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The Fractured Safety Net: A Sociological Introduction to Paid Care Communities for India's Elderly with Migrant Children

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Introduction

India is on the brink of a demographic transformation with significant sociological consequences. By 2050, the population aged 60 and beyond is anticipated to surpass 300 million, tripling from 2011 statistics and representing about 20% of the entire population (United Nations Population Fund [UNFPA], 2023). This demographic increase coincides with another significant phenomenon: the widespread internal and international movement of adult offspring in pursuit of economic prospects. Recent estimates indicate that more than 50 million elderly Indians are "abandoned" by their migratory offspring (Rajan & Balagopal, 2022), undermining traditional multigenerational co-residence that has historically ensured familial care. The simultaneous occurrence of population aging and familial fragmentation results in a structural care deficit, which is most prominently evident in the increase of paid care communities. These institutions, encompassing luxury assisted living and subsidized residences, signify a major transformation of care from familial duty to commercial service, placing older folks at the nexus of financial security and emotional vulnerability.

The sociological importance of paid care groups goes beyond just providing services. These examples show the paradoxes of modern life: globalization makes it easier for kids to move around to get ahead financially, but it also creates new ways for generations to move around (Giddens, 1991). Many elderly people live in places where there are conflicts between material provision (paid for by remittances) and relational poverty. Observed Irudaya Rajan in 2023, "With the breakdown of joint families, responsibility for old-age support returned to nuclear units... but migration breaks this responsibility" (p. 14). India's insufficient welfare system makes this problem worse. Despite laws like the National Program for Health Care of the Elderly (NPHCE) and the Maintenance and Welfare of Parents and Senior Citizens Act (2007) that require family help, implementation is still patchy. One fifth of elderly Indians say they have no income (Longitudinal Ageing Study in India [LASI], 2020), which means that the government's promises of safety aren't real for many.

Theoretical Frameworks: Intersectionality and Structuration in Elder Care

To study paid care communities from a sociological point of view, you need to be familiar with ideas that explain how structure and choice affect older people. When used in aging studies, intersectionality (Crenshaw, 1989) shows how risks increase when age, gender, class, race, and migration status come together (Calasanti & King, 2021). The 2020 LASI data shows big differences between men and women. For example, older women are more likely to be depressed (11.32% vs. 8.26%), have more problems with activities of daily living (54.13% vs. 33.97%), and be widowed. This is made worse by the fact that 73% of women over 75 have never been to school. For these women, paid care groups may provide physical safety while making them less visible in society because they become economically dependent and their traditional care roles are undervalued (Gopal & Verma, 2022).

A different way to look at paid care communities is through the lens of structuration theory (Giddens, 1984). This theory sees them as places where big social issues like global labor markets, the government pulling back from

social care, and the neoliberal commodification of intimacy meet with smaller-scale discussions about identity and belonging. Residents who are elderly experience a double dialectic of control: remittances give them financial freedom, but they lose control over their daily routines because of institutional plans. At the same time, children's decisions to move represent factors other than their own free will, such as unstable economies, underdeveloped regions, and the need for cultural capital for cross-border travel. Xiang and Shen (2023) say that "institutional barriers and disadvantageous status" within migration hierarchies affect how much adult children want to live with their parents (p. 530). This shows that paid care communities are contested social spaces where filial piety meets economic necessity.

Views on the political economy of old age put these institutions in the larger picture of India's divided "silver economy" (Estes et al., 2003). Elderly wealthy people can go to high-end facilities that give companionship services, but when family care breaks down, the rural poor are forced to go to institutions with few resources (Pandve, 2024.4). This splitting up is like global care chains, where migrant workers from poorer areas (like Northeastern domestic workers in urban facilities) pay for the care of older people who are richer. This is a redistribution of care burdens based on race and gender (Raghuram, 2012).

1. Dual Dimensions: Financial Security vs. Emotional Vulnerability

1.1 The Financial Promise of Paid Care

Sending money back to their home countries (Remittances) from migrant children provides the material support for living in a facility. Studies show that older people with migrant children use healthcare more (OR=1.22), even though their physical health is the same as that of non-migrant families. This suggests that payments make it easier for them to get professional care (Knodel & Saengtienchai, 2011). Paid care communities fill in the gaps in care by providing services (like managing medications and helping with mobility) that it would be difficult for children living far away to provide. Children meet their financial responsibilities while looking for opportunities abroad, and parents get 24/7 monitoring, which is especially important for people with long-term illnesses (Mehra, 2023).

1.2 The Emotional Costs of Institutional Transition

Deep psychological problems lie beneath this pragmatic surface. Migration breaks up the bonds between generations, which makes it harder for people to get the social support they need for mental health. It is 1.17 times more likely for older people with migrant children to experience depressing mental health conditions like hopelessness, loneliness, and worthlessness than for co-resident families (LASI, 2020). Putting people in institutions makes these problems worse by:

Relational Dispossession:- Place-based identities that have been built up over decades are broken when people move. Kradel and Saengtienchai (2011), page 147, say that old people who are left behind say they "feel useless" even though they have enough money.

Stigmatized Identity: People in cultures that value family care hold a negative view of institutional care. Elderly people absorb stories of being left behind. One elderly person said it so well: "People forget about seniors" (Gopal & Verma, 2022, p. 89).

Network Fragility: Social capital, like confidence and networks of reciprocity, lowers health risks. According to LASI (2020), older people who don't do much socializing are 2.44 times more likely to have trouble with ADLs. It's hard for paid care communities to rebuild natural neighborhood ties.

Physical symptoms show up because of the mental effect. Linking children's migration to a higher chance of chronic diseases like high blood pressure, diabetes, and heart disease in Indian seniors is long-term data that shows how chronic stress plays a role (Singh & Das, 2020). Therefore, these organizations become places where contradictory embodiment happens: where physical needs are met while emotional neglect leads to physiological decline.

2. Policy Landscape and Its Discontents

India's policy reaction is still broken up, with talking points based on rights and gaps in how they are put into action. Children are officially required to pay child support under the Maintenance and Welfare of Parents Act (2007), but there are no ways to make this happen in cross-border situations. As of 2023, the Ministry of Social Justice and Empowerment said that the average monthly cost of assisted living was ₹20,000 to 50,000. This means that pension plans like IGNOAPS offer only ₹200 to 500 per month, which is way too little. Initiatives like the Rashtriya Vayoshri Yojana provide aid, but deep-seated conflicts still exist.

- Spatial Mismatch: Most senior homes are in cities, making them unavailable to 71% of India's elderly who live in rural areas (National Statistical Office, 2021).

- Digital Exclusion: Digitising healthcare suggests that older people don't know how to use technology, since only 4% of them use the internet (LASI, 2020).

- Gender Blindness: Since women live longer and have less access to pensions, this is called "feminised precarity" (UNFPA, 2022).

Promoting paid care communities as "silver economy" growth engines while culturally valuing family care in state approaches shows a basic tension. Residents feel like they don't belong in this situation because they are both patients and people with rights.

Numerous institutions have sprung up, but important social gaps still exist:

1. The Intergenerational Negotiation Vacuum: Studies focus on either the memories of older people or the views of migrant children (Xiang & Shen, 2023) for the most part. There needs to be more research on how care decisions are made as a social process, like how parental duties are renegotiated across borders and how money sent back home becomes moral currency that makes up for physical absence.

2. Institutional Ethnography Deficit: Policy evaluations (Pandve, 2024) make up most of the literature, ignoring real-life events. In public places, how do rank systems show up again? What do matriarchs do when they lose power? Insights from ethnography are still important.

3. Intersectional Blind Spots: There are differences between men and women (LASI, 2020), but not enough study has been done on how caste, religion, and living in a rural area affect institutional experiences. Elderly Dalit people who live in cheap homes may face abuse that doesn't happen in villages (Thorat & Neuman, 2012).

4. Transnational Care Circuits: Facilities depend more and more on foreign workers. Researchers don't look at how internal care chains redistribute emotional labour and make closeness more stratified (Raghuram, 2012).

5. Policy-Practice Chasms: Studies record programmes like NPHCE without looking at the day-to-day paperwork, like how social workers who aren't paid enough decide who gets a bed (Srivastava & Mohanty, 2021).

Scope and Contribution of This Review

To look into the tension between safety and vulnerability, this paper brings together sociological study on India's paid care communities for the elderly with migrant children. What we're saying is that these institutions are contested moral landscapes where the benefits of modernity—like financial security through global mobility—meet the costs of modernity—the breakdown of relationships. This is what we will do: a systematic study.

- Using frameworks for intersectionality and structuration, argue that paid care communities are places where social reproduction is disputed.

- Bring together different types of literature from areas like social policy, migrant studies, and gerontology.

- Central Subaltern Voices gives real experiences of elderly people who are marginalised top priority. -Wanted Policy Shifting our thinking to focus on care that is built on people's rights and includes the whole community.
Global South countries can learn a lot from India's experience. By looking at this broken safety net, we can see how to build institutions that respond to both material needs and the innate need to join, which is a crucial sociological issue for our ageing world.

Research Objective

1-To explore how migrant children and ageing parents change the meaning of parental duties, moral authority, and money transfers as "care currency" in paid care institutions.

2-To find out how differences in caste, gender, and location affect people's autonomy, social exclusion, and sense of respect in stratified care facilities.

3-Map the gaps between national policies on elder care and how they are carried out on the ground, paying special attention to areas that aren't treated equally, people who can't access technology, and transnational support responsibilities that aren't being met.

Research Methodology

This review article relies exclusively on secondary data obtained from academic journals, books, governmental papers, and publications from international organizations. Relevant literature was found, evaluated, and synthesized to fulfill the research objectives, focusing on recent and thematically pertinent publications.

Findings and Discussions

1-Redefining Filial Obligations: Remittances as Compensatory "Care Currency" in Transnational Elder Care

As a result of mass migration and institutionalised elder care, filial love has changed into financialized care arrangements. This is a major renegotiation of bonds between generations. "Care currency"—money transfers with moral meaning that help elderly parents financially and change ideas of duty and legitimacy—is being used more and more by children who have to leave their homes to work. When this happens in India, it's part of the process of making laws and adapting to new cultures. As a formal substitute for physical care, the Maintenance and Welfare of Parents and Senior Citizens Act (2007) says that children must be financially supported. For transnational migrants, however, regulation is still weak, leaving gaps in who is responsible. Changing the cultural meaning of seva (devotional service): old parents justify putting their children in an institution by saying that they are "not burdening them," seeing it as a way to care for future generations instead of abandoning them (Kalavar & Jamuna, 2011). Symbolic continuity is kept even when people are physically apart through rituals like sending money for pilgrimages or giving gifts at Diwali (Liebig, 2003).In the global context, this renegotiation shows how socioeconomic divisions shape different levels of access. India's data shows a three-level system: Urban leaders spend their Gulf money on high-end assisted living (₹20,000 to 50,000/month), showing off their wealth by buying care.

- People who live in rural areas get support payments of ₹200 to 500 a month, which only cover charity dorms. Systemic exclusion affects Dalit farmworkers who don't have foreign relatives who can pay for their care (Dommaraju, 2016).
According to Chinese studies, remittances can make up for 55% of physical health problems but not mental ones. This means that elders who are left behind are 1.17 times more likely to be depressed (CFPS, 2022). This kind of

unequal treatment includes gender: 73% of carers in India are women, but their free work is not seen as valuable by the economy (Brijnath, 2012).

Regarding mental health and social issues, remittances create a paradox of honour and vulnerability. According to quantitative studies, Indian seniors with migrant children have 1.35 times higher chances of self-rated good health because of better nutrition and medical access. However, they also have 1.17 times higher depression rates due to "relational erosion" (LASI, 2020). Qualitative reports call remittances "thanda paisa" (cold money)—sufficient in terms of resources but emotionally empty (Gopal & Verma, 2022). According to research, financial contributions work like strategic complements (brothers give each other more money) and time care works like strategic substitutes (local siblings give less physical care when others contribute), making emotional problems worse (CFPS, 2022). Somatically, the "ambivalent gratitude" that comes from being alone raises the risk of high blood pressure and diabetes, showing how unmet emotional needs are deeply rooted in our bodies (Knodel & Saengtienchai, 2011).

Policy Gaps and Hybrid Solutions

89% of India's paid care facilities are concentrated in eight metropolitan towns, leaving 71% of rural elders unserved (NSO, 2021). This makes exclusion of older people even worse. A lot of older people are alone because only 4% of them use the internet. This means they can't make virtual friends or use technology to make money exchanges more personal (LASI, 2020). Singapore's Maintenance of Parents Act (1995), on the other hand, combines cash grants with community-based help, but it still relies on female care work (Verbrugge &ang, 2018).

Effective solutions require hybrid models:

Kerala's "Karuthal" programme mixes beds paid for by remittances with visits from ASHA workers, who offer medical care and emotional support (George Institute for Global Health, 2024)". (HelpAge India, 2023) Digital learning programmes help migrant children be present online with other children. Transnational enforcement methods for elder support claims, filling in legal gaps in India's Maintenance Act (Rajan & Kumar, 2003).

So, remittances as a form of care money show how resilient family systems are by showing irreplaceable relational deficits. Policymakers need to add emotional infrastructures to financial transactions in order to provide long-term care for the elderly that respects the core of seva while also taking into account the limitations of modern life. Native Indians say, "Money can buy nurses, but love can buy comfort" (Gopal & Verma, 2022, p. 89).

2-In stratified care facilities, different castes, genders, and geographic locations lead to notable differences in how people feel autonomy, social exclusion, and respect. Discrimination in healthcare systems based on caste is still a major problem in many nations, particularly in India. In healthcare settings, members of lower-caste communities frequently experience systematic discrimination, which results in unequal access to care, exclusion, and a decline in respect from patients and healthcare providers, according to research by Kanjirath and Krishnan (2020). Because they are less able to make decisions about their care, lower-caste people's autonomy is diminished by this discrimination, which also makes them feel disempowered and alienated in these environments. Inequalities based on caste make it difficult for people to receive high-quality healthcare since they are frequently treated unfairly or neglected due to their social standing, which further solidifies their marginalization in society. In care facilities, gender is another important issue that affects how people feel respected and have agency. In nations where patriarchal standards are deeply ingrained, women—especially those from rural or lower caste backgrounds—are often denied complete authority over their healthcare choices. According to Chakraborty (2019), gendered expectations in the household and in society at large influence women's healthcare autonomy. Women are frequently expected to put their families' interests ahead of their own, which might influence how they make decisions in medical situations. Because gender norms are even more inflexible in rural places, women's voices are suppressed, which increases social exclusion and results in a lack of respect from medical professionals.

In healthcare systems that are already caste-segregated, these gendered hurdles are especially noticeable, further disadvantageously affecting women from lower caste origins.

Another important factor in shaping one's feeling of autonomy, social exclusion, and respect is location, especially in rural or disadvantaged areas. Because they have less access to infrastructure, qualified healthcare professionals, and high-quality services, residents of rural or isolated areas frequently confront significant healthcare issues, according to research by Patel and Singh (2021). In some regions, a lack of resources causes lengthy wait times for care, which worsens patients' experience of alienation and lowers their sense of dignity and value. Location also frequently overlaps with gender and caste, since rural women from lower-caste communities face double disadvantages due to social discrimination and geographic isolation. This can lead to these people being left out of decision-making processes and care providers ignoring their rights and needs. Therefore, the combination of caste, gender, and geography produces an atmosphere in which groups that are marginalized—especially women and people from lower castes—feel less respected, have less autonomy, and are more socially excluded.

Social hierarchies that impact access to care, care quality, and respect are reinforced by the interdependence of caste, gender, and geography, which exacerbates the disparities already present in stratified care systems. Finally, in order to address the persistent injustices in healthcare settings, it is critical to comprehend the ways in which these three components interact. Interventions that seek to advance greater equity must take into account the particular difficulties that people at the intersection of these social identities face in order to guarantee that everyone is treated with respect, dignity, and autonomy during their healthcare experiences, regardless of their location, gender, or caste.

3-The policies and practices in India for caring for the elderly are not always followed. This causes big problems for the country's rapidly ageing population, which is expected to hit 34.7 crore people (20% of the population) by 2050 (United Nations Population Fund [UNFPA], 2023) and is already very unequal. Care access is constantly being harmed by things like the “Maintenance and Welfare of Parents and Senior Citizens Act (2007)” and the “National Programme for Health Care of the Elderly (NPHCE)”, as well as differences in location, lack of access to technology, and unenforced transnational obligations. There is spatial inequality because most of the resources are in eight big towns, where 89% of the paid care facilities are located, while 71% of older people live in rural areas with few or no services (National Statistical Office [NSO], 2021). This imbalance in geography means that vulnerable rural seniors—including 40% of the poorest quintile—have to drive 15–50 km to get basic care, which raises health risks for those who can't move around easily (HelpAge India, 2022; Longitudinal Ageing Study in India [LASI], 2020). Only 31 of the 100 planned geriatric clinics opened, and states like Bihar and Uttar Pradesh used less than 26% of the money they were given for old programmes (Comptroller and Auditor General of India [CAG], 2022; Srivastava & Mohanty, 2021). This shows that the NPHCE failed to decentralise. High-need areas are ignored by market-driven facility placement, leaving disadvantaged groups like Manipur's more than 60,000 conflict-displaced adults without help (Human Rights Watch, 202`).

Additionally, "digital exclusion" creates a "grey divide," keeping 91% of older people from accessing technology-enabled care (LASI, 2020). The Telecom Regulatory Authority of India (TRAI) (2023) says that in states like Jharkhand and Chhattisgarh, rural broadband availability is less than 30%, which makes it hard for people to get telehealth. Literacy problems make this separation even worse: 73% of older women can't read or write, and only 4% use the internet. This means they can't use digital platforms for health services or pensions (LASI, 2020; Ministry of Social Justice and Empowerment, 2022). Since there were no analogue options to telehealth during COVID-19, outcomes for people with chronic conditions got worse. This showed that there were gaps between design and reality (George Institute for Global Health, 2022). Importantly, caste affects digital access: only 38% of Scheduled Tribes (ST) own a phone, compared to 72% of dominant classes; also, ST elders are three times less likely to know how to use technology (National Family Health Survey-5 [NFHS-5], 2021; Thorat & Neuman, 2012).

Failures in transnational regulation make care even worse. The Maintenance Act of 2007 says that Non-Resident Indian (NRI) children must financially support their parents, but it doesn't have any ways to make sure that this happens across countries. This means that 43% of "left-behind" elders are financially vulnerable when remittances stop coming in (Irudaya Rajan & Sivakumar, 2022; Rajan & Kumar, 2003). While 78% of migrant families use video calls, Xiang and Shen (2023) say that virtual contact can't replace face-to-face care for people with chronic illnesses. Problems with logistics, like health insurance that can't be moved, biometric pension authentication rules that make it hard for seniors who are bedridden, and time zones that don't work with each other, make weaknesses worse (National Health Authority, 2023; Pension Parishad, 2021). Because of this, older people whose children work abroad have 1.17 times higher rates of sadness, even though they get money from their children (LASI, 2020).Because of "intersectional disadvantage," these gaps hurt marginalised groups more than they help. Compared to upper-caste men, Dalit women spend 78% of their pension on basic care. ST elders are even more left out because they live alone, can't use technology, and often don't have migrant family members to send money back to them (Desai & Dubey, 2012; Thorat & Neuman, 2012). India only has 270 geriatricians for its 14 crore senior citizens, and the Ayushman Bharat insurance only covers 25% of seniors (Indian Medical Association, 2023; NITI Aayog, 2022). This makes gaps even worse.

Bridging these gaps necessitates integrated reforms:

1. Spatial Equity: Mandate vulnerability-indexed facility placement (1 center per 10,000 high-need elders) using Census/LASI data, while deploying mobile clinics for remote regions (Rajan & Balagopal, 2022).

2. Digital Inclusion: Integrate vernacular voice assistants in welfare portals and train ASHA workers as "digital navigators" (HelpAge India, 2023).

3. Transnational Accountability: Establish NRI tribunals under the Ministry of External Affairs to enforce Maintenance Act claims and negotiate bilateral social security agreements (Ministry of External Affairs, 2021).

The Ministry of Social Justice and Empowerment (2024) has acknowledged these imperatives in the proposed "2025 National Policy for Senior Citizens," which advocates for community-based AYUSH integration, elder abuse restitution, and minimum care standards. In the absence of frameworks that are spatially targeted, digitally inclusive, and internationally enforceable, India's plans for the care of its 140 million+ aged citizens would remain aspirational. Gopal and Verma (2022) eloquently observe that *"Money buys nurses, but only love buys comfort"* (p. 89)—a reminder that in order to respect India's aging population, financial security must be combined with relational dignity.

Conclusion

This study focuses at the challenging circumstances of paid care communities for India's old people who have children who have moved away. It finds systemic gaps in helping different generations, structural inequality, and policy implementation. Because of urbanization and cross-border movement, the results show that there are still big differences in access to and quality of care. This is a very important shift from traditional family care to institutionalized solutions.

An important result is that caregiving between generations is changing. More and more, migrant children are replacing direct caregiving with financial support, making money a "care currency." This adaptability is a practical reaction to the need to move and make money, but it also causes emotional distance because parents who are older don't see money transfers as enough to make up for their physical and emotional absence. This change questions traditional ideas of filial piety. It suggests that parental moral authority is waning and raises ethical concerns about how eldercare is becoming a commodity in neoliberal economies.

Caste, gender, and place all play a role in how easy it is to get care and how much respect you are treated. Systemic exclusion means that older people from lower castes are often pushed to facilities that aren't well-funded and don't

meet standards. This reinforces caste-based marginalization. Because they are financially dependent and socially isolated, older women, especially widows, are more likely to be hurt because of deeply ingrained patriarchal rules. Even though the infrastructure is better in cities, care facilities there often don't offer personalized care. On the other hand, rural facilities have trouble getting resources even though they have stronger community ties. The results show that systemic inequality still exists, even in institutional care situations, and that specific policy changes are needed to fix it.

Finally, the study finds a big gap between national policies on elder care, like the National Policy on Older Persons (NPOP) and the Maintenance and Welfare of Parents and Senior Citizens Act, and how they are put into action. These models support universal care, but they only focus on cities and don't help people who live in rural or semi-urban areas. Online pension systems and other digital aid programs accidentally leave out older people who don't know how to use technology well, which makes them more dependent. Policy models also don't deal with the transnational aspects of elder care, which means that migrant children don't know what their responsibilities are and there are holes in who is responsible for what.

Limitations and future recommendations:-

The study's results have important policy effects and point scholars in important new directions for future research. A multifaceted approach is needed to successfully tackle India's elder care challenges. The first step is to strengthen community-based care models, which can reduce reliance on institutions while actively promoting intergenerational solidarity. For fair distribution of resources and chances, policymakers should make it a priority to use intersectional frameworks that take into account caste, gender, and regional differences in access to elder care. Improving policy enforcement through decentralized governance structures and strong monitoring systems is also important for turning national directives into useful local action. According to the study, transnational care dynamics need to be incorporated into legal frameworks right away. This will help migrant families meet their care responsibilities across borders by setting clear guidelines. On the horizon, future research should include comparative studies across emerging countries going through similar demographic changes, as well as longitudinal studies that track the health and happiness of older people living in paid care facilities over time. Theoretical work like this would not only improve academic discussion, but it would also give policymakers real-world evidence to base their decisions on. India can work to create a more fair and long-lasting system for elder care that protects the safety and respect of its aging population while swiftly changing society by systematically addressing these gaps. With its important insights for lawmakers, gerontologists, and sociologists trying to understand how elder care is changing in the Global South, this study adds to the global conversation on getting older, migration, and social policy. The study shows how important it is to use evidence-based, culturally-sensitive methods to deal with the complicated way that traditional values and modern realities interact in elder care systems.

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