The Changing Nature of Home-Based Care for Older Adults in Goa's Emigrant Households: Implications for Policy and Practice

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Abstract

In developing countries such as India, the consequences of aging within underdeveloped social security systems coupled with traditional expectations on filial provision of care mean that *families* continue to remain primary caregivers for dependent older parents. Concerns abound regarding the increasing costs of

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healthcare, inadequate access to geriatric care, competing time constraints, and difficulties experienced by filial caregivers that could necessitate caregiver support to alleviate burden and provide respite. These concerns are further exemplified in emigration contexts in India where the emigration of the adult child alters traditional filial intergenerational care arrangements. Housed within strong notions of filial piety and a sociocultural reluctance to accept institutional care, this chapter focuses on Goa's emigrant households where adult children emigration involves leaving behind older parents. We identify, describe, and reflect on the emergence of adaptive intergenerational care arrangements including the emergence of chaperoned provision of care for older parents through engagement of formal home-based older adult care services. While this could potentially offer respite to primary caregivers, it could also end up increasing family involvement in care and significantly impact family caregivers' financial situation, lead to time constraints, and affect employability. In juxtaposing policy and practice, we abridge that while notions of filial responsibility are being redefined by processes such as modernization and emigration, the preference for home-based care prevails and is interestingly and increasingly becoming visible through adaptive intergenerational care arrangements that are effectuated through filially orchestrated home-based formal care services – an emerging area with regulatory as well as policy implications for both caregivers and care recipients.

Keywords

Aging · Older adults · Emigration · Intergenerational care arrangements · Home-based older adult care · Geriatric care · Goa · India

1 Introduction

The number of older people in the world is expected to increase from 737 million in 2010 to two billion in 2050 (UN, 2020). A clear majority (62%) of the world's older population is living in the developing world with India and China contributing a larger share (Tao & McRoy, 2015; UN, 2020; Poot & Roskruge, 2020). India's older adult population (defined as those aged 60 and older) has been rising dramatically (MOSPI, 2011; GOI, 2011) and is reflective of a rapidly aging society (Goli et al., 2019). According to the Report of the Technical Group on Population Projections for India and States 2011–2036, there were nearly 138 million older adults in India in 2021 comprising 67 million men and 71 million women (MOSPI, 2021). While the general population grew by 12.4% during 2011–2021 as compared to around 18% in the previous decade, the older adult population grew by 36% consecutively in the last two decades, i.e., 2001–2011 and 2011–2021. The old age dependency ratio also rose from 10.9% in 1961 to 14.2% in 2011 and is further projected to increase to 15.7% and 20.1% in 2021 and 2031, respectively (MOSPI, 2021; Rajan & Mishra, 2020). The 2011 census also highlights the widely different demographic picture across Indian states; while some have a higher proportion of older adults than the

national average, others have significantly lower. Kerala (12.6%), among the larger states, and Goa (11.2%), among the smaller states, represented fairly high proportions of older adults as compared to the national average of 8.6% (GOI, 2011; Rajan & Mishra, 2020). In fact, Goa fits well into the advanced phase of demographic aging characterized by declining infant mortality, fertility, and adult mortality (Rajan, 2011).

The rapid aging of the population, as the twin phenomena of demographic transition and epidemiological transition roll on, is necessitating a comprehensive overhaul of healthcare systems, public spending, social security, healthcare and geriatric care infrastructure, and policies for older adults in developing countries (Bloom et al., 2010; Goodman & Harper, 2013; Lamb, 2013; Ugargol & Bailey, 2021). In developing countries such as India, the consequences of aging are far more serious because insufficient social security systems and traditional care expectations oblige families to remain primary caregivers for dependent older parents (Ng & Indran, 2021; Bloom et al., 2010; Ugargol et al., 2016). It is ironic that though enhanced life expectancy was achieved primarily on account of medical innovations such as drugs and vaccines, economic growth, better healthcare and medical facilities, and a simultaneous reduction in fertility rates (Mathers et al., 2015; Robine, 2021), there is still persistent inequality in longevity across the world and distinctly so within India (Liou et al., 2020; Asaria et al., 2019). Given the lack of preparedness in anticipating the consequences of this demographic change and the inevitable increase in the number and proportion of older adults, the aging of the population is being viewed as a problem and a cause of concern in India (Dhillon & Ladusingh, 2017; Dey et al., 2012; Raju, 2011). India is historically characterized by a chronically underfunded and unsupported public health system and a relatively fragmented healthcare system (Kamath et al., 2020; Jakovljevic et al., 2017) that largely fails to provide safety nets and healthcare security for its older adults (Bloom et al., 2010; Gorman, 2017; Ugargol et al., 2016). The persistent relatively flat national healthcare spending is a cause for concern especially for the welfare of its older adults (Acharya, 2018; Jakovljevic et al., 2017; Croll, 2006; Gupta & Raju, 2018).

This profound shift in the share of older adults in India has raised concerns and challenges with the emphasis being on advocacy and solutions for older adult care – within households and in the society in general (Croll, 2006; Gupta & Raju, 2018). Older adults are now living longer albeit with higher comorbidities, health deficits, and functional limitations (Ugargol et al., 2016; UN, 2013). With the aging of the population, there is a concomitantly increasing trend of modernization and adult child migration, both internal and external, leading to alterations in living arrangements and thereby creating gaps in the care availability for older parents (Breton, 2019; Ugargol & Bailey, 2018; UN, 2013). Human aging is vividly embedded in social contexts and is further shaped by societal factors (Elder & Johnson, 2018). Though there is a naturally expected decline in older adults' health over time due to biological processes, several other life course factors such as socioeconomic conditions, nutrition, family support, autonomy in decision making, disability, retirement from employment, abuse, and neglect tend to play a role in either maintaining or

deteriorating the health and wellbeing of older adults (WHO, 2016; Das et al., 2018; Sathya & Premkumar, 2020). This complex interplay of factors also defines the older adult population as a nonhomogeneous group with varying situations, entitlements, disabilities, and needs. To compound these, the unfortunate perpetuation of ageist attitudes and age-based discrimination that is widely prevalent in society leads to further marginalization and exclusion of older adults at homes, in workplaces, and in society (Ayalon & Tesch-Römer, 2018; Kagan, 2017) and could predispose older adults to vulnerability and being deprived of their rightful access to care (Agarwal et al., 2020; Baer et al., 2016). The complexity is grave in India where there is a misplaced resource limitation in a society where the older adult population is yet to be recognized as a priority (Irshad et al., 2021; Bhaumik & Ladusingh, 2021; Bloom et al., 2010). Even though the National Programme for Health Care of the Elderly (NPHCE) provisions for geriatric care across the landscape, on-the-ground preparedness and institutional infrastructure availability for providing geriatric care services are found wanting, more so in the rural peripheries (Yasobant et al., 2021; Pazhoothundathil & Bailey, 2021).

A lifecycle of scarce allocations towards older adult care, absence of older adult-focused provisioning, absence of geriatric health training in routine medical curriculum (Brinda et al., 2015; Yasobant et al., 2021), and the lack of a formal training course for older adult care at healthcare institutions showcase the apathy of the current healthcare milieu in failing to anticipate and reciprocate the needs of a rapidly aging population (Mathur, 2021; Mane Abhay, 2016). Across the world, healthcare systems initially focused on the provision of hospital-based geriatric care to older adults and there was limited enablement in caring for and keeping older adults in their homes (Tao & McRoy, 2015; Roy & Ayalon, 2020; Ugargol et al., 2016); however, this has changed in recent years (Biswas et al., 2020). It is quite natural that the needs of older adults arise at places where they live, work, and spend most of the time, and apart from medical care, they also require care and support for routine activities, social support, social security, community engagement, and cultural activities (Szanton et al., 2016; Luo et al., 2019). In this evolving context, we are witnessing an imperative and need-based shift from hospital-based care to home-based older adult care in countries with a growing proportion of older adults (Tao & McRoy, 2015; Brinda et al., 2015; Biswas et al., 2020; Westwood, 2020).

Situated within cultural norms that extol filial responsibility (Bongaarts & Zimmer, 2002; Lamb, 2009, 2013; Ugargol & Bailey, 2018; Ugargol & Bailey, 2021) with policy directives and legal provisions in India that intend to protect and maintain older adults through a notion of "aging in place" (NPOP, 1999; MWPSCA, 2007; NPSC, Giri et al., 2011), this chapter serves to describe the evolving nature of care frameworks and availability of care for older adults in the Indian context. This annotated review highlights older adults' need for care, the changing nature of care availability, and the changing household dynamics and complexities that define caregiving motives and direct the effectuation of care provision for older adults and discusses how home-based older adult care is emerging as an alternative to overcome the care gap. Home-based older adult care in India, though a relatively new emergence, is being rapidly accepted and is in increasing demand given the

need for supporting older adults and the infirm who face care gaps on account of living in nuclear households, lowered fertility leading to fewer children, and the aspirational mobility of adult children (Biswas et al., 2020; Singh et al., 2020). The demand is reflected through the increasing visibility of this home-care workforce that sprung up in realization of this need and the quiet increase in training programs for this new career pathway (Government of Goa, 2021). Though there is lack of credible information on the numbers of home health caregivers (mainly nurses) in India, the home healthcare market in India is expected to double year on year (Westwood, 2020). While interviewing 397 home health nurses in India, Singh et al. (2020) found that only 10.8% of them had reported having been specifically trained to deliver professional home healthcare nursing services, which is a cause for concern. Currently, home-based older adult care is in its nascency in India and is largely unregulated, and there is an impending need to regulate this home-based services sector and ensure safety and protection for the workforce as well as the patients they serve. We turn our focus on Goa, an emigration pocket in India, where older adults are typically left behind (Rajan et al., 2020; Ugargol, 2020; Ugargol et al., 2022), and discuss the contextual familial and societal environment that is creating a demand for home-based older adult care initiatives for emigration households and the implications for healthcare, the family, the older adult, the nursing workforce, and public policy thereof.

2 Aging in Place

The gradual waning of the joint family system, more so in urban India, is causing a perceptible strain on the availability of traditional forms of caregiving (Lamb, 2018; Singh, 2014). The evolutionary milieu of demographic transition, modernization, urbanization, globalization, rise of the nuclear family typical of modern-day society (Caldwell, 2006; Ugargol et al., 2016), and the consequent migration of younger family members for educational and/or economic opportunities mean that more older adults are commonly "left behind" when adult children emigrate (Rajan & Kumar, 2003; Ugargol & Bailey, 2018; Ugargol & Bailey, 2021). Studies have for long espoused that older adults in India prefer to age at home than at healthcare facilities, in institutional care facilities, or in old age homes (Jamuna, 2003; Brijnath, 2012; Ugargol & Bailey, 2018, 2021), and this probably reflects Indian cultural notions of collectivism and in finding greater values in relationships and their continuance. Care for older adults is hence considered as a part of normative family functioning wherein children are obliged to reciprocally return the care received during their childhood from parents back to them reciprocatively as they age (Ugargol & Bailey, 2021). Caregiving tasks are hence collectively shared among members of the traditional intergenerational household along with domestic helps, and it is commonly seen that the female member of the household (Liebig, 2003), more so the daughter in law, assumes the active caregiving role (Ugargol & Bailey, 2018; Ugargol & Bailey, 2021), while the male members support with noninstrumental care (Bongaarts & Zimmer, 2002; Gupta et al., 2009; Ugargol & Bailey, 2021). With

rapid industrialization and urbanization and the increased labor force participation of women in economically productive activities (Datta, 2017; Jamuna, 2003; and Klasen, 2019; Rajan et al., 2003), their absence from home is possibly reducing their active involvement and time available for caregiving to older adults. This along with the increased migration of the adult children for job opportunities and the corresponding increase in the number of nuclear families is necessitating a shift from traditional familial caregiving to institutional care or orchestrated home-based older adult care solutions (Esteve & Liu, 2018; Biswas et al., 2020; Ugargol et al., 2016).

Prevalent cultural norms find legitimacy and reinforced relevance through the legal framework for older adults in India and the ensuing discourse manages to place the primary responsibility of older adult care on family members, especially children with the objective being to encourage "aging in place." Current policy frameworks in India – the National Policy on Older Persons (NPOP, 1999), Maintenance and Welfare of Parents and Senior Citizens (MWPSC) Act (2007), and the National Policy for Senior Citizens (GOI, 2007, 2011) – reiterate and emphasize the responsibility of the family towards older adult care. Interestingly, these policies also in general call for an inclusive, barrier-free, and age-friendly society with supportive provisioning from the public as well as the private sector (Biswas et al., 2020; Ugargol & Bailey, 2021). While fulfillment of this expected norm or responsibility can earn considerable respect and appreciation for familial caregivers, the failure to do so can also attract penal provisions for adult children (MWPSC Act, 2007; Brijnath, 2012; Ugargol & Bailey, 2021). The direct connotation of such a policy is that if "aging in place" is *desired* and *to be effectuated*, then there must be that "someone" available at home to provide care and support to the older adult left behind. For Goa and many other states of India that witness continued migration of adult children, both internal and external, with older adults frequently left behind, the nuclearization of households and disruption in filial care provision due to the absence of family members or fewer members available to care (Ugargol & Bailey, 2018, 2021) and the emergence of adaptive intergenerational care arrangements (Croll, 2006; Ugargol et al., 2022) that include engagement of formal home-based older adult care seem an obvious progression.

3 The Reluctance to Institutional Care

Caregiving for older adults in India has been traditionally viewed, organized, and effected under the values of the joint family system (Lamb, 2009; Brijnath, 2012; Breton, 2019; Kaushik, 2020) where older adults majorly tend to live with a married son; however, as specifically noted by Bongaarts and Zimmer (2002), they are most likely to receive care, when needed, from a daughter-in-law (Ugargol & Bailey, 2018; Ugargol & Bailey, 2021). However, while the joint family system gives way to the nuclear family and smaller units of living, there is considerable strain being felt on provisioning for older adult care (Lamb, 2018; Roy & Ayalon, 2020). Demographically, the increased mobility of adult children, fewer siblings, and increased longevity of parents are influencing intergenerational care arrangements (Ugargol &

Bailey, 2021) in the Indian household (Croll, 2006; Dhillon et al., 2016; Ugargol et al., 2016). As a result of these societal changes, home-based formal care services for older adults are beginning to receive considerable attention (Mayer, 2017; Biswas et al., 2020). Though nonpaid familial care continues to be a major source of care for older people, institutionalized care, such as through care homes, caters to another smaller segment (Lamb, 2009; Menezes, 2020; Pazhoothundathil & Bailey, 2021). While care homes have mushroomed in India since the 1990s (Shankardass, 2002; Jamuna, 2003), their relevance and acceptance have been largely low on account of the stigma associated with *admitting* an older adult into a care home (Lamb, 2009; Menezes, 2020). As an alternative to traditional informal familial care, institutions providing geriatric care, such as old age homes, have become an alternative source of care to promote older adult wellbeing. However, the implication of older adults' change in place of residence (Datta, 2017; Lamb, 2009) – from (family) homes to institutional care homes and being referred to now as *inmates* – carries a connotation that institutional care homes reflect an absence of filial piety and symbolize the abrogation of familial responsibility and are hence stigmatized as sites where one abandons family members (Brijnath, 2012; Lamb, 2013; Medora, 2007). This hence reflects a breakdown in traditional values and violates the notion of "aging in place" for older adults that is widely prevalent culturally and further accentuated in policy. Since traditional expectations of caring for older parents are a social norm, institutional care facilities such as care homes are termed as places of abandonment and desertion (Lamb, 2009, 2010; Pazhoothundathil & Bailey, 2021) of older adults and are hence largely viewed as inappropriate in context (Biswas et al., 2020; Ugargol & Bailey, 2021). Cultural expectations on familial caregivers and filial norms are likely to make families reluctant to consider paid older adult care, either institutional or home-based, even though these could be a more practical and appealing solution for older adult care. However, we do see that changes in thought and action are increasingly becoming visible (Biswas et al., 2020; Lamb, 2018; Jayalakshmi et al., 2016). Older adults and their family caregivers are however quite ambivalent about home-based older adult care (Roy & Ayalon, 2020; Biswas et al., 2020). Since older adults experience a lack of autonomy due to their financial and emotional dependence on their families, they are in general content with compromising to the needs of the family than have specific demands for their care (Ugargol et al., 2016; Gangopadhyay & Samanta, 2017).

As a solution and as a definition, home-based older adult care is one that provides care to older adults in the comfort of their homes (Tao & McRoy, 2015; Biswas et al., 2020) while also allowing family members to dedicate their time to other essential activities, thereby potentially avoiding to some extent or mitigating the burdensome effects of direct caregiving roles (Gupta et al., 2012; Ugargol & Bailey, 2018). There are many such evolving interventions of this kind across the globe, a notable one being the Community Aging in Place, Advancing Better Living for Elders (CAPABLE) in the USA which was found to be effective in reducing disability among older adults belonging to the lower socioeconomic groups (Szanton et al., 2016; Tao & McRoy, 2015). Home-based older adult care can include a range of offerings – from standalone home healthcare aides or nurses to home health visits by professional

medical teams. From recent research explorations in India, certain challenges related to home-based older adult care have been identified including inadequate training of personnel appointed for caregiving (Singh et al., 2020), lack of understanding of the caregiver's role by family members, and hesitancy in accepting care from a person belonging to a different religion and caste or from one who speaks a different language (Biswas et al., 2020) indicative of certain inherent preferences and biases which may retard the uptake of this alternative. The acceptance for long-term older adult care provision through community-led initiatives has been nevertheless quite heartening and implies that well-trained teams can provide better care and support to frail older adults (Dias et al., 2008; Philip et al., 2018). Home-based older adult care could also turn out to be far-fetched for families who face financial difficulties to hire a caregiver as an out-of-pocket expenditure (Mohanty et al., 2014), especially since this sort of expenditure is not covered under traditional health insurance schemes (Biswas et al., 2020).

4 The Context of Aging in Goa

Goa is India's smallest state with an area of 3702 sq.km and measures 105 km from north to south and 62 km from east to west. However, Goa reports better health and development indices in comparison to other Indian states (Patel & Prince, 2001; Mukherjee et al., 2014; Institute of Applied Manpower Research, 2011). Once a Portuguese enclave from the early sixteenth to the mid-twentieth century, Goa has witnessed sporadic migration – both voluntary and forced for centuries. The people of Goa, or *Goans*, have been migrating before, during, and after the colonial period. Da Silva Gracias (2000) historically documents three distinct phases of migration from Goa: an initial wave of migration to neighboring kingdoms; second, migration mainly to British India and Africa; and most recently, the postcolonial migration to the Gulf region. The mean size of Goan households was 4.52 (GOI, 2011; Nayak & Behera, 2014) with parents largely living with their sons, son's wife, and grandchildren. While migration and seafaring have been a traditional and historically documented occurrence in Goa, migration is majorly male-dominated wherein women, older parents, and children are notably left behind (Tumbe, 2012; Government of India, Rajan et al., 2008; Sampson, 2005; Ugargol et al., 2022). From studying emigrant households of Goa, the Goa Migration Study (Rajan et al., 2008) reported that around 31% of older adults lived exclusively with their spouses, while around 46% of them lived with either married sons or married daughters (Government of India, Rajan et al., 2008). In terms of migration by religion, emigration is higher among the Christian population of Goa although they make up only a fourth of the state's population (Frenz, 2008; Government of India, Rajan et al., 2008). South Goa reported a higher emigration rate of 22.8 emigrants per 100 households compared to 10.7 emigrants for North Goa, while Salcete taluka from South Goa is conspicuous with the highest emigration index of 40.4 emigrants per 100 households (Government of India, Rajan et al., 2008).

In terms of the economic dependence of older adults in Goa, we see that 18% of them were "not dependent on others," 14.1% were "partially dependent on others," and 67.9% of them were "fully dependent on others" (MoSPI, 2014). The proportion of older adults from Goa who reported "as ailing," i.e., ailing on account of "any morbidity within a 15-day period," were 38.7% for men, 28.3% for women, and in total 33.7% (MoSPI, 2018). With respect to disabilities, 56% of older adults in Goa reported having "any kind of disability" and as high as 88% of them reported to be currently "not working" and having "any kind of disability." With respect to living arrangements of older adults, 1.4% of them lived alone, 14.3% of them lived with their "spouse only," and 84.3% of them lived with children and others (MoSPI, 2014). These figures crucially demonstrate the socioeconomic status as well as the extent of morbidity and disability encountered by older adults in Goa and highlight the relevance these may have to care needs, financial ability to access care, and the need for social support. The changing demographic landscape in Goa along with the continued emigration of adult children necessitates the emergence of adaptive modifications to traditional intergenerational care arrangements for older adults. These findings also point to the evolving need for short-term respite care as well as long-term older adult care for emigrant families which could either be provisioned "in place," i.e., homes, institutional care facilities, or at health facilities (Biswas et al., 2020; Ugargol et al., 2022; Brijnath, 2012). It is therefore of academic interest to explore the influence of emigration on adaptive intergenerational care arrangements that seemingly arise to sustain reciprocal support exchanges between older parents and adult children (Ugargol et al., 2022; Ugargol, 2020). Goa, being an advanced state in India, offers a compelling demographic setting for examining the evolving need for older adult care within an emigration context to explore the adaptive nature of intergenerational care arrangements in transition (Ugargol et al., 2022).

5 Emigration, Remittances, and Older Adult Care in Goa

Though migration of adult children is one of the oft-considered means to cope with and overcome poverty and ensure a decent standard of living for households in the developing world (Stark & Lucas, 1988; Clemens, 2011) and the inward remittances from emigrants are expected to provide financial investment to accommodate healthcare and support for older parents left behind, the most visible and stark realization is the pain from physical absence of the adult child in itself (Böhme et al., 2015; Dobrina et al., 2016). Among Indian families, Miltiades (2002) has succinctly remarked that migration of adult children changes household dynamics and leaves families, mainly older adults, in complete disarray. Migration of adult children, both internal and external, tends to create smaller left-behind family units where often it is the older parents who are left behind (Miltiades, 2002; Varghese & Patel, 2004; Patel & Prince, 2001; Ugargol & Bailey, 2021) along with spouses and other children (Ugargol & Bailey, 2018). Quite similar to Kerala in India, Goa receives sizeable inward remittances that were estimated to account for around

6.3% of the State Domestic Product in 2009 (Rajan & Zachariah, 2012). Interestingly, around 82% of Goan recipients had utilized the remittances for daily subsistence, only a third of the recipients had utilized it for education, and some amount was utilized towards managing debts (Pande, 2018; Ballard, 2004; Rajan & Zachariah, 2012).

On the other hand, there is evidence that the system of family care and support for older adults with mental health issues is not always guaranteed and there have been several instances where care and support for older parents have been conditional upon the adult child inheriting the parent's property (Patel & Prince, 2001; Patel, 2010). While care for those with special dependency needs was most commonly family-based with the absence of formal services that cater to this requirement, the emergence of formalized services – both institutional in nature (Pazhoothundathil & Bailey, 2021) and home-based (Biswas et al., 2020; Menezes, 2020; Westwood, 2020) – is becoming increasingly visible. However, from an access standpoint, for older adults with specific specialized needs, formal care is often not the most sought and not the most easily available and often comes at a price that is beyond their reach (Agarwal et al., 2020; Brijnath, 2012; Patel et al., 2008). From explorations in Goa, older adults have expressed fears regarding what the future holds for them through anxiety and hesitancy to becoming dependent on others (Prince et al., 2008; Cohen et al., 2018). Even recently, less than 3% of Goan older adults were living in care homes (Rajan, 2011; Liebig, 2003) and although the network of care homes in Goa had grown from 5 homes in 1961 to around 52 homes in 2010 (Menezes, 2014; Menezes, 2020), care homes remained the least preferred locations for older adults, whereas community-led home-based care alternatives were generally espoused (Cohen et al., 2018; Dias et al., 2019; Ugargol et al., 2021). Menezes (2014) also reports that Goan older adults who had opted for care homes were able-bodied (mentally and physically) and had chosen to live in care homes owing to the lack of alternatives for care at home. Cultural values, lack of acceptance of institutional care, and traditional norms of filial piety thus imply that older adults and their caregivers still prefer older adult care provision within their homes.

6 The Need for and the Nature of Home-Based Older Adult Care Services

Though family and nonfamily caregiving has attracted due attention by scholars and policy makers in developed countries, the need, availability, nature, extent, impact, and hybridization of family and nonfamily caregiving in developing countries remain largely underexplored (Chan, 2010; Roy & Ayalon, 2020; Ugargol et al., 2022). Academic interest to explore the evolving need for home-based older adult care services, caregiver-older adult relationships, expectations, and relevance of older adult care in developing countries where the population is aging within thick sociocultural contexts (Roy & Ayalon, 2020; Ugargol, 2020; Ugargol et al., 2016) is emerging (Biswas et al., 2020; Ugargol et al., 2022). While older adults' confinement to the home is consistently seen across both rural and urban areas in India

(Aliyar & Rajan, 2008), a key physical barrier to accessing facility-based or institutional care could be that many older adults may be requiring home-based care, a need arising from ill health-related home confinement at advanced ages.

It is postulated that when an adult child migrates or leaves home for various reasons and when no other children or family members are available to provide care and when the care needs and chronic conditions encountered by older adults are such that they cannot independently care for themselves – that is when formal paid caregivers are considered for supporting older adults at their homes. Home-based caregivers are usually categorized as nonprofessional and professional caregivers; however, the primary motive for involvement of either one is to provide care and support to older adults to remain healthy, manage their health conditions, and if required receive palliative care while living in the comfort of their own homes or within their communities (Tao & McRoy, 2015; Szanton et al., 2016). Non-professional caregivers include unpaid family caregivers and informal caregivers and could range from the spouse, son or daughter, relatives, and/or friends. Professional paid caregivers on the other hand are typically trained home-care aides either hired by the family on an individual level, through an institution or through a governmental agency (Biswas et al., 2020; Tao & McRoy, 2015).

Ingle and Nath (2008) had explored the relevance of an entirely distinct team of health providers termed "community geriatric health workers" who provided care to older adults through a community-based project in Cochin known as the "urban community dementia services." These health workers had provided home-based care as well as supervision and care through day care centers (Shaji & Jacob Roy, 1999). McDermott et al. (2008) had also explored the availability of hospice and palliative care services for end-of-life care across India and documented that there were fewer than required facilities for this growing need. In Goa, for example, they documented only one palliative care facility at that time that led to a rather low ratio of service availability to a population of 1:1357. However, this area has seen some growth and multiple community led home-care initiatives have been experimented for people with dementia including the provision of support to the caregiver (Chatterjee et al., 2008; Patel et al., 2008; Pereira et al., 2011). Home healthcare is a relatively recent addition to the existing array of health services in India, and as Singh and Chaudhari (2020) demonstrate, as high as 96% of the home health nurses were having less than 5 years of work experience in the home health nursing profession (Singh, 2017). Moreover, due to stigma and low social acceptability of the profession, attrition levels among home health nurses were considerably higher than formal institutional care nurses and this seems to commensurate with experiences from other settings (Singh & Chaudhari, 2020; Olang'o et al., 2010).

Home-based care nurses can thus be instrumental in providing continuous assessment and care over a long term that is possible on account of the rapport buildup and offering the convenience of continuity for the care receiver and the immediate family members. The COVID-19 pandemic brought about increased restrictions on the mobility of older adults, overburdened hospitals, and indirectly positioned home-based older adult care as an alternative that avoids the

considerable risk that older adults faced in visiting hospitals (Westwood, 2020). Home healthcare can be reassuring, provides the comfort of being "in place," and has the potential to offer caregiver respite and alleviate caregiver stress among primary family caregivers as well (Westwood, 2020; Ugargol & Bailey, 2018). The home-based older adult care model also appears unique in proposition and affords a good business value since the provision of home-based care services to older adults living alone or to older adult couples living independently is associated with a strong social value (Chatterjee, 2016). These home-based older adult care offerings are expected to be characterized by low physical investment and high volumes, allowing entrepreneurs in this space to attract trained home-care nurses and provide them employment through channelized professional consulting services that liaise with family members of older adults. Therefore, the home-based provision of older adult care through home-based care nurses is emerging as a possible alternative across geographical contexts (Yao et al., 2017), and older adults will no doubt stand to benefit to a great extent, provided this residential provision of medical care is regulated, price controlled, and expanded in scope and scale for aging societies such as India (Nanda & Anilkumar, 2021).

7 Intergenerational Care Arrangements in Goan Emigrant Families

Through an inductive qualitative exploration of 22 caregiver-older adult dyads from Goa, Ugargol et al. (2022) reported that family caregiving motives were primarily driven by feelings of spousal and filial duty as well as filial reciprocity entwined with gendered roles and expectations. In similar emigration contexts from South India, the absence of an emigrant son had changed family dynamics and made the left-behind daughter-in-law assume the mantle of temporary "head of household," albeit reluctantly, and sometimes having had to give up her job to juggle familial responsibilities (Ugargol & Bailey, 2021; Ugargol, 2018). Societal and familial expectations to take on older adult care responsibilities have the potential to create acute dissatisfaction among caregivers. Young left-behind daughters-in-law may be resentful at having had to sacrifice their careers and endure long-term separation from their husbands to provide care to their older parents-in-law (Ugargol & Bailey, 2018, 2021). Though the intergenerational filial contract is relevant even today, there seems to be a reinterpretation and renegotiation of the intergenerational living arrangement (Brijnath, 2012; Croll, 2006). Apart from being reflected through co-residence alone, the contract is now increasingly depicted through other newer forms of adaptive living and care arrangements (Ugargol et al., 2022) that include the engagement of formal home-based geriatric care services.

While considering co-residence of adult children with their older parents as a type of intergenerational care arrangement (Ugargol, 2020; Ugargol et al., 2022), we find that there are two ways in which this is established. We see that either the younger generation continues to reside with older parents even after getting married or alternatively the younger generation establishes a new household at the time of

marriage, birth of children, or when there is a household division into which widowed parents are later incorporated. The second possibility is that even when adult children do not co-reside with their parents, they try to remain in close proximity so that there is in essence no real breakdown in intergenerational reciprocal resource flows. Thirdly, even when generations decide to live in separate households that are geographically dispersed due to occupational mobility or migration, both households rely on greater ease of communication, such as the use of technology and transport, to facilitate intergenerational reciprocal resource flows across the distance through what are known as "embedded" or "enmeshed" households (Croll, 2006; Whyte, 2003: Ugargol et al., 2022).

These modes of enacting the intergenerational care arrangement are context-specific and embody the filial obligation augmented by evolving contexts of emigration and aging and are reflective of how filial expressions are adapted to sustain supportive resource flows between adult children and their aging parents (Ugargol et al., 2022). Given the plethora of permutations and combinations that intergenerational care arrangements can evolve into comes the argument that when caregiving is perceived as a burden or there is none available or motivated to provide instrumental care to older parents (Ugargol, 2018), when aging in institutional care or "old age homes" is not socially acceptable (Brijnath, 2012; Ugargol et al., 2016), when the care needs of the older adult necessitate constant care and supervision (Ugargol & Bailey, 2021; Ugargol, 2020), and when providing respite to caregivers is a requirement within the family, we find the availability of home-based formal older adult care provision a much-needed alternative. In the cultural context, this also seems to satisfy the notion of "aging in place" and has the potential to provide some respite to the primary caregiver (Ugargol & Bailey, 2018) and broadly seeks to reduce disability and unnecessary hospitalizations for older adults (Szanton et al., 2016; Tao & McRoy, 2015).

8 Are Home-Based Formal Older Adult Care Services a Possible Solution?

From emigration contexts in India comes forth the resilient mutual intent of older adults and adult children for reciprocal family relationships and their efforts to sustain them for supportive resource exchange flows (Ugargol et al., 2022). The resilience of the family and filial obligations are expected to guarantee intergenerational support for older parents through in-person, remotely monitored, or chaperoned home-based older adult care solutions. The notion for preference of home-based older adult care – be it informal, familial, or formal – finds resonance in literature on intergenerational care and transfers in Asian and Southeast Asian societies where reciprocity within families is strongly normative and wherein older adults expect to co-reside with at least one of their children, hold strong expectations of filial support, and largely depend on them for financial and routine assistance (Gupta et al., 2009; Knodel et al., 1992; Lamb, 2013; Ugargol & Bailey, 2021). Often the first step towards reciprocating care through any mode, for an

adult child, is to recognize the care needs of the older parent, beyond which the intention to reciprocate and act out their filial duties becomes clearer (Cicirelli, 2000; Miller, 2003; Ugargol et al., 2022). A gendered rationale exists among older adults to engaging paid home-care nurses or home-care aides for which Gangopadhyay (2021) recounts that elite older women from households in Delhi preferred and were probably more comfortable to receive paid home-based formal care as they were reluctant to be nursed by their husbands, whereas on the other hand it was relatively easier to comprehend that active care to older men would be largely provided by their wives so long as they are available and able to do so. However, these ideations could easily be affected if there was a loss of spouse or if both spouses were infirm and in need of supportive care. Hence, the process from informal caregiving to the initiation of home-based formal older adult care is of an evolving nature and is deeply embedded within the gendered roles and expectations that India's cultural schema for familial care provides. Another recent trend that is increasingly visible among transnational families from Goa has been the use of technology in supporting left-behind older adults with remote care which is often effectuated in tandem with the physical presence of a familial or formal caregiver with the older adult and becomes a vital link between older adults and their emigrant adult children (Ugargol et al., 2022; Ugargol, 2020). Though emigration is known to violate or disrupt the traditional reciprocal obligation and expectation to provide care for older adults, remote caregiving ensures it is still possible either with the help of other available family members or through chaperoned care effectuated through a paid home health nurse or aide in combination with the use of Internet technology. With the advantage of being able to see each other on screen, older adults often assisted by a family aide or paid caregiver feel "cared for" and can experience family connectedness while their immediate and routine needs are being met in person. This probably helps sustain the filial connect between the adult child and his/her parents, allows both to communicate, and permits the adult child to execute to some extent the social and filial obligation of caregiving (Ugargol & Bailey, 2021), while for the older adult it provides a semblance of being "cared for" and being able to "age in place" (Ugargol et al., 2022; Ng & Indran, 2021; Roy & Ayalon, 2020).

It is still however early days for home-based formal older adult care in India (Biswas et al., 2020; Westwood, 2020), and this is reflected by the scant to no mention of paid caregiving or home-based formal care services in any of the large older adult surveys in India (BKPAI, 2011; LASI, 2018). With the evolving need and emergence of home-based geriatric care services for older adults in emigration contexts, we see the concomitant rise in the number of training courses for home nursing in Goa that aim to train home-care nurses for older adult care as well as palliative care. A few notable frontrunners in offering such home nurse training courses include the St. Bridget Institute of Home Nursing, Aldona; the Don Bosco Vocational Training Institute, Dabolim; Indian Red Cross Society, Panjim; the Institute of Nursing Education, Bambolim; etc. (Government of Goa, 2021). While these courses are currently in steady demand, the government has also stepped in to regulate the admission criteria for candidates aspiring for these vocational training

institutes and those having completed their tenth grade are currently eligible (Govt of Goa, 2021). The Government of Goa is also providing scholarships for tribal students of the state who pursue such training in home nursing (Govt of Goa, 2021). From qualitative explorations among emigrant households in Goa, it was found that emigrating adult children would seek home-based formal older adult care options to supplement or complement the care offered by primary family caregivers, other siblings, or relatives; and when there are no family members available to provide care, they would then opt for formal paid home-based older adult care services (Ugargol, 2020; Ugargol et al., 2022). While the demographic transition continues to increase the proportion of older adults in India and emigration continues to affect the availability of adult children for older parent care, the need and market for home nurses, skilled home-care staff, and at-home health screening and monitoring aides are expected to grow exponentially. Institutions involved in training of home-based care workers will likely see a rise in interest and admissions as these trainings hold direct employment opportunities. Currently, home-based care workers are hired by families based on preferences of language spoken, age and gender of the care worker, and expected care requirements, and unfortunately, criteria such as religion and caste of the caregiver also figure in the decisions (Biswas et al., 2020). To cater to the growing need, institutes that offer home nurse training and the number of agencies/organizations that recruit trained nurses are increasingly marketing their home nursing training and services through advertising in print, visual media, and social media. As traditional informality in caregiving to older adults seemingly moves towards formalized care offerings, at least in emigrant contexts for now, there is an imminent need for the government to regulate and develop policy frameworks for such home-based care offerings. These could ensure standardization of training curriculum, duration and quality of training, expected skillsets, and supportive labor laws and can also aid in preventing abuse or harassment of both the older adult and the home nurse caregiver – a workforce that is largely feminized and possibly vulnerable in a home setting (Pyle, 2006; Lamech et al., 2019; Wichterich, 2020).

Explorations among family caregivers to older adults in India have described filial norms of reciprocity, the pervasive influence of culturally ascribed caregiving norms, and perceptions of caregiver stress and burden that necessitate provisioning supportive measures to alleviate caregiver stress and support family caregivers in their roles (Shubham & Joshi, 2021; Ugargol & Bailey, 2018, 2021; Ugargol et al., 2022). Though there is a perceptible decrease in the availability of adult family caregivers due to emigration or internal migration for education and employment, a continued fall in fertility rates, and increasing life expectancies (Roy & Ayalon, 2020), there is still, however, scant scaling up of long-term geriatric care solutions in India (Roy & Ayalon, 2020). Modernization and nuclearization of families are also leading to significant gaps and challenges for family-based older adult care in India. While the nation remains largely underprepared to meet the challenges of its aging population, steps towards older adult care provisioning, raising social security, and providing healthcare and income security for its senior citizens are found wanting (Rajan & Balagopal, 2017; Roy & Ayalon, 2020). The policy framework is currently

quite content to place the responsibility of older adult care on "families" through the culturally drawn notion of "aging in place," and while existing legislations provide legal protection for older adults in cases of abuse or neglect by children, heirs, or relatives; however, the utilization of these remedies is not as seamless as it seems (Rajan & Balagopal, 2017; Brijnath, 2012). There is also a pressing need to accommodate, prioritize, and deliver policy directives that provide social security and guarantee safety nets for older adults in poverty-stricken households, for older adults precariously employed in the informal sector, for older adults subjected to ageist discrimination, and for older adults living alone (especially rural women). This calls for considering the changing trends in living arrangements, understanding the complexity of adult child migration (both internal and external), and the increasing proportion of transnational families with left-behind older adults exposed to the precarity of remittance-based family economies. While home-based older adult care may appear as an alternative relevant for emigration contexts, the feasibility of families utilizing this offering will largely depend on the costs of hiring paid home-based care and the favor it can command from older adults themselves (Prince et al., 2008; Westwood, 2020) as older adults co-create their left-behind environment.

9 Conclusions and Implications for Policy and Practice

In summary, we see that in lower- and middle-income countries such as India, the care needs of older adults are largely expected, both culturally and policy-wise, to be managed by family members given the lack of dedicated state-supported older adult social welfare services (Brinda et al., 2015; Ugargol et al., 2016; Brijnath, 2012). In instances where, on account of emigration or otherwise, there is an inability to commit to the intergenerational contract through co-residence or even when co-residence in dual career homes leads to an inability to instrumentally provide older adult care, the intent towards engaging a home health nurse or aide is seen. While it remains the intention of the emigrant adult child to sustain reciprocal supportive care exchanges in spite of his/her own absence from the household, these motives are most likely to be effectuated through intergenerational care arrangements such as through engaging a paid home-based caregiver for the older adult – an arrangement that is seemingly more acceptable and reflects a more socially acceptable means of effectuating filial piety to say admitting older parents into institutional care facilities (Burholt et al., 2020; Rajan & Balagopal, 2017; Ugargol et al., 2016; Shubham & Joshi, 2021). There is seemingly more *in principle* acceptability to home-based older adult care given the sociocultural schema of aging in one's own home as compared to availing institutional care in India (Ng & Indran, 2021; Brijnath, 2012). While prior experimentation with community-led and home-based older adult care from emigration contexts in India is more in relation to dementia care and palliative care (Patel & Prince, 2001; Dias et al., 2008; Philip et al., 2018; Ugargol & Bailey, 2018, 2021; Ugargol et al., 2022), it would be of academic interest to explore family empowerment

through home-based older adult care through eliciting the perceptions of older adults, family caregivers, and the home-based older adult care aides themselves (Funk et al., 2019; Turjamaa et al., 2014; Ng & Indran, 2021). Although we see that the location of care continues to change and altered social and family dynamics characterize the emigration context for older adults, the complexity of caring for older adults within a home setting has been largely underexplored (McGarry, 2003; Tao & McRoy, 2015; Szanton et al., 2016). While the location of care for older adults continues to move closer to home, it becomes important for policy makers to realize, augment, and rationalize home-based formal caregiving for older adults in India as an inevitable and necessary solution (Tao & McRoy, 2015; Roy & Ayalon, 2020; Shubham & Joshi, 2021).

We succinctly encapsulate that on account of the epidemiological and demographic transition, the growing global burden of noncommunicable disease, rising disabilities among older adults as they tend to live longer, emigration of adult children, and the unheralded consequences of adult child mobility within a context of culturally derived filial piety are necessitating a complex reorientation of older adult care provisioning and efforts need to be drawn to support older adults as well as their primary caregivers in their mutually reciprocally roles. An obvious progression that is increasing becoming relevant is the emerging need for engaging home-based formal older adult care services (Philip et al., 2018; Ugargol et al., 2016; Ugargol & Bailey, 2018) to support older adults. There now exists an opportunity to offer meaningful respite to primary caregivers, especially in dual-career households, and a possible support alternative to help alleviate feelings of stress and burden for family caregivers (Ugargol & Bailey, 2018; Dias et al., 2008) through the need-based involvement of trained home-based older adult care aides while at the same time regulating this care space and making care work safer for all stakeholders (Lamech et al., 2019; Wichterich, 2020; Shubham & Joshi, 2021). The growth of formal home care can also lead to more unpaid in-home labor, mostly by women family members (Livingstone, 2001; Biswas et al., 2020), and this line of thought finds resonance in Asian filial contexts where family care involvement is bound to increase through socioculturally situated policy changes that are more implicit than explicit and can further impact family caregivers' time constraints, employment options, and the ability to engage in other tasks (Kodate & Timonen, 2017; Ugargol & Bailey, 2018). However, it is also important to realize that formal care work in such home-care contexts is largely served by women workers who are less protected and prone to care extractivism which could often turn exploitative in nature (Wichterich, 2020). Just as we situate the older adult as being prone to abuse and neglect, there is a pressing need for ensuring adequate regulatory safeguards for both the older adult and the home-based care worker. In juxtaposing policy and practice, we abridge that while notions of filial care are being redefined by processes such as modernization and emigration, the preference for home-based care prevails and is increasingly and interestingly becoming visible through adaptive intergenerational care arrangements that are effectuated through filially orchestrated home-based older adult care provision.

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