# Informal Care for the Elderly in India: New Evidences from a Nationally Representative Ageing Survey

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**Abstract**

India is fast becoming an ageing population, but could not produce the required support systems for its elderly citizens. Providing care to the elderly, who need them, is a critical issue in all ageing societies. In Indian scenario, where caregiving mostly centres around informal sources like family and close relatives, and the gender differentials in instrumental care can be a major concern. Previous studies have already focused on how gender plays a role among the caregivers whereas this study tries to explore what is the nature and extent of gender differentials regarding in-house instrumental support received by the elderly. For this purpose, the survey data from the Longitudinal Ageing Study in India (LASI) was used. This survey covered 31,000 elderly respondents from all states of India. Significant gender differentials were observed and the likelihood of receiving care is higher for female elderly over males. Among the demographic factors, number of children the respondent has, place of residence, living arrangement comes out to be significantly related in receiving care at home. The spouse is often considered as the primary caregiver for the elderly from the same generation, but if we consider intergenerational aspects, the daughters-in-law come out to be the major caregivers, compared to own sons and daughters, due to the pattern of family living arrangements in India. Comparatively longer life expectancy with higher prevalence of limitations in activities of daily living (ADL) and economic dependency increases the elderly women's, particularly of elderly widows, requirement of care in India.

***Keywords:*** *Elderly, Care-giving, Gender differentials, Family, India.*

## Introduction

Ageing is an outcome of the demographic transition, is a process whereby reduction in mortality is followed by reductions in fertility; and this process leads to a relative reduction in the proportion of children and an increase in the share of people in the working age and older age in the population. The emerging changes in the age and sex structure of India's population, especially at older ages will have a profound impact on the demographic scenario, and are expected to pose multifaceted developmental challenges for country. The Changing pattern of demographic characteristics and increasing share of older population was discussed in detail in 1982 at the First World Assembly on Ageing held in Vienna. The International Plan of Action on Ageing was approved to evolve countrywide crucial policies and initiatives. In the year 1991, the United Nations Principles for Older Persons was formulated to address independence, participation, care, self-fulfilment and dignity of the older adults. In 2002, a modified and more contemporary plan of action was prepared; Madrid International

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Plan of action on Ageing (MIPAA) which focused on integrated development, advancing Health and Well-being into old age and ensure Age-friendly environment. The 2030 Agenda for Sustainable Development calls to "Ensure healthy lives and promote well-being for all at all ages" (Sustainable Development Goal 3) and to "Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate" (Sustainable Development Goal 5, target 4) (UNESCAP, 2020).

According to Census of India 2011, there are nearly 104 million people aged over 60 years; constitute more than 8% of the population of the country. However, this scenario is going to change drastically in the next two decades, where India will have about 20% of its population as elderly by 2050, which is approximately 340 million senior citizens in the country. According to the UN World Population Prospects (2019), the ageing index of India is expected to increase 74.5 by 2050 and similarly the old age dependency ratio is expected to witness a steep rise up to 31.5 by 2050. With increasing dependency, the aged population also demands support; physical, mental, social and above all, financial. Advancement in medical facilities may ensure increased life expectancy, but does not always ensure healthy ageing and happiness.

## Informal Care: Review of Literature

Informal care refers to the provision of day- to- day support in terms of instrumental, financial, social and emotional without involving financial transactions. The support required, varies considerably from partial requirement of assistance to full-time assistance for the senior citizens. According to Kleinman (2010), care giving as the daily provision of financial, material and emotional support necessary to enable life and alleviate suffering in particular social institutions; in short caregiving can be very diverse in nature with the commonly noticed tangible acts being instrumental caregiving and financial support (Ugaragol, Hutter, James, & Bailey, 2016). In other words, caregiving is a process of mutual exchange results in both costs and rewards to those who provides care and the aim of all individuals in the relationship would be to maximise rewards and minimise costs. In a nutshell, Liu and Kendig (2000), classified into "not so mutually exclusive" four categories of caregiving; i.e., medical care, personal care, help with instrumental activities of daily living, and providing emotional support and personal safety. The need for care cannot be separated in only one type as they often overlap; the concept is multifaceted as well as multidimensional in different social and cultural settings.

In the global context, there is a dichotomous concept regarding caregiving; in European model caregiving comes under welfare state, i.e., as an individual right (Liu, 2000); whereas, in most of the East Asian countries, like China, Japan and India, caregiving is a continuous and reciprocal process, in which family shoulders the primary source of informal caregiving and they are mutually dependant on each other throughout their life course (Liu & Kendig, 2000). The significant difference in concept of caregiving within Western countries is that, caregiving is accepted as a more public responsibility in Europe which is more of a private responsibility in North America (Liu, 2000). But in changing social scenario, the long-term care policy in European context is shifting towards a quasi-formal process between the family and the state (Walker, 2000). However, though countries have developed its separate care system for elderly according to their own culture and traditions, by and large, family has been considered the traditional primary source of informal support (Pushpam, 2021). Other than in-house personal support, social security system or economic support is another dimension of caregiving, which is a strong concern mostly for aged in most developing countries, including India.

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In Indian context, the concept of caregiving lies similar with other East Asian countries. As, co-residence was inevitable familial structure for centuries, the immediate family members are the foremost primary and perhaps the only source of informal care to elderly; both in terms of monetary and non-monetary support required. The important objective of this research article is to examine the extent of in-house instrumental care provision in Indian households. In changing family structures, migration of youngsters for education and employment leaving behind the aged parents/ grandparents, and the increasing share of elderly living alone, the need for instrumental support would be a major policy concern in India.

Instrumental care usually mean to provide assistance in performing daily life activities; such as dressing, walking, bathing, eating, getting out of bed, using toilets etc. in daily life or a few additional activity limitations like preparing food, buying groceries or medicines etc. to those having several functional limitations. With increasing age, the prevalence of functional impairments and disabilities likely increase. According to a study, one in every seven older adults in India are suffering from at least one functional limitation; be it restrictions in mobility or instrumental activities (Kastor & Mohanty, 2016). At national level, the prevalence of work limiting impairments is high among women (31%) than men (28%). Similarly, the overall prevalence of at least one ADL limitation is 16% in India; which reduces to 9% if the number of restrictions in ADL increases to 2 or more in number. Among the elderly (age 60 years and above), both the prevalence of at least one ADL limitation and two or more ADL limitations are higher among women (26% and 16%, respectively) compared to their male counterparts (21% and 12%, respectively) (IIPS, et al, 2020). Thus, it is evident that the provision of informal care is inevitable and gradually the burden of care for the elderly with several impairments will likely to increase. In the intergenerational co-residing joint family culture, elderly expect support from their children as a return of their care investment towards the younger generation. With increasing number of impairments and disabilities with advancing age, the burden of caregiver also increases positively which leads to deterioration of caregiver's mental and to some extent physical health (Ajay, Kiran, & Malhotra, 2017). However, for same generation, spousal support was found to be significantly high as a caregiver towards the partner in need and female spouses are found to be devoting more time towards taking care of their old husbands (Glauber 2017, Kumari & Sekher, 2021). If we concentrate on intergenerational caregiving, for centuries, across most Asian societies, children have been mandated and regarded as the primary caregivers for their aging parents. However, in many Western countries where formal elderly care services are available which are supported and financed by the government (Chen & Jordan, 2018).

## Informal financial support for elderly

Lack of social security provisions and economic dependence are the major limitations that very often affect the wellbeing of older persons. Although, in general, the population ageing is most advanced in Europe, it has been very rapid in the Asia-Pacific region with many countries "getting old before they get rich" (UNESCAP 2020). The majority of the India's older people do not receive any form of pension and are directly or indirectly dependent on someone in the family and this will be the case for the foreseeable future; about 20.3% are partially dependant and a majority of 53.4% are completely dependent on others regarding economic security. The transfer of resources between generations is of multiple importance to the family as well as to society with perhaps the most important being the economic resource (Fingerman et al. 2010; Leeson and Khan 2013; Arber 2013). In the agricultural sector as well as in the rural and urban informal sectors, there is no fixed age at which people will

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normally retire, and stop working. Both men and women continue to work as long as they are physically able, although the type of work they do may change and they may work with diminished capacity. They are working to support themselves and their family, despite failing health and mental capabilities. This is true for both men and women and not only for rural agricultural sector but for urban unorganised sector too. Economic problems are more common among female widowed elderly in lower- and middle-income countries due to the absence of universal social security system and over dependency on spousal economic support (Lloyd-Sherlock, Corso & Minicuci, 2015).

**Gender dimensions of receiving and providing care**

In Indian society, gender based cultural norms and discrimination is prevalent even now. Gender differences in care; in terms of financial support, instrumental support for daily life activities, health seeking behavior and long-term care exists both in developed and developing societies (Kadoya & Khan 2017*;* Glauber 2017*;* Chen et al., 2018; Ugargol et al., 2016; Guo, Chi & Silverstein 2016; Song, Li & Feldman, 2012; Huang, 2018; Zimmer & Knodel, 2013*)*. The Global Report on Ageing in 21st Century recognised that there are multiple forms of discrimination experienced by older persons, particularly elderly women. This includes access to jobs and health care, subject to abuse, denial of the right to own and inherit property, and lack of basic minimum income and social security (UNFPA, 2011). In India, patrilineal and patriarchal structures place women in an unequal position both within the family and in the wider community. This asymmetric gender and power relationship means that women are disadvantaged at various stages of the life course, and these disadvantages accumulate over the life course. As a result, women enter old age with fewer resources and lesser capacity in decision-making. As the state support is very limited in Indian scenario, the support from family becomes important and crucial for their own survival (Dommaraju & Visaria, 2017).

Traditionally, Indian patriarchal culture suggests that the (eldest) son is the predominant caregiver for elderly parents. Daughters are treated as members of their husbands' families after their marriage, as described in saying: "Married daughters are like spilled water which cannot be gotten back." (Kadoya et al., 2019; Guo et al., 2016). But with changing cultural values and familial living condition, the typical role of care giving is changing both in a positive and a negative way. With increasing mobility of the younger generation for education and employment, the physical presence of children at home has been sharply decreasing which further deteriorated the flow of emotional and physical care towards the elderly family members. On the other hand, irrespective of marital status, daughters play an important role in both physical and financial help towards their parents. Gender gap is always present in care-giving for the intergenerational caregivers and holds equally relevant for the caregivers of the same generation. Health and Retirement Studies (HRS) of USA indicates, men's odds of receiving care, primarily from a spouse, were nearly 3 times larger than women's odds of receiving care primarily from a spouse though the gender difference reduces significantly with increasing age; the median hours of monthly spousal care received by middle-aged women (50–65) was 31 hrs, whereas the median for older women was 61hrs. In other words, older women received 30 more hours of spousal care per month than middle-aged women (Glauber, 2017). In Indian scenario, in case of daily activities limitations (ADL), the spouse was the primary caregiver for co-habiting older adults while in an intergenerational household, other younger family members are primary caregivers (Ugargol *et al.,* 2016). Examining gender differences in elderly caregiving is similar to studies concerning other types of family labour, such as housework and childcare. Generally, women are found to be investing more time on family labour. The gender-role expectations posits that it is socially desirable for women to

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provide care, but simultaneously they are also subject to more stress in doing so (Kadyoa *et al.,* 2019). Thus, daughter-in-law is found to be the primary care giver to elderly household members in most of the oriental culture (Ugargol et al., 2016; Samantha, 2019), and when men emigrate, gendered contexts burden women more, especially spouses and daughters-in-law, with caregiving duties including elder care that forces daughters-in-law to sacrifice careers and separation from husbands to transition into the caregiving roles, costs borne to effectuate their husband's filial role. Perceived non-reciprocity, unbalanced exchanges and unmet expectations increased the perceptions of burden for caregivers (Ugargol & Bailey 2018). The studies in rural China and Thailand (Knodel & Chayovan, 2009) also supports the existence of gender differentials in receiving and providing care to the elderly. Analyses by parents' and children's gender suggests that there are significant differences in intergenerational support because of gender roles and divisions in families; older mothers receive more returns, which reciprocates their support, while older fathers benefit more from the out-migration of adult children and although sons take more responsibility for family's financial need, daughters reciprocate support from their elderly parents more (Song *et al.,* 2012). Along with the gender, care provision varies with the number of children the elderly has, and having more children ensures more support in later life (Weng & Li., 2020; Chen *et al*., 2018).

Not only the gender of the caregiver, but also the co-residence of elderly with their caregives allows the pooling of resources and support individual family members in the time of need, and thus plays a significant role in care and support to older adults (Ugargol *et al*., 2016). With changing familial norm and economic globalization, the intergenerational living arrangement is rapidly changing that has direct impact on the care giving for the older adults (Mao, Chi & Wu*.,* 2017). Social networks and family ties are among the core institutions providing support and opportunities for engagement to older adults around the world (Berkman*,* Sekher, Capistrant & Zeng*,* 2012). Caregiving also has direct impact on health trajectories of the elderly population. A study based on rural China identified, gender differentials in the cumulative effects of intergenerational relationship on the health of elderly (Lu, Luo, Zuo & Chi, 2017). This study tried to identify the existing scenario of informal care needs and the provision among the elderly of Indian households, and thus try to understand the gender dimensions of care.

**Data Source**

The study used the data from the well-known Longitudinal Ageing study in India (LASI Wave-1). The LASI is a nationally representative survey of 73,000 older adults age 45 years and above across all states and union territories of India. LASI follows the framework of HRS studies underway in more than 40 countries around the world. The similar survey sin Asia includes ageing surveys in China, South Korea, Japan, Thailand, and Indonesia. LASI has the questions according to Indian context and cultural practices prevalent, but most of the measures have been harmonised to the possible extent with its international sister surveys on Ageing and Retirement (Bloom, Sekher & Lee, 2021). The basic goal of this survey is to collect longitudinal data on living arrangements, burden of disease, functional health, mental health, caregiving, healthcare and social-economic wellbeing of older adults based on internationally comparable research design. The LASI is designed to provide reliable estimates of all health outcomes and social and economic wellbeing indicators for older adults age 45 years and above, representative to India's population and also for all states and union territories (IIPS et al., 2020). Wave 1 of the LASI survey covered a sample of 73000 individuals (aged 45 years and above) and their spouses irrespective of their ages in 2017-18, including nearly 32000 elderly (aged 60 and above). LASI covers

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demographics, household economic status, chronic health conditions, symptom-based health conditions, functional health, mental health (cognition and depression), biomarker, health insurance, health care utilisation, family and social networks, welfare programmes, work and employment, retirement, discrimination, satisfaction and life expectations. The age of the respondents for the study is restricted to 60 years and above. Among the respondents, after filtering for age was 31,464, among them 15,340 are males and 16,564 are females. For estimating the instrumental care, the respondents who have reported any kind of limitations in ADL or IADL activities or anything related to mobility were taken into consideration in this paper

## Methodology

In this study, a few factors of physical limitation; i.e., the limitations in mobility, ADL and IADL and presence of Chronic diseases as well as overall self-rated health are taken into consideration. For mobility restrictions, 9 set of questions are quantified and categorized into 3 classes; if the respondent has opted for "no" for all the mobility related questions, then it is classified as no restrictions; if the respondent has opted for "yes" in any 1 or 2 restrictions then he/she is put under the 2$^{nd}$ category and beyond that all other respondents are considered under the 3$^{rd}$ category. For ADL limitations, the survey used 6 set of activities: Dressing, Walking, Bathing, Eating, getting out of bed and using the toilet. The IADL limitations had 7 questions like cooking, shopping for groceries, financial management, making phone calls etc. Thus, the classification for ADL and IADL restrictions are similar with that of mobility restrictions. Presence of chronic diseases were categorised into 9 separate groups and a respondent having any one of the issues are categorised as those having chronic health issues. Over all self-rated health (SRH) were categorised into binary classes; those who reported their health as excellent to good are put in good SRH, and others are classified under poor SRH.

Other independent variables are broadly the background characteristics of the respondent; such as age, gender, place of residence, level of education, marital status, living arrangement, religion, caste, number of children, etc..

## Important Findings:

As expected, with the increasing health impairment, the requirement of support also increases. In India, overall, a quarter (25%) of the elderly (aged 60 and above) with any ADL or IADL limitations, needed a helper / assistant; which is higher among female elderly (26%) compared to males (23%).

If we analyze across the states, Arunachal Pradesh shows highest percentage for providing care to the female elderly (57.58%); followed by Karnataka (39.74%). Among the rural males in Karnataka 37.45% and 74.40% respondents in urban areas receives instrumental help. For female respondents 44.27% in rural Karnataka and 28.83% in urban Karnataka gets instrumental support from informal sources. Kerala and Lakshadweep among the southern states shows that 35.92% and 33.16% of the respondents receives instrumental care, which is higher than the country's average.

In caregiving responsibilities, spouse is the primary caregiver of the same generation family members in most rural households, but if we consider on intergenerational aspect, the daughters-in-law are the major caregivers compared to own sons. Table 1 illustrates that how with different socio-economic characteristics of the interviewed respondent, the prevalence of instrumental care varies.

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## Discussions

This study primarily focuses on what is the nature and extent of gender differentials in informal care receiving among the elderly, based on the recent data sources; how does different demographic and socio-economic characteristics influences the uneven distribution of care receiving among the elderly. Irrespective of social and economic characteristics of the elderly population, the gender differentials in receiving and providing care is very prominent. The most important and significant variables are age, household size, number of children the respondent have, living arrangement and the present health related issues which have contributed significantly in determining the availability of informal care. Number of children is positively correlated with the availability of informal care as traditional Indian cultural norm supports to have more children thus the responsibility of caregiving can be divided among the adult children which ensures a sense of security to the elderly. Elderly parents used to depend on children in their later years, reflecting the norm of filial piety and the tradition of 'bringing up children to provide care against old age' in Indian culture. Similarly, increasing number of household members is interrelated with children alive. In absence of the children, the kins can play the most important role in caregiving to the elderly. Along with gender, the place of residence (rural or urban) also reflects the differences in receiving care. In urban areas the availability of household members and hours devoted to care for elderly would be much lower than in rural areas. Due to social and cultural dimensions, the filial piety is yet deeply rooted in rural India. Similar pattern is seen in rural areas, the percentage distribution of caregiving for female elderly is higher than males, though familial culture is changing all over India but intergenerational co-residing families are still prevalent in rural India. In urban areas, available persons in the household to take intensive care of the elderly is less in number (Ugargol *et al.,* 2016). Specially for instrumental care, co-residence is an inevitable fact, as physical presence of caregiver is what is most needed (Weng *et al.,* 2020). With a higher mobility and migration, the urban households had limited persons and time for the elderly people that leads to devaluation of traditional care giving trends towards the older parents or grandparents. Health conditions are important controlling factor for caregiving to the elderly; with increasing physical limitations, the requirement of care and assistance also increases. The research on gender differentials on global health outcome supports the statement that in most of countries, women confronts more problems or limitations in performing daily life activities whereas men do better in measured performance of functioning (Crimmins, Shim, Zhang & Kim, 2019). Thus, elderly women need to have more instrumental support in carrying out their daily living activities. From the findings of this research, it clearly indicates that with increasing limitations in ADL and IADL, the instrumental support received by the elderly also increases 2 to 3 times. For male elderly, marital status plays an important factor as female spouse is counted as primary caregiver in Indian households (Dommaraju *et. al*., 2017), If we consider the available evidences from past studies, the gender differentials in spousal care (Glauber 2017; Chen et al. 2018), in both developed and developing counties, the in-house informal caregiving is done mostly by the female spouse towards her husband. Where Spouse is identified as the primary caregiver of the same generation family members, in intergenerational family setups, the daughters-in-law are the primary caregivers for instrumental support compared to their own sons who are also living in the same households (Khan, 2014).

## Conclusions and Policy Implications

Indian government's National Policy for Older Persons (1999) strongly emphasizes that the elderly should continue to live with the family and that the family act as primary caregivers. Considering the

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cultural and social norms prevalent, institutional care for aged is seen as a last resort. The Maintenance and Welfare of Parents and Senior Citizens Act came into being in 2007 to ensure proper care and to give justice to the abandoned elderly parents. This can ensure flow of "maintenance" including provision of food, clothing, shelter and medical attendance and treatment from the children to their older parents as obligation. But the psychological bonding and intergenerational love cannot be ensured through enactment of any law. Public transfers to the elderly through welfare or social security measures remain low and inadequate in meeting the needs of the aged poor; e.g., Indira Gandhi National Old Age Pension Scheme (IGNOPS) provides a monthly pension of meagre amount, which is not enough for a living. The concept of care giving is highly rooted in cultural and moral values. With prominent gender differentials persisting, the quality of care can be maintained if both men and women performed their duty without any compulsion, out of sheer love and affection. As caregiving is highly interrelated with health condition of the elderly, especially the mental health, the assurance of financial security and good assistance in daily life can make the ageing population a healthy ageing cohort.

The in-house or informal sources of support are the cultural aspects in Indian context, which cannot be mandated by state policy or through legal provisions. Males are always ascribed as the 'supreme bread earner' in the Indian culture, whereas the "cooking, caring, cleaning" which includes physical care giving, is highly expected from the females. The unpaid care provided by the family member needs to be recognized, as gender differential is prominent in a bi-directional way of care giving and care receiving. And most importantly, as the study indicates, elderly women require more assistance due to physical impairments. To meet the increasing need of in-house informal support for the elderly, strengthening of family bonds and social security measures are crucial in Indian context.

**Table 1. Percentage Distribution of Instrumental Support Received by Elderly in India by Background Characteristics.**

| Background Characteristics | Categories | Males (Percentage distribution) | Females (Percentage distribution) |
|---|---|---|---|
| Marital Status | Currently Married | 21.18 | 14.14 |
| | Widowed | 25.51 | 27.96 |
| | Divorced/Separated/Deserted | 18.08 | 14.94 |
| | Never Married/Live-in | 18.63 | 19.80 |
| Age of the Respondent | 60-69 | 16.96 | 19.83 |
| | 70-79 | 25.87 | 26.49 |
| | 80 or above | 36.52 | 44.03 |
| Place of Residence | Rural | 19.53 | 19.30 |
| | Urban | 29.17 | 21.12 |
| Completed Years of Schooling | No schooling | 21.99 | 19.80 |
| | Less than 5 years | 20.93 | 22.68 |
| | 5-9 years | 20.58 | 20.26 |
| | 10 or more years | 23.60 | 13.50 |
| No. of Children Alive | No child | 22.14 | 20.39 |
| | Single child | 22.82 | 15.02 |
| | 2-3 children | 22.03 | 17.40 |
| | 4 or more | 21.33 | 22.28 |

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| | | | |
|---|---|---|---|
| **Household Size** | **Single** | **10.72** | **11.24** |
| | **More than two** | **21.64** | **17.28** |
| | **More than three** | **22.32** | **22.43** |
| **Living Arrangement** | **Living alone** | **10.78** | **11.29** |
| | **Living with spouse** | **21.99** | **12.67** |
| | **Living with spouse and children** | **20.98** | **14.39** |
| | **Living with children** | **27.02** | **29.65** |
| | **Living with others** | **22.05** | **31.23** |
| **Household Wealth Index** | **Poorest** | **18.54** | **16.76** |
| | **Poorer** | **19.49** | **19.54** |
| | **Middle** | **23.73** | **21.36** |
| | **Richer** | **18.28** | **22.69** |
| | **Richest** | **30.61** | **18.78** |
| **Religion** | **Hindu** | **20.59** | **19.39** |
| | **Muslim** | **30.21** | **22.86** |
| | **Others** | **19.69** | **18.59** |
| **Caste/Tribe** | **Schedule Caste** | **18.28** | **19.00** |
| | **Schedule Tribe** | **18.71** | **19.58** |
| | **Other Backward Caste** | **24.01** | **19.01** |
| | **Others** | **21.87** | **22.47** |
| **Restrictions in Mobility** | **No restriction** | **10.09** | **15.06** |
| | **1-2 restrictions** | **15.87** | **14.06** |
| | **3 or more restriction** | **33.78** | **28.62** |
| **Restrictions in ADL** | **No restrictions** | **12.36** | **14.02** |
| | **1-2 restrictions** | **20.26** | **20.41** |
| | **3 or more restriction** | **45.00** | **38.46** |
| **Restrictions in IADL** | **No restrictions** | **8.67** | **11.27** |
| | **1-2 restrictions** | **13.82** | **12.60** |
| | **3 or more restriction** | **33.85** | **27.45** |
| **Self-Rated Health** | **Poor** | **23.67** | **23.51** |
| | **Good** | **15.52** | **13.02** |
| **Perceived Health** | **No Chronic Disease** | **14.91** | **15.86** |
| | **Any Chronic Disease** | **27.26** | **23.08** |

**Note: ADL- Activities in Daily Living; IADL-Instrumental Activities in Daily Living**

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