resource allocation. Reassuringly, the long-term national decline in elderly mortality rates stands as a clear indicator that advancements in diagnostic screening, earlier clinical detection, and standardized management protocols are successfully translating into tangible public health gains.

To capitalize on these insights, public health authorities must transition toward developing region-specific COPD control programs that directly target and concentrate essential resources within high-burden and high-workload states. The foundational healthcare infrastructure must be reinforced by significantly strengthening primary health centers, ensuring they are systematically equipped to provide early screening, diagnostic spirometry, and accessible, standardized long-term management for chronic respiratory conditions.

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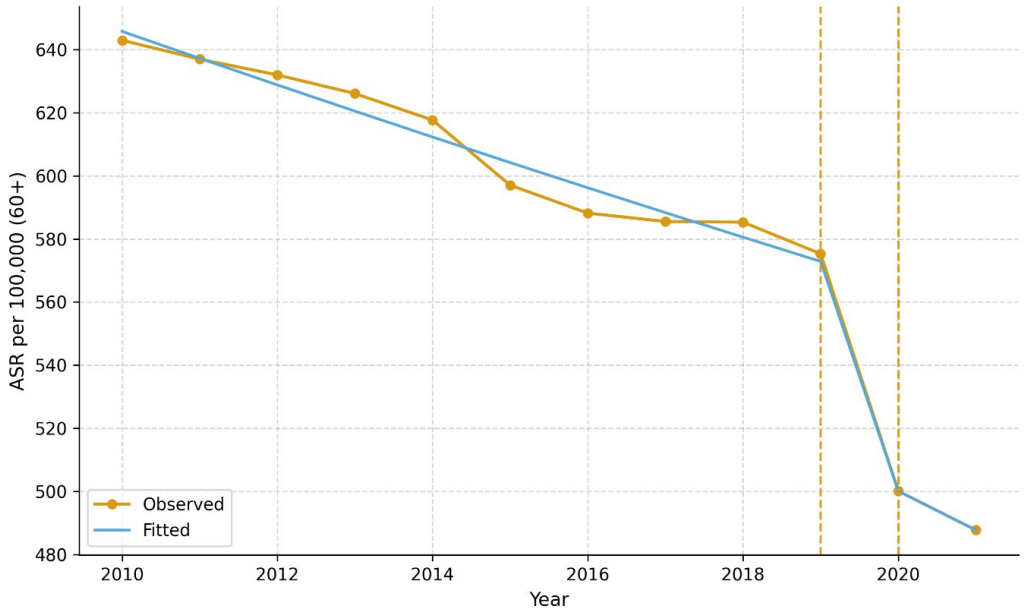


Figure 1. Joinpoint regression analysis of the Mortality Rate (MR) for COPD among the elderly (≥60 years) in India (2010-2021). Yellow markers indicate observed GBD data points showing a sharp deceleration post-2019, while the solid blue line represents the modeled multi-segment Joinpoint regression trend line.

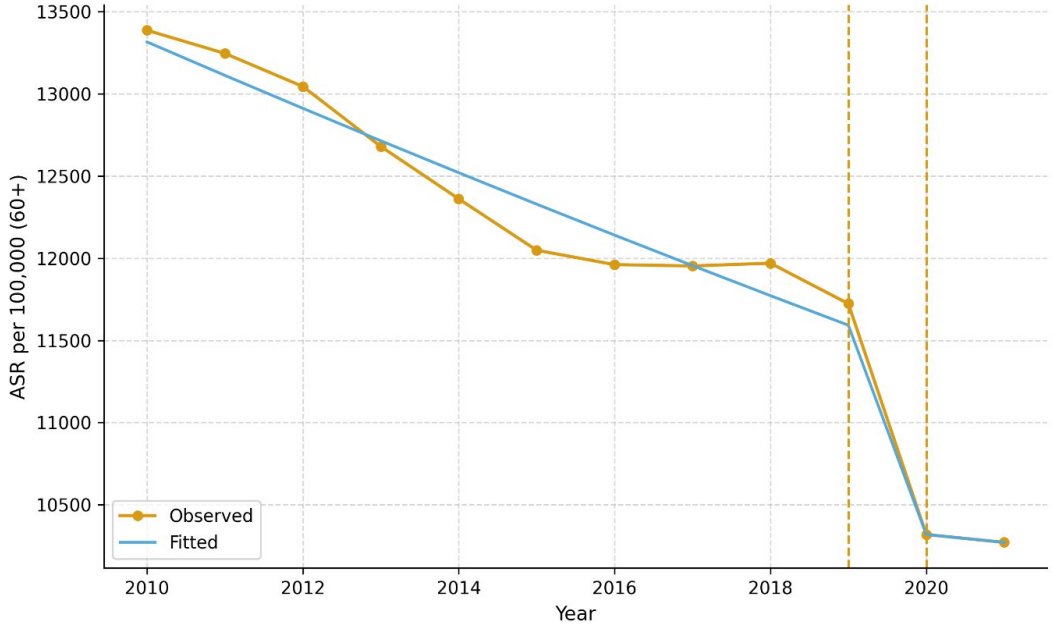


Figure 2. Joinpoint regression analysis of the Disability-Adjusted Life Years (DALYs) rate for COPD among the elderly (≥60 years) in India (2010-2021). The timeline showcases a long-term reduction in overall disability burden that closely parallels national mortality declines.

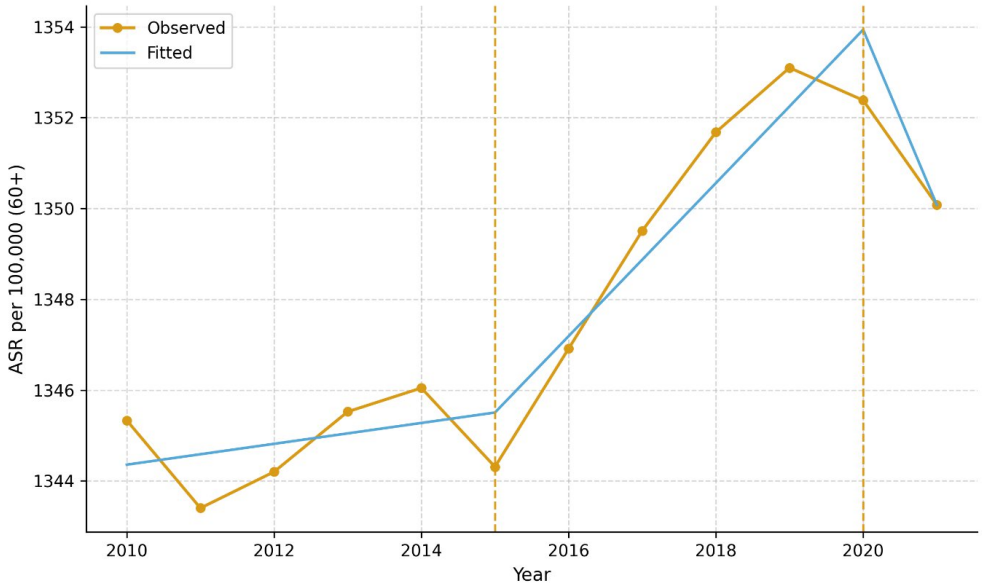


Figure 3. Joinpoint regression analysis of the Incidence Rate (IR) for COPD among the elderly (≥60 years) in India (2010-2021). The trend demonstrates an essentially flat baseline trajectory with minimal absolute variation (< 0.5% total change across the decade), reflecting stable community-wide incidence rates.

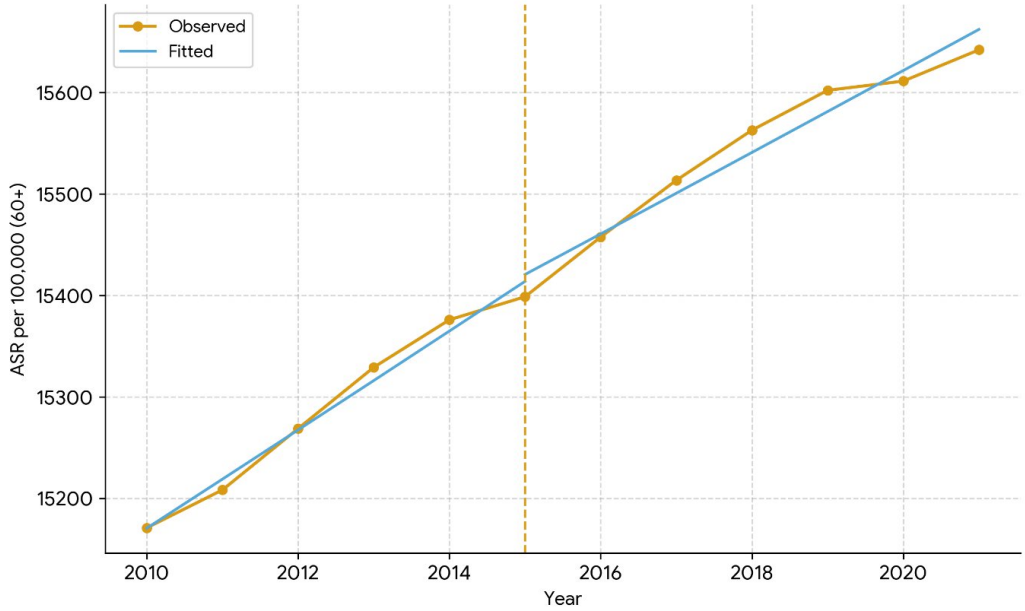


Figure 4. Joinpoint regression analysis of the Prevalence Rate (PR) for COPD among the elderly (≥60 years) in India (2010-2021). The continuous upward trajectory reflects an accumulation of surviving patients within communities over the study duration.

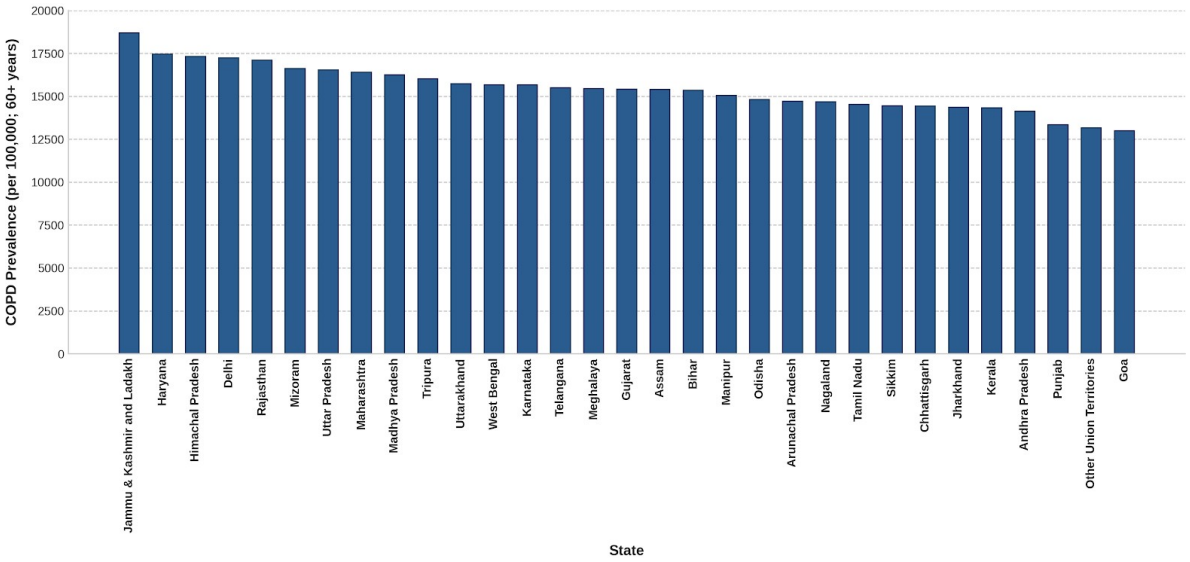


Figure 5. State-wise COPD Prevalence Rate per 100,000 population among older adults (≥ 60 Years) in India (2021). States are organized in a structured, descending order of epidemiological burden, showcasing a subnational spectrum spanning from a baseline minimum of 12,986.76 per 100,000 in Goa to a maximum peak of 18,680.00 cases per 100,000 population in Jammu & Kashmir and Ladakh.

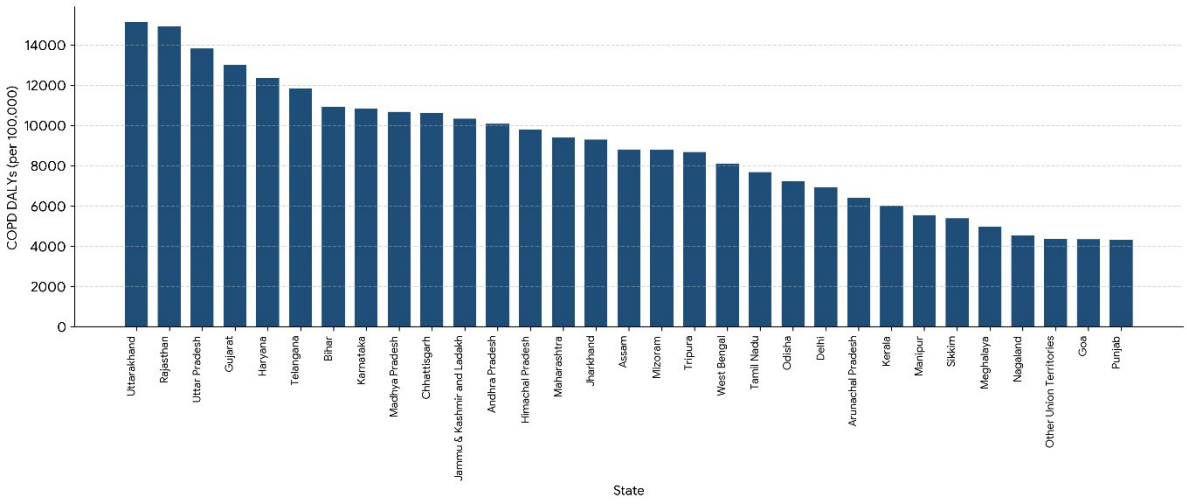


Figure 6. State-wise Disability-Adjusted Life Years (DALYs) rate of COPD per 100,000 population among the elderly (≥ 60 years) in Indian states (2021). The variable geographical distribution illustrates distinct subnational disparities in chronic disability and healthy life years lost among older adults, highlighted by critical regional spikes across northern and western territories in the country.

Table 1. Joinpoint regression analysis of national COPD burden indicators among elderly adults (≥60 years) in India (2010-2021).

Indicator	Overall AAPC (2010-2021) [95% CI], p-value	Segment 1 APC [95% CI], p-value	Segment 2 APC [95% CI], p-value	Segment 3 APC [95% CI], p-value	Joinpoints identified
Mortality (MR)	**-1.39%/yr** [-2.16%, -0.61%], p=0.005	**2010-2019: -1.22%/yr** [-1.41%, -1.03%], p<0.001	**2019-2020: -13.06%/yr** [-15.20%, -10.92%], p<0.001	**2020-2021: -2.47%/yr** [-5.10%, +0.20%], p=0.072	2019, 2020 (p<0.001)
DALYs Rate	**-1.49%/yr** [-2.13%, -0.85%], p=0.001	**2010-2019: -1.46%/yr** [-1.62%, -1.30%], p<0.001	**2019-2020: -11.98%/yr** [-13.80%, -10.10%], p<0.001	**2020-2021: -0.46%/yr** [-2.10%, +1.20%], p=0.582	2019, 2020 (p<0.001)
Incidence (IR)	**+0.04%/yr** [+0.02%, +0.07%], p=0.001	**2010-2015: +0.01%/yr** [-0.02%, +0.04%], p=0.120	**2015-2020: +0.12%/yr** [+0.08%, +0.16%], p<0.001	**2020-2021: -0.17%/yr** [-0.32%, -0.02%], p=0.045	2015, 2020 (p=0.018)
Prevalence (PR)	**+0.28%/yr** [+0.26%, +0.30%], p<0.001	**2010-2015: +0.30%/yr** [+0.27%, +0.33%], p<0.001	**2015-2021: +0.26%/yr** [+0.23%, +0.29%], p<0.001	-	2015 (p<0.001)