Family Dynamics in Elderly Care: The Interplay of Living Arrangements, Spousal Presence, and Proximity to Children in Shaping Caregiving Choices

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Introduction

In India, the family has been a core institution providing care and support for their elderly members, especially during their sunset years, and this tradition has been followed down the ages. Even the religious and sociocultural milieu also dictates that it is the *dharma,* or moral duty of adult children (primarily sons), to provide care for their older parents and in-laws[1]. The mythological stories dictated that elders in ancient India were accorded high status as decision-makers both in family and society. The mythological stories of dedicated son '*Shravana'* who carried his frail elderly parents on his shoulders, and *Lord Rama's* unquestioning devotion to his father, who spent 14 years in the forest abiding by his instruction, remind us the nature of the relationship between age groups and between generations within the family that persists in our culture since long back [2, 3].

Over the years, India has been experiencing considerable change in its social structure and institutions as a result of modernization, industrialization, urbanization, changing family structure, migration of children, and the rising cost of living. One of the major significant changes over the past few years is the weakening of the family institution, which has played a significant role in the care of older adults, especially for those who, due to physical disability, are unable to care for themselves [4] and such changes can be seen in the family structure and living arrangements for both rural and urban[5]. But still, family has been the core (especially in rural areas where a majority of Indian elderly reside) providing care and support to the elderly[6-8]. The social compulsion that tradition prescribes with regard to elderly care is an obligation to filial piety and a general expectation among the elderly that their children should care for them in their old age. However, the changing structure of societies, patterns of family independence, family and kin structure, demographic, social, and economic trends have affected intergenerational relations, which have tremendous implications for future societies[9].

Living arrangements have been an important indicator in identifying the status of the elderly in a society. The changes in living arrangements have a profound implication for the care and support of the elderly, especially for a country like India, with more than 153 million elderly population, which is projected to rise to 347 million by 2050[10]. The causes and consequences of living arrangements have been a topic of debate among academicians, and there is ample evidence cited that modernization, industrialization, urbanization, changing family structure, shifting of the traditional agricultural economy, migration of children, and the rising cost of

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living are some important factors. However, changes in living arrangements do not necessarily reflect a weakening of intergenerational family bonds. Several studies found that declining co-residence has paralleled increasing elderly living independently in close proximity. This arrangement has been cited as 'networked family' or 'intimacy at distance'[11-13]. Elders residing in networked families have several benefits: they enjoy the assistance of care and support from their near ones, while on the other hand, they avoid the downside of co-residence, like the feeling of being burdened, potential intergenerational conflict, privacy, and independence.

Spousal loss is one of the most stressful experiences in old age. So, the elderly who are either widowed and residing alone or do not have any children residing nearby are the worst sufferers in terms of caregiving. Therefore, the presence of alternative caregivers in the form of extended family members is extremely crucial in a country like India, where social support is very limited. Previous studies in the Indian context highlighted the care needs, caregiving mostly from the health, functional status, and living arrangements mostly from the children's perspectives[1, 2, 14-16]. The role of spouse in informal caregiving for the elderly has always been neglected in previous studies.

Therefore, the present paper explores the family dynamics in the caregiving pattern of Indian elderly with specific to living arrangements, presence of spouse, and children's proximity based on their functional needs. In particular, we seek to answer the following research questions (1) How does the provision of elderly care vary by living arrangements? (2) How does the presence of spouse affect caregiving choices? (3) How does the proximity of children affect caregiving choices?

Materials and Methods

Data Source

The data for the current study were drawn from the first rounds of the Longitudinal Ageing Study in India (LASI) conducted during 2017-18[17]. LASI is a nationally representative survey of older adults aged 45 and above across all the states and union territories in India. The survey provides a comprehensive scientific evidence base of demographic, health, economic, social, and biomarker-based information on older adults in India. LASI adopted a multistage stratified area probability cluster sampling design with a three-stage sampling design in rural areas and a four-stage sampling design in urban areas. The goal was to select a representative sample in each stage of sample selection. Further, individual survey schedule was administered to each consenting respondent aged 45 and over and their spouses in the sampled households. In addition, the LASI included an individual module on biomarkers and direct health examination. The detailed methodology, with complete information on the survey design and data collection, was published in the survey report [17].

LASI covered a sample size of 73,396 individuals aged 45 and above. However, our study focused on elderly care, so we restricted our sample selection to those elderly with any functional limitations and who need someone to assist them in their activities of Daily Living

(ADL/IADL). The current study is conducted on the elderly aged 60 years and above. Therefore, the sample size for the present study is 14,320 elderly across all India's states and union territories. The sample selection procedure is summarized in Fig. 1.

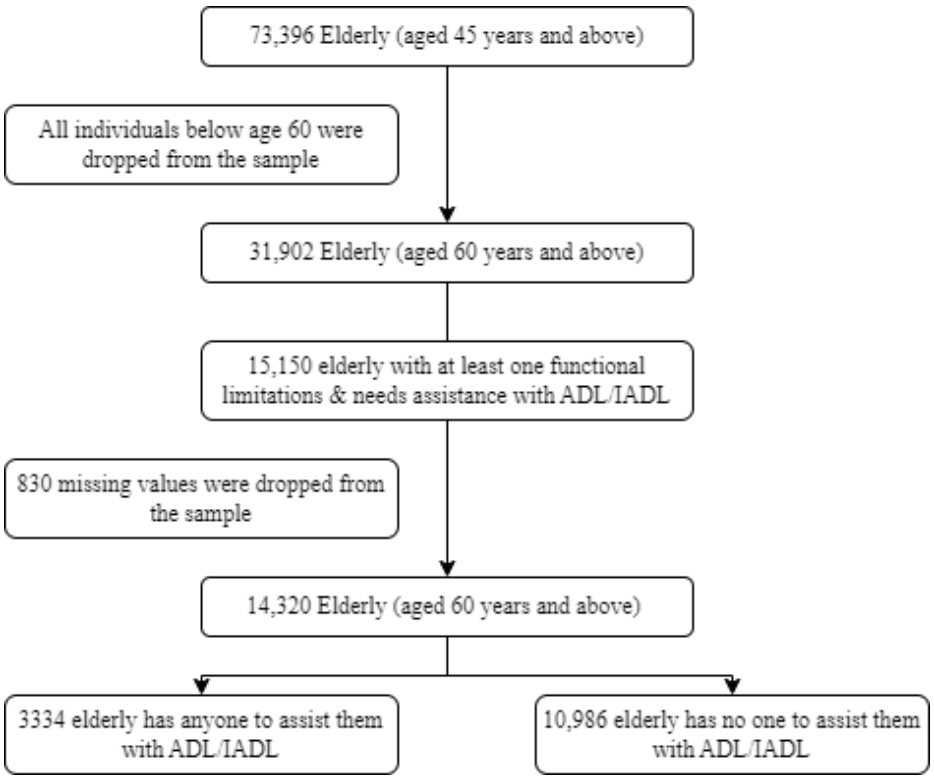


Fig. 1 Sample Selection Criteria

Methods

Outcome Variables

Based on Ulhenberg's definition, caregiving is defined as "assistance provided to persons who can't perform the basic activities or instrumental activities of daily living for themselves for whatever reasons"[18]. The caregivers are the family members who assist the elderly with activities of daily living (ADL) and instrumental activities of daily living (IADL). ADL/IADL are standard measures of functional ability and have been incorporated in most health-related household surveys[2, 19].

For our study, we considered 13-item functional limitation scales combining items from both ADL and IADL, including dressing (putting on chappals and shoes), walking across a room, bathing, eating, getting in or out of bed, using the toilet (including getting up and down), preparing a hot meal (cooking and serving), shopping for groceries, making telephone calls, taking medications, doing work around the house or garden, managing money (paying bills and keeping track of expenses), mobility (getting around or finding an address in unfamiliar places). We have categorized the primary caregivers into four categories: (i) No one, (ii) Spouse, (iii) Son/daughter (includes son-in-law and daughter-in-law), and (iv) Other family members

(father, mother, brother, sister, grandchildren, in-laws, other relatives). The detailed classification is given in Fig.2.

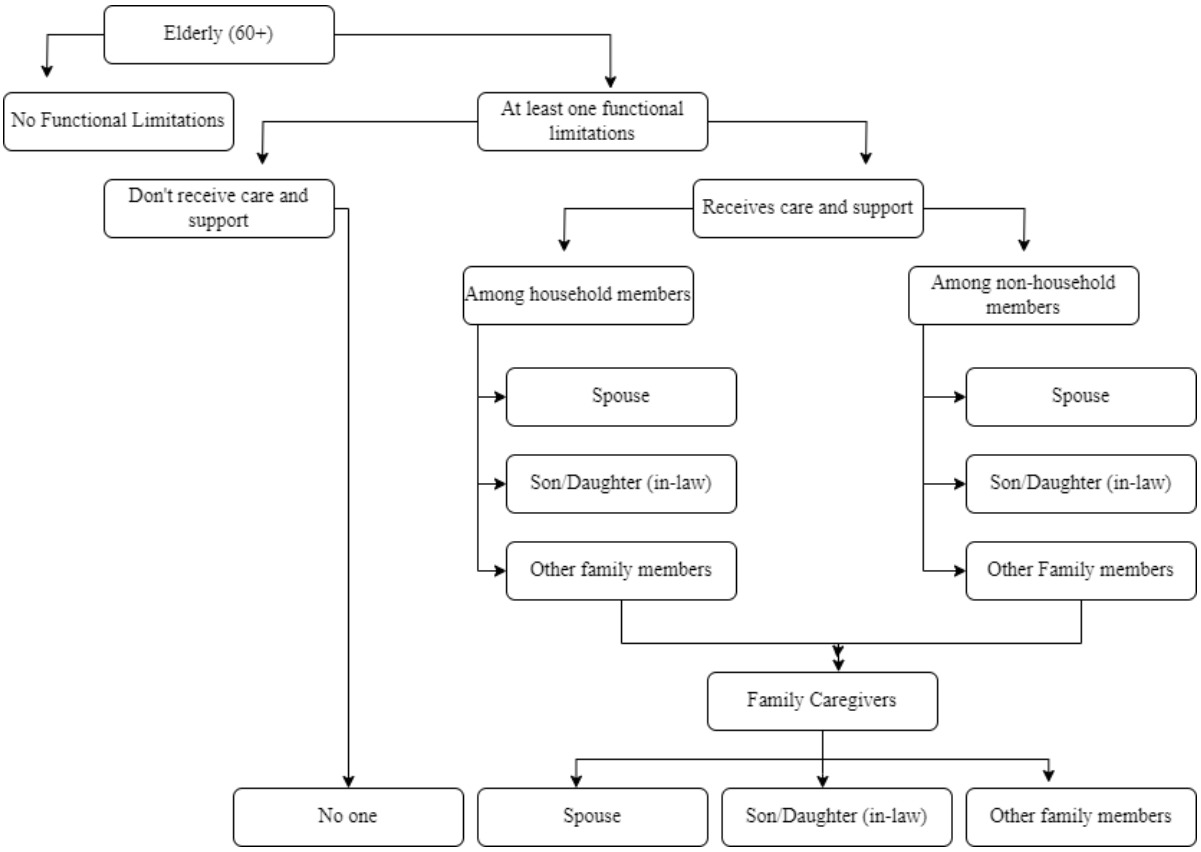


Fig.2. Primary Caregivers for the elderly

Explanatory Variables

living arrangement:

The primary variable of interest for this study is the living arrangement, and is constructed based on the information about the elderly living arrangement. Living arrangement was categorized into: 'living alone,' 'living with spouse,' 'living with spouse and children,' and 'living with children and other family members.' 'Living alone; meant the elderly living without a spouse and other kin. 'Living with spouse' meant the elderly living exclusively with spouse only. 'Living with spouse and children' meant elderly co-residing with spouse and children (if available). 'Living with children and others' meant the elderly living with children and other extended family members, including father, mother, brother, sister, grandchildren, in-laws, and other relatives in the same household.

Proximity of children:

Based on the previous literature, it was found that close proximity to children can be the functional equivalent to coresidence, while some studies see any kind of non-coresidence as a sign of weekend intergenerational ties.

In order to test this, we considered the proximity of children's residences into three categories: (i) coresident with elderly, (ii) networked (no coresident, but at least one child residing in the same village/city, and (iii) isolated (not coresident, all children living outside the village). We also include all the elderly who either don't have any children, or their children died within the third category, i.e., isolated to include all the elderly sample in our study. The detailed classification is given in Fig.3.

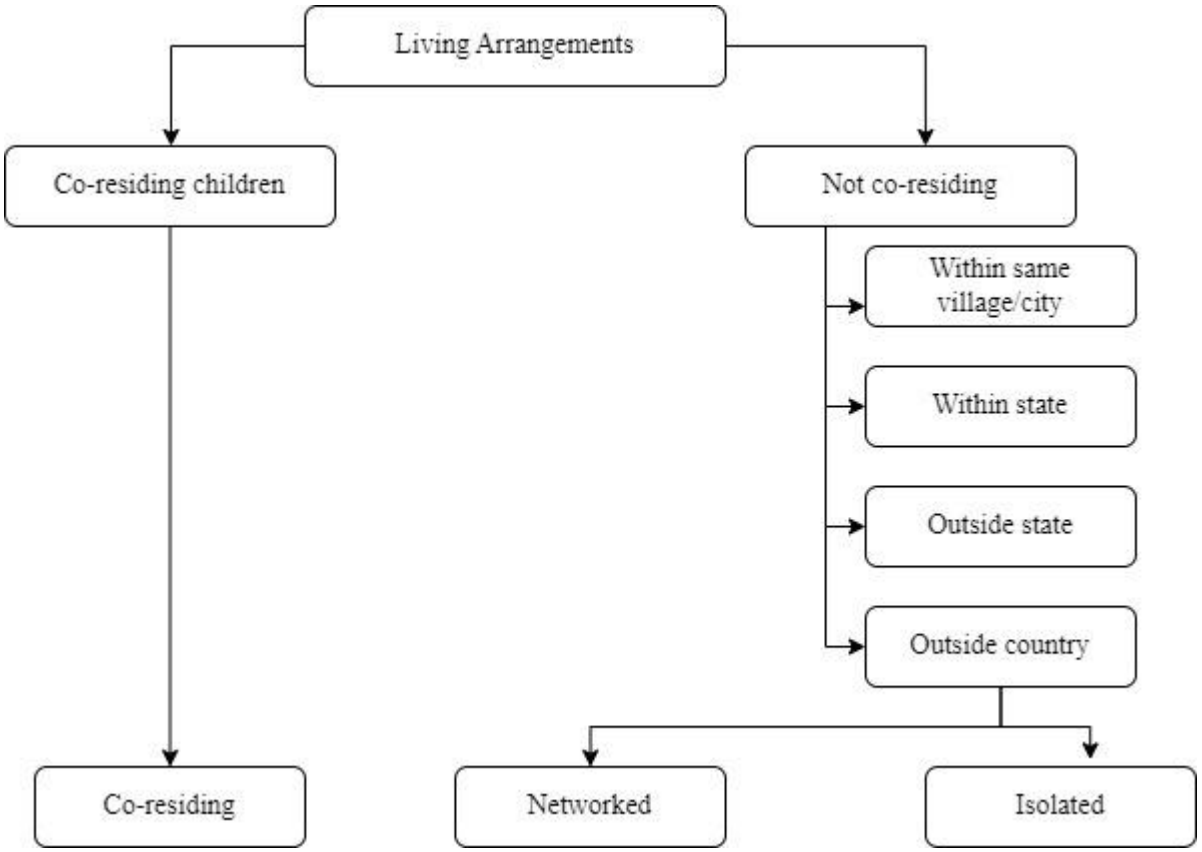


Fig. 3. Children's Proximity of Living

Health Related Factors

Perceived Health:

Self-reported health has been widely used in studies, especially among the geriatric population, to know their current health conditions. Respondents were asked to rate their current health status on a scale of very good, good, fair, poor, and very poor. Very good and good were clubbed

to make ‘good.’ ‘very poor’ and ‘poor’ were clubbed as ‘poor.’ ‘Fair’ was retained as such as ‘average.’

Functional Limitations:

Respondents were asked to self-report whether they had any difficulties with the aforementioned activities of daily living (ADL) or instrumental activities of daily living (IADL). The sum scores were coded into ‘one functional limitation,’ ‘two limitations,’ and ‘three & more limitations.’

Socio-demographic Factors:

The following socio-demographic variables were included in the analysis. Age was categorized into three groups 60–69 years, 70–79 years, and 80+years. Sex was coded as male and female. Place of residence as rural and urban. Marital status was coded as currently married and single (including widow, divorced, separated, deserted, never married, and live-in-relationships). Years of education were coded as no education, less than 5 years, 5-9 years, and 10 & more years. Working status was coded as currently working and currently not working. The monthly per-capita consumption expenditure (MPCE) was assessed using household consumption data and was coded into 5 quintiles: poorest, poorer, middle, richer, and richest. Caste was coded as Scheduled Castes (SC), Scheduled Tribes (ST), Other Backward Classes (OBC), and others.

Analytical Strategy

Descriptive statistics were used to present the weighted percentage distribution of the socio-demographic and health profiles of the elderly in India (Table 1). Logistic regression analysis was used to assess how living arrangements affect the likelihood of not having a caregiver (model-1), receiving care from spouse (model-2), and receiving care from children (model-3), controlling for the covariates. To assess how the presence of spouse affects the relationship, these analyses were done separately for married and single elderly and then calculated the average predicted probability of receiving care from family members by living arrangement. Here, single elderly refer to elderly belonging to any of these categories, including the widow, divorced, separated, deserted, never married, and in a live-in-relationships. Since LASI adopted a multistage stratified area probability cluster sampling design, sampling weights are applied to all descriptive tables and figures. Regression diagnostics, such as multicollinearity and normality tests, were run to ensure the fundamental regression assumptions were followed. STATA 17.0 has been used to perform all the statistical analysis.

Results

Table 1 presents the sociodemographic and health profile of the elderly. The present analysis was carried out using 14,320 respondents who had responded to all the variables of interest for

this study. Most of the study participants were females (61%) belonging to the young age group (60-69) and rural residents (76%). More than half of them were currently married (55%), and around two-thirds of them had no education (66%). In terms of living arrangements, nearly one in every four elderly were currently staying alone or exclusively with their spouse (25%) and are still engaged in the workforce (24%). All the categories in the MPCE quintile represented approximately equally, except for the richest quintile (16%). Considering children's characteristics, nearly four percent of the elderly had no children, while around three-fourths had three or more children (74%). In terms of the children's proximity of residence, a majority of elderly had at least one coresident child irrespective of sex (68%), followed by networked (23%) and isolated (10%). Taking into account their health status, a significant proportion of the elderly had three or more functional limitations (63%) and needed assistance in their activities of daily living (ADL/IADL), while only 22% received any form of care and assistance from their family members.

Table 1. Sociodemographic and health profile of the respondents

Sociodemographic & Health Characteristics	Frequency	Percentage
Age		
60-69	7,441	50.78
70-79	4,732	33.93
80+	2,147	15.29
Sex		
Male	5,591	39.49
Female	8,729	60.51
Place of residence		
Rural	10,089	76.2
Urban	4,231	23.8
Living arrangements		
Living alone	883	7.13
With spouse only	2,503	18.21
Spouse and children	5,336	35.98
Children & others	5,598	38.67
Current marital Status		
Currently married	7,940	54.8
Single elderly*	6,380	45.2
Years of education		
No education	9,132	65.48
Less than 5 years	1,721	12.4
5-9 years	2,163	13.57
10 and more	1,304	8.55
Work Status		
Currently Working	3,185	24.39
Currently not Working	11,135	75.61
Wealth Quintile		
Poorest	3,031	22.57
Poorer	2,981	22.38

Middle	2,908	20.28
Richer	2,825	18.9
Richest	2,575	15.88
Caste		
SC	2,496	20.26
ST	2,090	7.79
OBC	5,718	46.32
Others	4,016	25.63
Number of children		
No children**	545	3.62
1	1,101	8.32
2	2,191	13.87
3 & more	10,483	74.19
Children's proximity		
Coresident	10,041	68.16
Networked***	2,763	21.98
Isolated****	1,516	9.86
Perceived Health		
Poor	4,618	32.28
Average	6,336	45.68
Good	3,366	22.05
Functional Limitations		
One limitation	3,303	21.17
Two limitations	2,388	15.54
3 & more limitations	8,629	63.29
Primary Caregivers		
No one	10,986	77.71
Spouse caregiver	1,295	8.74
Son/Daughter (In-law)	1,332	8.51
Other family members	707	5.05
TOTAL	**14,320**	**100**

*Single elderly include widows, divorced, separated, deserted, never married, live-in-relationships
**No children refers to no alive children
*** Networks means living nearby either within the same village or city
****Isolated refers to those elderly who either don't have any children or their children are not co-residing with them.

Provision of Elderly Care by Living Arrangements

Table 2 highlights the living arrangement patterns of the elderly aged 60 and above classified by socio-demographic and health characteristics. Age plays a crucial role, with younger old (60-69) more likely to live with a spouse and children, while older individuals (80+) increasingly depend on living with children and others. This suggests that older individuals rely more on extended family or others as they age. Males predominantly live with their spouse and children (51.78%), while females are more likely to live with children or others (50.81%). The proportion of females living alone was nearly four times that of the male elderly, reflecting the feminization of ageing in later ages. A higher proportion of elderly live with 'Children &

Others' in urban areas, while rural residents show a more even distribution in living arrangement patterns. Almost all the currently married elderly live with their 'spouse' or 'spouse & others.' Higher education and wealth are linked with living independently or with a spouse, while less education and lower wealth are associated with living with children and other extended family. Elderly, those currently working tend to stay with their spouse only. Considering their health status, the elderly with poor health or multiple functional limitations, the majority of them live with 'children & others', while those with good health tend to live with their spouse and children. The chi-square ($Chi^{2)}$ test and p-values indicate a significant association between sociodemographic and health characteristics of the elderly and living arrangements. A lower p-value suggests a stronger association between sociodemographic factors and living arrangements.

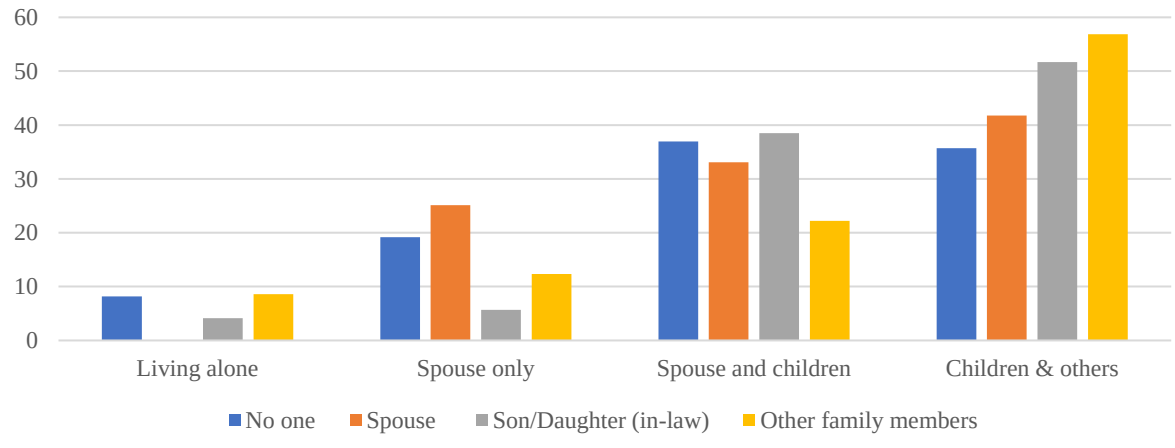
Table 2. Percent distribution of living arrangement by socio-demographic characteristics

Sociodemographic & Health Characteristics	Living Alone	Spouse Only	Spouse & Children	Children & others	Chi 2 (P-value)
Age					
60-69	6.01	20.49	45.07	28.44	0.003
70-79	8.76	18.78	28.58	43.87	(0.00)
80+	7.26	9.36	22.24	61.14	
Sex					
Male	2.85	25.29	51.78	20.08	0.002
Female	9.93	13.59	25.67	50.81	(0.00)
Place of residence					
Rural	7.66	19.68	36.22	36.44	86.08
Urban	5.45	13.5	35.23	45.82	(0.00)
Current marital Status					
Currently married	0.17	33.23	65.67	0.94	0.001
Single	15.58	0.00	0.00	84.42	(0.00)
Years of education					
No education	8.58	17.12	30.89	43.4	509.6
Less than 5 years	5.98	18.02	42.36	33.65	(0.00)
5-9 years	4.32	21.81	47.59	26.28	
10 and more	2.15	21.08	47.32	29.44	
Work Status					
Currently Working	7.71	25.02	43.99	23.28	483.8
Currently Not Working	6.95	16.01	33.40	43.64	(0.00)
Wealth Quintile					
Poorest	7.66	13.11	38.17	41.06	230.6
Poorer	4.42	13.48	39.47	42.63	(0.00)
Middle	7.02	18.95	36.9	37.13	
Richer	9.45	20.49	33.82	36.24	
Richest	7.59	28.47	29.38	34.56	
Caste					
SC	6.74	18.62	35.01	39.63	50.3
ST	6.03	19.45	36.88	37.64	(0.00)

OBC	8.39	19.1	34.65	37.85	
Others	5.5	15.89	38.89	39.72	
Number of children					
No children	28.37	21.59	0.00	50.03	638.15
1	8.79	16.7	26.84	47.68	(0.00)
2	7.76	19.63	32.2	40.41	
3 & more	5.79	17.95	39.47	36.79	
Perceived Health					
Poor	9.44	18.49	32.16	39.91	74.87
Average	6.25	16.95	37.44	39.36	(0.00)
Good	5.58	20.41	38.57	35.44	
Functional Limitations					
One limitation	5.73	21.05	44.10	29.12	312.1
Two limitations	7.47	22.59	37.17	32.77	(0.00)
3 & more limitations	7.52	16.18	32.98	43.32	
TOTAL	**7.13**	**18.21**	**35.98**	**38.67**	

The proportion of primary caregivers as extended family members is highest when the elderly stay with 'children and others' while the tendency of having no caregivers is higher than a spouse as a caregiver when staying with 'spouse and children.' The presence of extended family members plays a major role in providing care when the elderly stay alone (Fig. 4). Among the elderly living with spouse and children, a significant proportion of elderly reported that they are not getting the expected care and support from their family members.

Fig. 4. Primary caregivers across different living arrangements among elderly in India



Effect of Living Arrangement on Caregiving Choices

Table 3. presents logistic regression showing the likelihood of not having any caregiver (model-1), receiving care from spouse (model-2), and receiving care from children or children-in-law (model-3). The regression analysis shows that living arrangements, age, sex, marital status,

current work status, health, and functionality are strongly associated with the caregiving dynamics among the elderly.

Elderly individuals living with 'children and others' have higher odds of receiving care from a spouse (OR=3.87, p<0.00) than those residing with 'Spouse and children' (OR=0.77, p<0.00). Those living with 'Spouse and children' have higher odds of having a child as a caregiver (OR=4,75, p<0.00) than those residing with 'children and others' (OR=2.37, p<0.00). This indicates that the likelihood of care from spouses and children may vary among co-residence elderly. As expected, the odds of having no caregiver is lower among the elderly residing with 'spouse and children' (OR=0.70, p<0.00) and 'children and others' (OR=0.37, p<0.00).

With increasing age, the odds of not having a caregiver decrease at age 80+ (OR=0.54, p<0.00), but more likely to have a spouse as the primary caregiver (OR=1.67, p<0.00). Suggesting the role of the spouse in caregiving at later ages. Females are less likely to receive care from their spouse (OR=0.75, p<0.00) and more likely to receive care from their children (OR=1.37, p<0.00), indicating higher widowhood in later years and more dependent on children for care and support. Currently, married elderly have significantly higher odds of having spousal care than their counterparts (OR=5.89, p<0.00). The role of marital status and spousal caregiving will be explored further in the next section.

Similarly, perceived health status and the intensity of functional needs also play an important role in determining family caregiving patterns. Elderly, those with poor health and multiple functional limitations are more likely to receive care from spouse (OR=2.92, p<0.00) and children (OR=1.56, p<0.00) in comparison to their counterparts. However, the elderly with good health are more likely to have no caregivers compared to those in poor health (OR=2.11, p<0.00).

Table 3. Logistic Regression showing the likelihood of not having any caregiver (model-1), receiving care from spouse (model-2), and receiving care from children or children-in-law (model-3)

Variable and Categories	Model-1		Model-2		Model-3	
	No Caregiver		Spouse Caregiver		Children Caregiver	
	OR (SE)	p-value	OR (SE)	P-value	OR (SE)	P-value
Living Arrangements						
Living alone®						
Spouse and children	0.70(0.05)	0.00	0.77(0.06)	0.00	4.75(0.64)	0.00
Children & others	0.37(0.04)	0.00	3.87(0.67)	0.00	2.37(0.30)	0.00
Age group						
60-69®						
70-79	0.81(0.04)	0.00	1.12(0.08)	0.11	1.14(0.08)	0.05
80+	0.54(0.03)	0.00	1.67(0.14)	0.00	1.26(0.11)	0.01
Sex						
Male®						
Female	1.00(0.05)	0.96	0.75(0.05)	0.00	1.37(0.10)	0.00
Place of residence						
Rural®						

Urban	1.03(0.05)	0.53	1.05(0.07)	0.43	0.94(0.06)	0.33
Currently marital status						
Single elderly®						
currently married	0.56(0.06)	0.00	5.89(1.02)	0.00	0.48(0.22)	0.00
Number of children						
No children®						
1 child	1.29(0.17)	0.05	0.64(0.11)	0.01	1.57(0.36)	0.05
2 child	1.24(0.15)	0.06	0.73(0.12)	0.06	1.64(0.35)	0.02
3 & more child	1.26(0.14)	0.03	0.71(0.10)	0.02	1.73(0.36)	0.01
Education (in years)						
No schooling®						
Less than 5 years	0.91(0.06)	0.02	1.13(0.11)	0.19	1.07(0.10)	0.49
5-9 years	0.93(0.06)	0.26	1.21(0.11)	0.03	0.98(0.09)	0.87
10 and more	0.85(0.07)	0.48	1.38(0.15)	0.01	1.18(0.14)	0.17
Work Status						
Currently not working®						
Currently working	1.70(0.11)	0.00	0.59(0.06)	0.00	0.72(0.07)	0.00
MPCE Quintile						
Poorest®						
Poorer	0.92(0.06)	0.19	1.17(0.11)	0.01	1.04(0.10)	0.63
Middle	0.85(0.06)	0.01	1.21(0.12)	0.05	1.08(0.10)	0.43
Richer	0.87(0.06)	0.03	1.22(0.12)	0.04	1.08(0.10)	0.42
Richest	0.72(0.05)	0.00	1.65(0.16)	0.00	1.25(0.12)	0.02
Caste						
Others®						
SC	1.00(0.07)	0.99	1.18(0.11)	0.83	0.85(0.08)	0.09
ST	0.93(0.07)	0.31	0.98(0.10)	0.88	1.23(0.12)	0.02
OBC	0.99(0.06)	0.94	1.17(0.08)	0.03	0.92(0.22)	0.23
Perceived health						
Poor®						
Fair	1.95(0.09)	0.00	0.52(0.03)	0.00	0.66(0.04)	0.00
Good	2.11(0.12)	0.00	0.46(0.04)	0.00	0.60(0.05)	0.00
Functional limitations						
One limitation®						
Two limitations	1.03(0.09)	0.71	1.19(0.16)	0.17	0.91(0.10)	0.36
3 & more limitations	0.42(0.03)	0.00	2.92(0.29)	0.00	1.56(0.13)	0.00

® *Reference category*

Provision of Caregiving by Proximity of Children's Residence

Table 4: Primary caregivers for the elderly in India by children proximity

Primary Caregivers	**Co-resident**	**Networked**	**Isolated**	**N**
No one	66.67	23.12	10.21	10,986
Spouse	69.58	20.79	9.62	1,295
Son/Daughter (in-law)	83.21	11.99	4.8	1,332
Other family members	63.16	23.32	13.52	707
TOTAL	**68.16**	**21.98**	**9.86**	**100**

The proximity of children's residences largely determines the types of solidarity, intergenerational relationships, and the patterns of family exchanges. Many studies found that closed proximity can be the functional equivalent to co-residence, while others see any kind of non-residence, whether it is in closed proximity or distance, as a sign of weakening intergenerational ties. In our study, we have classified the proximity of children's residence as coresident, networked, and isolated. The proximity of children's residence largely determines the pattern of caregiving to the elderly. Children (including son, daughter, son-in-law, and daughter-in-law) are the primary caregivers for the elderly co-residing with their children. While other family members (including father, mother, brother, sister, grandchildren, in-laws, and other relatives) became the primary caregivers for the elderly residing in the closed network or residing in isolation (outside the village, district, or state) (Table 4). Therefore, it can be said that the proximity of children is not the only factor that determines the care needs of the elderly. The presence of extended family members plays an equally important role in caregiving and may reduce the complete dependence on children for care. In fact, the role of the spouse has also been neglected while studying the care and support for the elderly because of the predominance of children as the primary caregivers. But, Table 4 suggests even in co-residence, there is a significant proportion of spouses providing care for the elderly.

The Role of Marital Status and Alternative Caregivers

In order to better understand the role of marital status in defining the provision of care, Table 5 & Table 6 present a separate analysis for the married and single elderly. The predicted probability for each model is plotted in Fig 5.

Table 5. Predicted probability of receiving care from family members by living arrangements among the married elderly

Living Arrangements	Model 1		Model 2		Model 2	
	No one		Spouse		Son/Daughter (in-law)	
	OR (std.err)	P.P	OR (std.err)	P.P	OR (std.err)	P.P
Spouse only	1.20(0.33)	0.82	2.92(1.51)	0.12	0.39(0.18)	0.02
Spouse & children	0.95(0.25)	0.78	1.94(1.00)	0.09	1.83(0.84)	0.10

*P. P (Predicted Probability)

Table 6. Predicted probability of receiving care from family members by living arrangements among the single elderly

Living Arrangements	Model 1		Model 2		Model 2	
	No one		Son/Daughter (in-law)		Other family members	
	OR (std.err)	P.P	OR (std.err)	P.P	OR (std.err)	P.P
Living Alone	Ref.	0.88	Ref.	0.05	Ref.	0.06
Children & others	0.33(0.035)	0.71	2.51(0.39)	0.12	1.13(0.16)	0.07

*P. P (Predicted Probability)

Fig. 5 shows that spousal caregiving was predominant among the married elderly when residing with a spouse. Even though the elderly resided with their spouses and children, the probability of spousal caregiving was almost equal to that of the children.

Similarly, for the single elderly, most of whom were widowed largely on children when residing with their children and other family members. However, the probability of other extended family members stepping in as primary caregivers when neither spouse nor children are available to provide care.

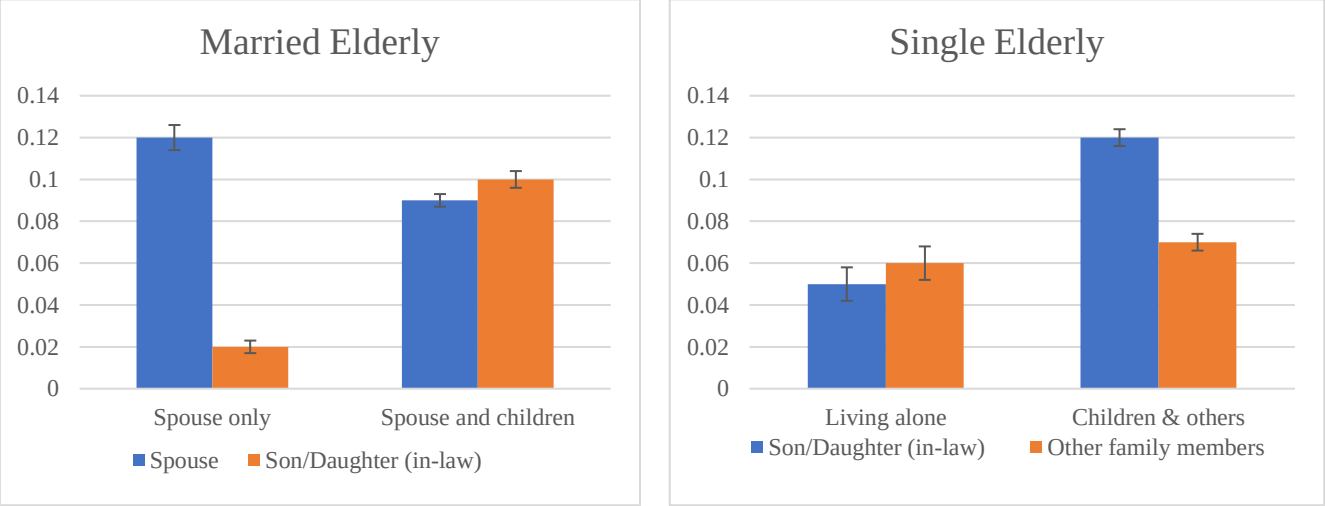


Fig 5. Predicted probability of receiving care from family members by living arrangement and presence of spouse

Discussion

The purpose of this paper was to identify the family dynamics in the provision of care and support for the elderly in India, which has been undergoing substantial changes in the last couple of decades with an unprecedented decline in multigenerational co-residence. Importantly, this study highlights the care provisions for the elderly with functional limitations and how living arrangements, presence of spouse, and proximity of children's residence affect their caregiving choices.

Our findings show that the dynamics of elderly care are influenced by a complex interplay of factors, with family structure and living arrangements playing a crucial role in shaping caregiving decisions. With increasing age, a large number of elderly become widowed, and the proportion of elderly staying with their spouse and children increases. However, still around one-fourth of the elderly population are staying alone or exclusively with their spouse, and around two-thirds of them are females. In addition, nearly half of the elderly have at least one functional limitation (48%), while only 23% of them receive care or assistance in their activities of daily living (ADL) or instrumental activities of daily living (IADL). That means only one in every four individuals has any caregivers to assist them in ADL/IADL activities. These statistics highlight the unmet care needs among the elderly, especially among the elderly staying alone or the single elderly.

We didn't find any hierarchy model of caregiving like that of the West, where children step into the role of caregiver when the spouse is no longer able to fulfil this role. Indian scenario is different in the context that when elderly individuals live with their children or close relatives, caregiving responsibilities often fall on those household members. Co-residence facilitates constant care, and family members can more easily provide emotional and physical support. However, Older adults who live alone are often more reliant on formal care systems or external caregivers. However, children or relatives may still play a role in arranging care, checking in frequently, or providing part-time assistance.

Spousal presence can positively contribute to the caregiving dynamics within the family and provide crucial emotional stability for the elderly, reducing the reliance on children for day-to-day care and support. When elderly individuals have a spouse, the spouse often becomes the primary caregiver, especially in the initial stages of aging. Spousal caregiving is marked by strong emotional commitment, though it can lead to burnout, especially if both partners are elderly or if one spouse has significant health issues. However, the situation might be different among the single elderly (widowed, divorced, or separated), where the caregiving burden typically shifts to children or other extended family members. In such cases, siblings or other family members may negotiate caregiving roles, leading to complexities in caregiving responsibilities.

Proximity to children's residence is another major factor in deciding caregiving choices. When children live nearby, they often take on regular caregiving responsibilities, whether through visits, errands, or direct care. This proximity enables informal care, reducing the need for formal care services. Children living far away often face challenges in providing consistent care. They may contribute financially, manage medical decisions, or organize professional care. The emotional toll of being a distant caregiver can create additional stress. When multiple children are involved, proximity to the elderly parent can influence which child assumes the primary caregiving role. Siblings may decide the caregiving role, and those living closer often provide more day-to-day support.

Family caregiving dynamics are shaped by various other factors like the health of the elderly, spousal health, and various socio-cultural factors. For example, in some cultures, co-residence and caregiving by children are considered normative duties, whereas, in others, the elderly may prefer or expect more independence.

The current findings should be considered in light of a number of limitations. Since the paper is based on the cross-sectional nature of the data we cannot infer causality from our associational estimates. There is evidence that parents move in with their children (or vice versa), and rotational living arrangements can be found in different parts in order to receive care and support, but this information is not available in LASI. We highlighted the role of spouse without considering their health. Because of the possibility of having similar kinds of unmet care needs among the spousal caregivers that might affect their health and well-being. Therefore, future research is needed to understand the life course transition in both caregiving and living arrangements.

Conclusion

The study presents a new perspective on elderly care and highlights various care gaps that exist for the single elderly or those living alone. Family dynamics in elderly care are shaped by various interconnected factors, including living arrangements, spousal presence, and the proximity of children. These factors influence the type, intensity, and emotional appearance of caregiving. Understanding these dynamics is critical for both families and policymakers in addressing the challenges of elder care and ensuring that elderly individuals receive the care and support they need.

Reference

1. Gupta, R., *Systems perspective: understanding care giving of the elderly in India.* Health care for women international 2009. **30**(12): p. 1040-1054.
2. Ugargol, A.P., et al., *Care Needs and Caregivers: Associations and Effects of Living Arrangements on Caregiving to Older Adults in India.* Ageing Int, 2016. **41**: p. 193-213.
3. Prasad, B.D. and N.I. Rani, *Older Persons, and Caregiver Burden and Satisfaction in Rural Family Context* Indian Journal of Gerontology, 2007. **21**(2): p. 216-232.
4. Okumagba, P.O., *Family support for the elderly in delta state of Nigeria.* Studies on Home Community Science 2011. **5**(1): p. 21-27.
5. Raju, S.S., *Health status of urban elderly : a medico-Social study / S. Siva Raju*. 2002, New Delhi: B.R. Publishing Co.
6. Kumari, D., *Role of informal care and social cohesion on health and well being of elderly and care givers A case study of Delhi*. 2019, International Institute for Population Sciences (IIPS).
7. P, M.K., *A sociologcal study on the care given to the elderly in Manipur*. 2018, Madras: Queeen's Mary College, University of Madras.
8. Kaushik, A., *Elder Care from a Distance: Emerging Trends and Challenges in the Contemporary India*, in *Ageing Issues and Responses in India*, M.K. Shankardass, Editor. 2020, Springer Singapore: Singapore. p. 97-113.
9. Anil Chandran, S., *Extent of Population Ageing and Intergenerational Support in the States of India*, in *Ageing Issues and Responses in India*, M.K. Shankardass, Editor. 2020, Springer Singapore: Singapore. p. 115-127.
10. Wojnar, A., *India's ageing population: Why it matters more than ever*, in *Hindustan Times*. 2023.
11. J Knodel, M.B.O., *Patterns and determinants of living arrangements*, in *The Well-Being of the Elderly in Asia: A Four-Country Comparative Study*, A.I. Hermalin, Editor. 2002, University of Michigan Press. p. 143-184.
12. Thang, L.L., *Intergenerational relations: Asian perspectives*. 2010. p. 202-214.
13. Gruijters, R.J., *Family care-giving and living arrangements of functionally impaired elders in rural China.* Ageing and Society, 2017. **37**(3): p. 633-655.
14. Rajan, S.I. and S. Kumar, *Living arrangements among Indian elderly: New evidence from national family health survey.* Economic and Political Weekly, 2003: p. 75-80.

15. Rajan, S.I., A. Shajan, and S. Sunitha, *Ageing and elderly care in Kerala.* China Report, 2020. **56**(3): p. 354-373.
16. Bansod, D., *Care and Support During Twilight Years: Perception of Elderly from Rural India*. 2017. p. 133-150.
17. International Institute for Population Sciences (IIPS), N., MoHFW, Harvard T. H. Chan School of Public Health (HSPH) and the University of Southern California (USC), *The Longitudinal Ageing Study in India (LASI) Wave-1, 2017-18 India Report*. 2020.
18. Uhlenberg, P., *The burden of aging: a theoretical framework for understanding the shifting balance of caregiving and care receiving as cohorts age.* Gerontologist, 1996. **36**(6): p. 761-7.
19. Mandi, R. and D.W. Bansod, *Exploring the nexus of health and happiness: A study on the life satisfaction of urban elderly in India.* Clinical Epidemiology and Global Health, 2023. **21**: p. 101308.