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A Qualitative Analysis of the Emergence of Long Term Care (Old Age Home) Sector for Seniors Care in India: Urgent Call for Quality and Care Standards

Shanthi Johnson[1] · Swati Madan[1] · Jade Vo[2] · Ansa Pottkett[2]

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Abstract
Aim The aim was to understand the emerging sector of long term care (old age homes, OAHs) in India through the voices of facility administrators as they see the imminent issues of importance in this new sector and care for the elderly.
Methods Sixty five administrators, representing 55 OAHs located in Chennai, India, were interviewed using a semi structured interview guide by two trained research assistants. The interview guide elicited information related to the current status of OAHs and the recommendations to improve the standards and quality of care of the elderly. The interviews informed the thematic areas highlighted in the results section.
Results The emerging OAH sector is managed by individuals with diverse professional and disciplinary background without any aging-specific qualifications. The OAHs operate for profit or as a charity with often unreliable funding. The administrators felt that they were unable to provide the services they wanted at a level they felt appropriate. Staffing and training issues were common concerns impacting level of care. Lack of government leadership was cited as a reason for lack support for the OAHs. No standards of care and quality assurance mechanisms currently exist for OAHs and the elderly these institutions serve.
Conclusion Existing policies and schemes pertinent to aging care must be reviewed, adjusted, and coordinated to reflect the emerging sector in India, and the government

SJ was responsible for the overall conceptualization, implementation of the project, and the final manuscript. AK and JV were responsible for the data collection and analysis of results. SM was responsible for literature review and manuscript.

✉ Shanthi Johnson
shanthi.johnson@uregina.ca

1 Faculty of Kinesiology and Health Studies, University of Regina, 3737 Wascana Parkway, Regina, Saskatchewan S4S 0A2, Canada

2 Shastri Indo-Canadian Institute, Calgary, Canada

must take leadership in providing guidance and addressing the needs of the residents of OAHs. Effective multi-sector and multi-level partnerships and communication are urgently needed to inform both on appropriate steps and policies required moving forward.

Keywords Long-term care · Old-age homes · Health care services · Elderly

Introduction

Population aging has become a global phenomenon as every country is experiencing an increase in the number and proportion of elderly. This demographic shift has been most pronounced in high income countries. Developed countries began experiencing this phenomenon many decades earlier than low and middle income (developing) countries, where some changes, including declining birth rates, have been relatively recent (United Nations 2015). Estimates by the United Nations Population Division (2015) have suggested that by the year 2050, 8 in 10 older adults will live in the less developed countries, that is, older persons will be increasingly concentrated in the less developed regions of the world. The growing proportion of older adults in these countries will lead to an increased demand for long-term care services. The consequences of population aging are far more serious for developing countries as these nations have fewer financial resources to cope with the challenges associated with this phenomenon (United Nations 2015), such as an increase in demand for long-term care services. India is one such nation undergoing this transition.

India's current elderly population of 60 million is projected to exceed 227 million by 2050, an increase of nearly 280% (World Health Organization 2011). Factors such as reduced infant mortality, boosts in education and employment opportunities for women, increasing gender equality, and improved access to family planning play an instrumental role in reduction of birth rates and subsequently contribute to population aging (United Nations 2015). Although the shift from a younger age structure is indicative of massive improvements in health care delivery, it creates numerous challenges for policy makers and health care providers. The transition reduces the support base for the elderly, leading to increased dependency on the younger generation and higher levels of social and economic supports from elsewhere including the state (Subaiya and Bansod 2011). The traditional Indian family system provided care for older family members. In the past several years, societal changes in India have led to the reduced availability of care support for the elderly at home. Skilled Indian professionals have moved to more developed countries for employment opportunities, and many others move to larger cities. These factors have contributed towards the erosion of traditional joint family systems and led to the growth of nuclear families (Bhattacharya 2005).

This combination of factors in India has led to the emergence of the long term care or nursing homes (also called old-age homes in India) sector (Ara 1997; Lamb 2005). These homes provide sheltered accommodation and a spectrum of health, personal, and supportive services to the elderly who do not receive care from family at home or are unable to be cared for at home. There are primarily two types of old age homes for elderly: free homes and paid homes (Gupta et al. 2014; Tiwari et al. 2012). Free homes

are usually funded by government or charitable organizations, while paid homes are largely private, for-profit entities. In India, one percent of the elderly live in old age homes and the number and types of these institutions are growing (Liebig 2003). The most recent information available shows that there are 1,286 LTC facilities in India, whereas there were only 90 in 1950 (HelpAge India 2009). Given that the emergence of long term care is a relatively new trend, there is paucity of research in this area. Thus, the present study examined the status of old age homes in Chennai, India, from the perspectives of administrators on issues of importance for this newly emerging sector.

Methodology

Participants/LTC Facilities

For this study, interviews were conducted with 65 administrators from 55 old age homes in Chennai. LTC facilities were included if they were located within the Chennai city limits, had been in operation for at least one year, and served older adults. LTC facilities were located through directories provided by HelpAge India, Probus Club of Chennai and the Vishranthi Home for the Aged. In addition to these directories, additional facilities were identified from the city phone book and from referrals from local people. In total, researchers obtained listings for one hundred and twenty facilities. However, the majority of these were either located outside of Chennai or have relocated with outdated contact information. The facilities were first contacted by telephone. If they could not be reached, a physical visit was made to the address. Of these 120 homes identified, 55 facilities were contacted and invited to participate in this research study. From each facility, one or more administrator(s), as self identified, were invited to participate in in-depth interviews. A total of 65 administrators were interviewed. The study was approved by the research ethics board at the first authors' institution and the administrators provided consent prior to being interviewed.

Interview Guide and Interviews

An in-depth structured interview guide was developed with open ended questions about services and policies. The interview questions were broad, so that themes and issues were able to emerge inductively and inform the research question. The interviews lasted from one to two hours. All interviews were conducted by both research assistants and were conducted in English, with the exception of seven that required the help of a Tamil translator. We also translated instruction sheets into Tamil for participants' convenience. Quotes were recorded by hand. The interviews were usually conducted in the organizations' offices. Field notes were also prepared following each interview to provide additional context. This grounded theory approach was used given the nature of the study.

Analysis

The study was primarily qualitative in nature. Qualitative data was entered data into the computer program NUD*IST and was analysed thematically using open, axial, and

selective coding. Drawing from both interviews and field notes, we began focusing on recurring themes and used open codes to identify the phenomenon. We used the grounded theory approach to analyze the qualitative data collected. As interviews were conducted, themes such as the gaps in services provided by organizations and the policies legislated by government began to emerge. To describe the study participants, the background characteristics including demographic information and professional background information were analyzed and summarized using SPSS software and descriptive statistics.

Results

The present study included 55 facilities (n=24 free or not for profit; 17 paid/ for profit facilities; and 14 paid but free for some residents). The administrators interviewed come from a wide range of backgrounds (see Table 1). Many take on honorary positions as a social service rather than an occupation. The majority of the administrators were women. Most of the well established homes, existing for more than 50 years, were usually Christian run as a charity and social service.

Old Age Homes

The concept of long term care or old age homes (OAHs), as it is commonly called, in India is fairly new; most of the well established homes care for the destitute, rather than

Table 1. Occupational backgrounds of administrators

Occupation	Number of Participants
Housewife	11
Religious persons	8
Social Worker	8
Business Person	8
Engineer	5
Teacher/Professor	5
Manager	4
Secretarial	3
Civil Servant	2
Yoga Instructor	2
Nurse	2
Nurse's Aide	2
Lawyer/Judge	1
Counsellor	1
Manufacturing Employee	1
Medical Technician	1
Doctor/Physician	1
Total	65

the aged. Homes focused mainly on older people tended to be established more recently, within the last five to ten years.

The administrators felt that one of the main reasons that older people go to OAHs is the breakdown of the joint family system. Previously, the aged lived with extended family, but increasing urbanization and globalization creates a trend towards a more nuclear family structure. Children move and are unable to care for their aging parents. Without their children's support, the elderly lack the resources to get the care they need. Several have difficulties maintaining a household on their own.

Difficulties OAHs Face

A major problem faced by OAHs is funding, as homes are often dependent upon irregular and unreliable sources of funding, such as public donations. Some homes try to generate income by selling arts and crafts, ice cream, having shops and making brooms.

Staffing was another difficulty faced by OAHs; most homes had employees untrained in providing senior care. The area of geriatric care is still a relatively new field; thus, many caregivers have only personal experience caring for the elderly. It is also not a well paid field, so many administrators have difficulty in finding enough helpers to care for residents since "not everybody wants to work with old people, it's difficult." Thus, understaffing was a pervasive issue for administrators.

Infrastructure was another problem, many had difficulty finding land to build old age homes on, or renting from others. The rising costs of living in a growing city put even more pressure on OAHs. Many administrators cited bureaucratic barriers as impediments to taking care of elderly. For example, government recognition is required to become a charitable trust and receive public donations. Many have to apply multiple times, and it takes a long time to receive a response from the government.

Programs/Services and Policies related to OAHs

With the increasing need for old age homes, there is a range of services provided for the elderly. Homes range from meeting basic needs like food, shelter, clothing and medical care to more social and spiritual activities. The primary service provided includes medical care (see Table 2). Most homes are at full capacity, straining to meet resident needs. Since this is a new field, there is a lack of experience among administrators and managers as many do not have health care related training, or any regulations governing these homes. Only a few facilities reported having had inspections from the Social Welfare Board.

Almost all homes wish to increase the care that they provide. Some suggestions were infrastructure improvements, admission of more complex patients, in-house medical care and increased accessibility such as hand railings or ramps. Others wanted to meet social needs by providing entertainment, hiring a social worker, day care, and short term stay. Another suggestion was to have in-house staff education programs.

A major problem is that the administrators did not know about Central government legislation. Out of 65, only six respondents knew the National Policy on Older Person

Table 2. Medical Services provided for the elderly in OAHs

Types of Medical Services	Number of Homes
No regular doctor checkups (only go to doctor when an elderly is sick)	11
Doctor visits for checkups several times a year	2
Doctor visits monthly	7
Doctor visits several times a month to do checkups	8
Weekly doctor checkups	13
More than once a week	3
In-house medical facilities, 24 hour medical care	7
Not applicable	4
Total	55

in any detail. Most had basic knowledge of the State government schemes for elderly people, but did not know about the Central government schemes. One administrator suggested that reason for this lack of knowledge is, “we are totally in the private sector, so we are not interested in government policy and politics.” However, we sense that this lack of awareness is due to the lack of communication between the government and the old age homes. Some administrators felt the government should educate the administrators and general public about its policies.

Because most administrators are not familiar with government policies on aging, we feel it is important for them to learn more, even if they are not linked with the government. A partnership between NGOs and the government could help strengthen communication about the needs of the elderly and the resources available to meet those needs. Such partnerships are also advocated for by administrators. One manager said, “I don’t think government can ever fill gap between need and implement. There needs to be partnerships with private institutions to supplement. Government can’t do it alone.” Another administrator remarked that a partnership could utilize the existing knowledge concerning care of elderly people saying, “Strategic partnership with existing NGOs with experience and expertise rather than starting [new homes] without knowledge. This becomes business.”

Shared responsibility and increased communication among relevant NGOs could alleviate pressures from both sides by improving policy implementation and provision of services. One administrator describes the phenomenon of a budding old age industry as an opportunity, “They should support old age homes, give 50 percent tax rebate, regulate industry; it’s very new, ability to shape now before becoming well established. There is a population problem, 100 million aged people”.

Recommendations from the OAHs’ administrators

Most of the old age homes suggested that existing state policies are inadequate in meeting seniors’ needs. Administrators suggested increasing the pension amount and distributing to all seniors. Many administrators agreed that 400 rupees per month for those living below the poverty level is not enough to survive. This is especially true

when the cost of medicines and medical services for a senior already exceeds that per month. Administrators suggested both an increase to the pension and provision of free geriatric services for the elderly at all hospitals, not only government hospitals. These two recommendations would alleviate the most concerning problems of finances and health for the aged.

Other administrator suggestions were to support NGOs by providing grants, concessions and tax breaks. While most suggested that the government support the NGOs, some suggested the government run its own OAHs. Others recommended improving on the existing medical services provided for seniors by the government.

Another suggestion was the creation of a special corporation to meet seniors' needs while improving funding accountability and transparency. This type of corporation could keep records on the demographic information of older people, and the services available to them. Administrators suggested that the bureaucratic nature of government departments makes it very difficult for funds and benefits allocated to elderly people to actually reach them. The implication is that these schemes are not properly implemented, and the people cannot approach the government directly. The public needs better access to politicians, and corruption was a repeated concern for administrators.

One administrator commented that the government had many concerns to contend with and it was difficult for them to accurately assess and meet the needs of the elderly saying, "Government has lots of problems, so they think needs of old people [are] very small. [There is also a] lack of equal distribution. Example, give government employees pension higher than salary (over 3000 rupees) but only 400 rupees for the villagers."

Also, the government must balance the concerns of other disadvantaged groups and administrators often felt the elderly were not a priority. One administrator noted, "Government cares for weak population like women and children, and old people after 70 years are also weak, but government does not consider them weak." This sense of elderly being left behind may also come from the limited communication between old age homes and government, which leads to a lack of knowledge and understanding of government policies. We also found it difficult to find information on policies regarding aging as no central agency provides this information.

While administrators were aware of the existence of some policies on the Central and State levels of government, they had varying interpretations of the schemes. For example, one manager noted that, "Pension increased from 200 rupees per month to 400 rupees per month, but that is not enough. Government gives 25 rupees per month for each of 40 [residents]. The government won't improve anything because they are all money minded people." This was a recurring pattern as administrators could identify old age pension plans, ration programs and concessions, but identified the specific details of the schemes differently.

Discussions

With old age homes being such a new industry and emerging area of care for the elderly in India, the government must do more in terms of regulations and standards. Many homes have no government contact unless required to register as a charitable trust, or receiving government grants. In all other cases, there is no requirement for registration

of OAHs. Given the lack of standards, any person could start an OAH without consideration for the appropriateness of space and care provision. As such, many facilities are overcrowded, effectively warehousing seniors without considering the quality of care. Efforts should be taken to ensure appropriate infrastructure with adequate accessibility and space. In many facilities, especially in homes with dormitory style housing, people often are confined to their beds with limited ability to interact with others. Creating more common areas, like living rooms, can facilitate a more home like environment, and help decrease the sense of isolation that seniors face. A wide variability exists in terms of OAH infrastructure and facilities. A recent study showed that the medical facilities, recreational facilities, staff and space availability are generally better in the private OAHs as compared to the public OAHs. Thus, the overall quality of life is greater in private old-age homes in India (Gupta et al. 2014).

Within the OAH sector, there is also a general lack of guidelines, quality and care standards, and relevant staff inexperience and training compromises the care provided. There is an urgent need to develop, deliver and evaluate quality and care standards for this emerging area. Furthermore, all homes should be subject to inspections to ensure that infrastructure is up to code in terms of accessibility and that standards are being met..

Although the primary focus of these homes is on medical care, there is a need for holistic and evidence-based programs and services beyond this to ensure quality of care and life. For example, the unique dietary and nutritional considerations of older adults and meal provision to meet those needs are important. In addition, psychosocial issues such as social isolation, loneliness, and depression are common among older adults. Activities for continued engagement and participation are important. Among the administrators, there is a desire to expand programs and services without careful consideration of quality and standards. Further evidence based programming and impact evaluations are urgently needed. In an emerging area of aging care, support should also be given for those types of elderly services outside the old age home, such as day care centres and home care. These help to support and give respite to families taking care of elderly, and may be more ideal for the elderly person, if not more economical than OAHs (Chaubey and Vij 1999).

Another major area is education and training needs. While the field of gerontology and geriatrics has grown in India since the proclamation of the National Policy on Older Persons in 1999, most of the administrators and program staff are not formally trained on aging care and are not generally aware of relevant national or state level policies. Also, many of the homes have difficulty finding trained staff members, thus understaffing is a major issue, especially those homes with a large population of residents with complex health concerns.

Many homes operate in isolation without active communication with other OAHs, care facilities such as hospitals or health care units, or government departments. Associations between hospitals and health care units and old age homes can help improve the care provided to elderly. Also, networking and partnership among OAHs and NGOs facilitates support, along with the sharing of problems and knowledge. The government should also partner and provide training opportunities so that standards of care are properly implemented. This could also serve as a forum to discuss policies. There is a lack of knowledge on the schemes or benefits for older people on the part of administrators and the general public. The government should not only license OAHs, but review the needs of older people in order to develop appropriate and effective policies.

Conclusion

The present study provided some insights into the current status of old age homes in Chennai, India. In particular, concerns emerge around the lack of regulation of what an OAH should entail in terms of elderly-appropriate infrastructure. In addition, with the proliferation of OAHs and the range of programs/services provided, there is an urgent need to develop, implement, and ensure adherence to care and quality standards. Education and training is also a major area of concern. While there has been significant progress in opportunities for geriatric and gerontology training in India, there are significant gaps in trained staff engaged in all aspects of old age homes from the administration to service delivery. There have been great strides in the development of the National Policy on Older Persons in 1999 and the Maintenance and Welfare of Parents and Senior Citizens Act, 2007 in India. Yet, the level of awareness of these policies and the practical translation of the policies into actual care of the elderly is limited without standards and accountability. Further research is needed to understand and address key issues of importance. The present study elicited the perspective of administrators. Research is needed from the perspective of the elderly themselves living in OAHs.

Compliance with Ethical Standards

Conflicts of Interest None

Informed Consent Informed consent was obtained from all individual participants included in the study.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

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Shanthi Johnson is a professor in the Faculty of Kinesiology and Health Studies at the University of Regina, Regina, Canada and a research faculty at the Saskatchewan Population Health and Evaluation Research Unit.

Swati Madan is a doctoral student in the Faculty of Kinesiology and Health Studies at the University of Regina, Regina, Canada.

Jade Vo was a Shastri Indo-Canadian Institute sponsored intern during the time of the study.

Ansa Pottkett was a Shastri Indo-Canadian Institute sponsored intern during the time of the study.