

## Caregiving for Older Adults in India: The Role of Kinship and Non-kinship Networks

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### Abstract

India is witnessing an aging revolution in unprecedented ways. This review explores the changing trends in the care of the elderly. The current dynamics of family, culture, economics, and social provisions are not entirely favorable for the well-being of old adults. Recommendations for alternatives in all these areas are provided to improve the elder care scenario in the country.

*Keywords:* aging, family, older adults, social security

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As the population of India is expected to overtake China by 2028 (United Nations, 2015), a noteworthy change has been the country's share of older adults. According to the United Nations (2015), there has been a six-fold increase from 20.3 million in 1950 to more than 116 million. It is projected that the proportion of Indians aged 60 and older will rise from 7.5% in 2010 to 11.1% in 2025 (Mane, 2016). Life expectancy at birth in India has increased from 37 years in 1950 to 68.3 years in 2015, due to better health care facilities (Johanna et al., 2017). Those who are 60 old can expect to live on an average for another 16 years. The life expectancy at 60 years is in favor of women characterized by widowhood, poverty, and dependency. The gender ratio in the elderly population is imbalanced as there are significantly more elderly women than men past age 60 years. As reported by Nair (2014), in the year 2016, 60% of the 80+ population comprised elderly women. A little more than half of the elderly population are women, about 40% are poor (below poverty line) and have not had formal education (73%), and around 90% of older people have no formal social security like provident fund, gratuity and formal pension (National Sample Survey Organisation, 2006). Increasing longevity coupled with falling fertility has led to a demographic explosion in the population of adults aged 60 and over.

As a population superpower, India is witnessing an aging revolution in unprecedented ways. While there is huge paradigm shift observed in aging, what is very unfortunate is the geriatrics is not even offered as a branch of study by the Indian medical science. It has traditionally continued to be an abandoned area of medicine (Bhaidkar, 2017). With increasing age, we see a rise of age-associated conditions such as cardiovascular diseases, diabetes mellitus, arthritis, Alzheimer's, and so on (Brijnath, 2012). Aging in individuals is associated with an increase in dementia. For every addition of five years in age, the population suffering with dementia doubles in India. Consequently, India will have one of the largest populations of elderly individuals with dementia (Narayan et al., 2015).

Aging is associated with multiple morbidities including cardiovascular functioning, physical impairments, and challenging mental health issues. Therefore, an increasing population of the elderly will only lead to greater morbidity in the future (Marengoni et al., 2011). At some point in the life continuum, every individual will either be a caregiver or care recipient (AARP International, 2008, November). As a nation's demography shifts so dramatically, not surprising that the health vulnerabilities, demand for services, and care costs also escalate. Such a boom carries implications for health, caregiving, living arrangements, financial planning, transportation issues, and psychosocial considerations of the elderly. The timing, pace, and scale of population aging warrant priority attention for various social, economic, and health policies as well as caregiving programs to become senior-friendly in India.

Along with the seismic demographic shifts, the social landscape of India has been changing over the past few decades. According to Help Age India (2015), such changes are evident in both rural and urban India. In rural India, the bastion of deeply ingrained Indian values, older adults are increasingly being left behind as the young seek work opportunities in urban communities. On the other hand, in urban locations, the young are busy working and battling the challenges of urban life that their elders are unwittingly unattended frequently, sometimes bereft of financial, health, and psychosocial support.

As the national poverty level is high (about one third), the role and responsibility of family members in the care of the elderly is being minimized and gradually the family support of the elderly has significantly diminished. In view of other priorities, the state is also not in a position to take on total responsibility of caring for the older persons. This dual incapacity of the family and the state to care of the needy senior citizens of the country with regard to their food, shelter and health, may lead to a crisis situation (Pattanaik, 1999).

### **Asian Indian Cultural Ethos and Changing Family Values**

Caring for older people, once considered a problem only in Western nations, poses an interesting challenge for India. The traditional practice of co-residency with children, especially male child, is still predominant in rural India; 75.4% of the elders stay with their children (Johanna et al., 2017). In Gambhirananda's (1957) English translation of the *Taittiriya Upanishad*, an ancient Vedantic text, it is explicitly prescribed that both the parents are to be revered as God. Many older adults in India symbolize children particularly male children) as security during old age (Jamuna, 2001). Madhuand Jain (1991, September) summarized the expectations of the elderly, "A child is like a sapling you plant. It will grow into a tree, and in your old age you can sit under it for shade." For many older adults, children are their old age security, and this is highlighted by norms of filial piety (Dhar, 2011). While modern practices of caring for the elderly have diluted over centuries, a sense of obligatory duty continues to prevail towards the family.

The typical Indian mindset considers it the family's basic responsibility to take care of the aged, and only when this doesn't happen, should there be state intervention to come forward to provide assistance. In fact, Section 125(d) of the Criminal Procedure Code (1973) makes it compulsory for an individual with enough means to sustain either of his/her parents who cannot afford to maintain themselves. A first-class magistrate on obtaining proof of any neglect or refusal in taking care may order the individual to pay a monthly allowance. The Hindu Adoption and Maintenance Act 1956, also, acknowledges the obligatory responsibility of an individual to sustain his or her aged or ailing parents. Yet, such regulations are rarely enforced as a few elders seek these options. In 2007, **The Maintenance and Welfare of Parents and Senior Citizens Act was enacted by the Government of India, for providing need-based maintenance and better healthcare facilities to the elderly by setting up old age homes in each and every district in India and for institutionalizing the mechanism for protection of life and property of senior citizens. The most important part of the bill**

**was to take into account the maintenance of parents by the family members as a legal right.**

Several support services like respite care, bedside assistance, nursing assistance are envisaged, and some services have been started in some urban areas where children are not available for the care of their aged parents. If aged parents make a representation to a district tribunal (specially created for the purpose as per the 2007 act, [www.socialjustices.nic.in/oldageact.php](http://www.socialjustices.nic.in/oldageact.php)), steps will be taken to arrange to reasonably meet the maintenance cost of senior citizens. However, many senior citizens feel inhibited to represent against their children. Under the policy directive, old age homes in each district are planned to be started to take care of the poor and destitute older persons. Old-age homes, elderly day-care centers, and Medicare (mobile) units providing care to the elderly are run by various NGOs and charitable trusts (Bhaidkar, 2017). Also, as part of the national directive on the care and welfare of older persons, a number of measures, mostly subsidies, concessions and a few special privileges have been provided for the senior citizens. The elderly population in India is much more susceptible due to the government spending minimum on the social security system (Mane, 2016). Research on the health and welfare of elderly has been encouraged. Geriatric services at district hospitals are being envisaged.

The *āśramā* system is a theological construct reflecting paths or ladders to liberation (Olivelle, 1993). The four *āśramās* include: (a) *Brahmacharyāśramā*, or the stage of a celibate learner, (b) *Grihasthāśramā*, or the stage of life as a householder, (c) *Vanaprasthāśramā*, or the stage of gradual disengagement from worldly duties and loosening of social bonds, and (d) *Sanyāsāśramā*, or the stage of complete disengagement leading to renunciation for achievement of spiritual freedom. Clearly, the system has undergone extreme changes over time since its original prescription. In the present scenario, the values of *Sanyāsāśramā*, including *vairagya* (detachment) are commonly practiced within the family

context. It is not very unusual for many elderly Indians to retire from their homes, and pilgrimage for long periods of time similar to the wandering ascetic (Tilak, 1989). According to Tilak and Pathak (2006), disengagement does not imply a total withdrawal from social relations but rather the acquisition of a new set of roles. While the householder sustains and support members of the other three stages, the third stage is inner-directed, altruistic, and directed towards meaningful contributions to society. In their words, “Successful aging requires not only internal accommodation to one’s own system of needs but also reasonable conformity to the demands of one’s community.” Gokhale (2008) explained this further by describing spirituality as not an escape from the ethical responsibilities of the material world, but a cyclical period of withdrawal and return. A harmony of doing and simultaneously remaining aloof. He elaborated as follows: “It is like the lotus-leaf, which despite being in water, doesn’t get wet by not letting the droplets of water cling to it.” Van Willigen, Chadha, and Kedia (1995) reported in their study of middle-class Asian Indians in India that “the values expressed by the *āśramā* concept may still operate in the sense that the value legitimizes a strategy of changing reduction of social involvement. The *āśramās* are widely regarded as a good way to model one’s life.” Ramamurti and Jamuna (1993) have found belief in *karma* philosophy as deep-rooted in the Indian culture. According to them, “When the frustrations of life get overwhelming, such belief in *karma* offers succor and comfort to the helplessness that many experience.”

In traditional India, parent care is a normative experience for many adult children (Ramamurti & Jamuna, 2010). However, the situation is showing signs of change in the recent past, because of shrinkage of joint land holdings, transformation of agrarian rural economy into industrial economy and the dwindling of the joint family system which acted as the safety net for elder care (Prakash, 1999). Among Asian Indians, the “contraction” of the extended family is most apparent in urban locations within India, and clearly evident in

locations outside of India. Modernization, technological advancements, mobility, changes in lifestyle and loss of values has resulted in an altered face of India. The scarcity of housing in cities, rising costs of living, and dual career families have contributed to changing priorities which impact the intra-family income distribution in favor of the younger generation (Kalavar, 2006, July-August). In caring for the elderly, the gulf between the generations is being further widened by the growing pressures of modern life—the crunch of time, space, and money. Socio-technological advancement, migration of children away from parents, increasing need for dual careers, consumer/market orientation mindsets in younger generations, shifts in value orientation from collectivism to individualism together have wrought serious inroads into the burden of family care of older people in India (Ramamurti, Liebig, & Jamuna, 2015). With a time-constricted, fast moving demographic transition, a crisis situation is fast developing with regard to elder care in India.

Alienation is more likely to be experienced by men than women among older adults as the latter participate actively in the kitchen and social demands of the family (Kattakayam, 2002). However, Jamuna (2003) reported that elderly women in cosmopolitan cities are end up feeling more socially alienated than their counterparts in the rural areas. Such alienation stems from urban living that primarily affects the elderly who feels disempowered when their adult children leave the nest for better life opportunities, leaving behind an emotional vacuum that is further challenged by crimes against the elderly (Nair, 2014). Sivakumar (1998) pointed out that the income created by the elderly is used for the family but their due share from the same is not given to them. While a large number of older adults in India live with their children or other relatives, approximately 30% of the elderly either have no family to stay with or cannot stay with their family (Ara, 1997). Golandaj, Goli, and Das (2013) found that in India, family is the primary source of old age care, support and security. They reported that the majority of older adults live in joint families, and that majority of elderly women

want to live with their sons from whom they expect financial and emotional support in late life, especially among those who are less educated, currently married, and belonging to an older age group. Older adults' dependence on sons has been utilized to explain the "son preference behavior" of parents. This behavior is generally marked by parental investment and preferential treatment given to sons while the children are young (Self, 2013).

In the study by Narayan et al. (2015), caregiving was not understood as a separate role but was included in the role and responsibilities of a family member. The 'caregiver' is an individual who is primarily responsible for the physical, emotional and financial care of the elder person (Johanna et al., 2017). The primary motivation to provide care was a sense of duty or obligation followed by affection for the care recipient. Despite changes in urban India, Brijnath (2012) reiterated the concept of *seva* (service) in caring for elders across generations and gender. Though families experienced hardship, they sought respite in different ways. Many caregivers developed health problems which compounded the strain they experienced. Additionally, financial worries, unemployment, and family issues were also noted. Jagannathan (2014) reported that most caregivers in India do not consider the caregiving process to be burdensome or stressful, and that their resilience is higher than their Western counterparts. He posited that the strong family and value system may help caregivers cope effectively. His argument being that we should not assume that all caregivers are equally burdened by the process. Instead, he advocated that health professionals should assist with improving the social support to family caregivers and need-based support or intervention to ease their caregiving demands.

Murthy (2016) stressed the need to develop systems of sharing of skill sets, support and supervision to caregivers who provide care as caregiving is such a complex healthcare activity. Due to limited public health services, caregiving by family has become the norm. What makes caregiving so complex is urban living within nuclear families. Based on a



systematic review of the literature, Boland et al. (2017) concluded that home interventions and or supports that promote health in late life and independence are effective in helping elders age at home.

Conventionally, the joint family provided a safety net for elderly who weren't self-sufficient enough to support their physical or economical needs by themselves. In a joint family, several generations lived in a household by sharing income and resources (Brijnath, 2012). Bhat and Dhruvarajan (2001) articulated the gender difference in household tasks seen in this arrangement. Men handled social and economic tasks while the women took care of the household, and handled casual efforts. Vatuk (1990) spoke of the multi-layered concept of *seva* (service) towards elders by younger family members that was rooted in respect, and a form of divine worship. In traditional India, parent care is a normative experience for many adult children (Ramamurti&Jamuna, 2010). Within the framework of a large family, an extra member did not result in significant difference, and the act of caring for elderly members was incorporated into the routine comfortably (Jamuna, Lalitha, & Ramamurti, 2003). However, the deterioration of the joint family is an important factor that has weakened the position and status of the older adult (Bose, 1994; Jamuna, Reddy,& Ramamurti, 1991).

In Indian culture, elder care is predominantly a feminine function, for example, the care of a husband by the wife, and of elders in the family by the daughter-in-law/daughter in the family. It is rarely that a man assumes this role (e.g., care of the wife by her husband) (Jamuna, 2003). It is also evident that more care receivers are women. Thus, there is a feminization of elder care (Jamuna, 2000). Essentially, caregiving involves a dyadic interaction between the caregiver and care receiver that is influenced by the interpersonal perceptions of the dyad members, that are determined by a host of dynamic factors (Jamuna, 2004; Jamuna et. al., 2003).

Generally speaking, when the family is indicated as a care provider, one has in mind the role of the spouse, daughters-in-law, the daughter, and other relatives. In this arrangement, women predominate as caregivers (Pattanaik, 1999). Very rarely do men take on this role in the Indian setting. Traditionally, it is the daughter-in-law of the family who assumes this role. Dual careers in the family raises the stress of these persons as caregivers. If the daughter-in-law is also the primary caregiver and is employed, she may find it difficult to judiciously apportion her time and effort among her professional obligations, the care of elders, care of children, and attending to other domestic responsibilities (Jamuna, 1990). Simultaneously, younger women, who were traditionally the care providers for elderly family members, have joined the work force in unusual numbers, thus constraining the care available for the increasing population of elders.

Older adults in the context of family in India reported feelings of powerlessness, loss of respect, loss of authority, and alienated in later stages of their life (Srivastava, Singh, & Kumar, 2003). According to Dandekar (1996), "Even if unwanted, the old have to live with their children since most of them cannot afford to have independent households." This may be specifically magnified for elderly widows, given the sociocultural framework of widowhood. The shortage of housing, high costs of living, and dual career families have led to the crunch of time, space, and money. Traditional multigenerational households coexisted under the same roof previously but now with urbanization and women in the workforce, we see the breakdown of the joint family system. With the onset of globalization and economic development, youth in large numbers are migrating in search of better employment, educational or economic opportunities, leaving behind the elderly to look after themselves (Paul & Asirvatham, 2016).

Care for the aged parents by adult children has been on the decline over the last few decades. A study at different time points in 1972, 1982, 1992, 2004, and also 2010 showed

how the perceptions of youth with regard to obligations of elder care has been changing. In 1972, the study reported that 82% of youth felt that children would take care of their aged parents. This figure declined to 64% in 1982, 57% in 1992, just 42% in 2004, and 38% in 2010 (Jamuna, 1997, 2003; Ramamurti et al., 2015). If this trend continues, then elder care by these children may become highly difficult. Increasing migration of children away from parents, high cost of living, dual careers, and change in values of filial piety, may severely disable the capability of adult children to give care to their aged parents. Nair (2014) identified technological developments and a colonized mindset of the youth that have altered the status and role of the elderly. Further, changing priorities affecting the intra-family income distribution in support of the younger generations are increasingly evident (Bose, 1994). Interestingly, the aged parents themselves are preparing for alternative care arrangements as they feel that they should not over burden their adult children. In the backdrop of an evolving social setting, an increasingly large number of older adults in the middle-income category are choosing to live in an old age home (Kalavar & Jamuna, 2011).

### **Residential Care Homes**

The concept of old age homes is not new in India as there were such facilities to care for destitute older adults even during the 18<sup>th</sup> century (Nair, 2014). Noteworthy is the new breed of old age homes that are dubbed ‘pay-and-stay’ homes. What is new in India is the concept of ‘pay-and-stay’ catering primarily to the elderly in the middle-class. This option is affordable only to the middle or higher income families and are being considered as a feasible alternative to a life of feeling uncared for, marginalized and discriminated. They are the “pioneer residents” of “pay-and-stay” homes, being the first generation to stay with strangers rather than family. Studies linking chronic illness with living arrangements, researchers reported that older people living all by themselves are more prone to having an illness when compared with other living arrangements (Mahapatro, Acharya, & Singh, 2017). Ramamurti

and Jamuna (1993) reported that most of the old age homes are maintained by religious and voluntary organizations. Panday and Srivastava (2017) observed that elderly individuals living in old age homes had better health and emotional adjustment than a control group of older adults living in family setup.

In recent times, an increasingly high demand for residential care of senior citizens, living away from their adult children is observed. A detailed analysis in a research study made on the residents of senior care homes reported that certain predominant reasons for seeking residential care were childlessness, poverty and destituteness, and low functional competence (Kalavar&Jamuna, 2010). The demand for all types of residential care for senior's (free homes and pay-and-stay homes) is gradually increasing. This is more so with the poorer sections of the population, where the earning capacity of adult children is low and they are hard pressed to take care of their aged parents, in addition to their own unitary families.

Residential care homes are of two types, viz., free homes (no payment) and pay homes that charge for services. The free old age homes are mostly run by Non-Governmental Organizations (NGO) and most of them are subsidized by the state/central government to the maximum. The criterion of admission is elderly who are destitute or very poor. The facilities in these homes are mostly meeting the bare physical needs (shelter and food) of residents. Except a few, majority of these do not admit disabled persons (those with severe restrictions in their basic ADLs) or those who are sick and need constant health care. The governmental subsidies for the homes are low and fall much short of the running expenditure ([www.helpageindia.org](http://www.helpageindia.org)). The pay-and-stay homes are fast growing in towns and cities. The access to facilities is dependent on their financial capability. There are wide range of care homes to cater to all economic levels. Some of them are upscale and high-end (e.g., NRI) with most modern facilities. There are multilevel apartments (similar to retirement

communities in USA) in a gated community, where senior citizens can buy or rent the apartment for themselves and stay. The building complex has all the facilities, like a lounge, a TV room, a clinic, a meeting/function hall, and so on. The walkways are elder friendly with railings to hold on the sides and the flooring (non-slipping) are without steps predominantly age-friendly, safe and with a host of elder friendly facilities, e.g., for using wheelchairs, medical assistance for minor ailments. In case of hospitalization, it will be at the cost of the residents and with their own arrangements. In case of death, the next of kin are informed to come and take care of their last rites.

Moving elderly family members into institutions in India is even now deemed a social stigma as less than 1% of the elderly population resides in nursing homes (Liebig, 2005). Brijanth (2012) identified old homes as “spaces which symbolized an abrogation of family responsibility”. Kalavar and Jamuna (2008) also reported that the stigma surrounding formal or institutional care continues to exist, being primarily cast in the light of abandonment, family conflict, and psychological distress.

Apart from the residential facility, day care facilities are also of two types, i.e., free and paid. The free type (mostly run by NGOs with governmental support) offer service for senior citizens from morning to evening with a provision of lunch (mid-day) and some schedule of activities to engage the seniors (e.g., income generating activities). The facilities differ in terms of cost, with some of these being very luxurious such as with library, air conditioning, and entertainment facility. It is noteworthy that residential care and day care facilities are not adequate, and where available their functioning leaves large scope for improvement. Facilities for the sick and disabled senior citizens are very few. Similarly, hospice arrangements for the very sick and terminally ill are not a part of majority of the facilities.

### **Home Health Services**

Starting early 21<sup>st</sup> century, home healthcare services for the elderly began to sprout in various metropolitan areas. According to a published newspaper article (The Times of India, 2014, June), these agencies offered a suite of services from palliative and geriatric care, companionship, emergency services, routine medical visits, and ‘concierge’ services that ran errands for seniors and accompanied them on outings. Each set of services are preset and packaged, and in metropolitan areas with a rising number of senior citizens, such services are not only being sought after by adult offspring who live in distant locations but also those who reside in the same city. This is largely due to adult children leading busy professional lives and finding themselves unable to tend to their aging relatives. There is a huge rise in the demand for such services that are tailored to meet client needs. For instance, some seniors want companionship, some require specialized care, some want physiotherapy, some want their vital stats checked regularly, some want to make sure that prescribed medications are taken in a timely manner, and some want assistance with medical visits. While these services are part of a fledgling industry, those who patronize these services are primarily wealthy.

To enable seniors to continue to reside in their own houses, senior care services are mushrooming throughout India. The intention being that seniors continue to reside in familiar surroundings (‘aging in place’) giving them a sense of security, control, and peace of mind. These agencies tout the message that relocation in late life can lead to disorientation and depression. That healthy older adults who need companionship or travel assistance must not be placed with those who are infirmed in any way.

A significant contribution to elder care among middle- and higher-income families in India is made by domestic household workers. Domestic work in India provided by women constitutes over two-thirds of the workforce in this unorganized sector (Saldanha, 2017, July). They usually migrate from the poorer states of India, are often hardly from the legally eligible age group to work, and their salaries are less than the minimum stipulated by the

government. According to the National Sample Survey Organisation (2006), there are nearly five million paid domestic workers in India that eke out their living by working long hours in a low status job, facing various types of harassments and abuse, and dismally low wages (Barua, Haukanes, & Waldrop, 2016). The tasks these women performed were sweeping, mopping, dusting, washing of clothes and cleaning utensils. As more couples work, additional responsibilities may be tagged on such as cooking meals, assistance with food preparation, gardening, babysitting children, and caregiving for elders (Surabhi & Nigam, 2017, February).

One of the major problems of old age is healthcare. As poor health is evident with increasing age, the cost of treatment tends to be prohibitive. Health insurance for senior citizens (especially for the 65 plus) is nearly non-existent, and the very few that are there, charge exorbitant premium. Indian constitution (Article 41) advocates social welfare to its citizens who are unemployed, elderly, sick, and disabled and fall within the limits of the states' economic capacity and development (Goswami et al., 2019). Some recent government schemes are coming up to meet hospitalized expenses for those below poverty line (e.g., the Arogyasriswasth program). Majority of the poor and middle-class families are unable to meet the high cost of treatment of their sick elderly parents. This may lead to neglect and elder abuse of various types (mostly open conflicts and neglect) in the lower economic rungs. In extreme cases, physical abuse is manifested. Very often, elder abuse is subtle and not openly manifested (Jamuna, 2003).

The elder care situation in the coming years in India is bound to turn acute and problematic, if adequate preventive steps are not taken. As material- and non-material resources as well as attitudes towards elder care by adult children are showing signs of deterioration (Jamuna, 2003), it is necessary to plan strategies to protect the role of the family in elder care (Barusch, 1995; Jamuna, 2004). The community around too has not assumed

any major role in eldercare except in support to the norm of family care of the elderly (Sivakumar, 1998). However, in a few Indian states (e.g., Maharashtra) federations of senior citizens' organizations are assuming responsibility in the care of elderly. The community can play a significant role by organizing neighborhood caring networks and community homes for elderly particularly in rural areas (Jamuna, 2003). The state as such cannot assume the responsibility of elder care because the cost of supporting 80 million elderly even partially would become a prohibitive expenditure, consuming a major share of the national budget. Hence the family, the community, and non-governmental organizations may have to play a major role with support from the government (Muttagi, 1997).

Some supplemental elder care services e.g., meals on wheels, home care services, respite care, helplines are restricted to metro cities, and are to be expanded to other towns and rural (Jamuna et al., 2003). Many middle-class old people are choosing to stay by themselves or join 'pay-and-stay' homes rather than old age homes (OAHs) for the destitute (Jamuna, 2003). Real estate developers are offering programs of 'own your flat' for seniors in metropolitan and other urban areas which resemble the concept of Independent Living localities in USA. Some corporate construction companies are starting to provide housing for the elderly using the Retirement Communities Model. Even pay-and-stay facilities for the elderly are on the increase in many cities and towns, and are turning out to be good commercial enterprises. Some private organizations, for example, Heritage hospitals and senior services at Hyderabad are offering model services for the elderly such as dial-a-driver, meals on wheels, companion services, home health check-ups, and the like (Gangadharan, 2003). The very first geriatric care service, established in 1994 here in India was the Heritage Hospitals and Foundation at Hyderabad ([www.heritagehealthcareindia.com](http://www.heritagehealthcareindia.com)). The Calcutta Metropolitan Institute of Gerontology was established to cater to the services of senior



citizens ([www.cmig.org.in](http://www.cmig.org.in)). The conditions of family care are paving the way for the elderly to seek alternate care facilities (self-care, hiring home care services, care in OAH).

### **Future Directions**

The aforementioned is a brief description of the elder care scenario in India. Despite being a traditional culture, socio-demographic and technological changes are fast eroding the safety net of family care of the elderly. Strategic measures of meeting the growing economic, health and social care needs of the elderly population need to be put on a war footing with both short-term and long-term plans to forestall the development of a crisis situation. Empowering older persons towards greater self-dependency on social, economic and health fronts is a necessary goal towards which national care policy has to be geared and efficiently implemented.

Supporting families through subsidies, establishment of respite care centers, enhancing community support through volunteerism, making older adults economically self-sufficient, employing senior-friendly technology to promote well-being are some important measures. Caregiving, whether at home via home health services, in residential care facilities or nursing homes, must be carefully regulated to protect seniors. In India, there exists a strong socio-cultural inclination for the care of the elderly at home. Therefore, services and resources need to be targeted to support families that continue to care at home. Though social structures and lifestyle are being continually modified, the underlying traditional notions of *seva* need to be nurtured and fostered.

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