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CARE UNLIMITED: AN ENTREPRENEURIAL GROWTH DILEMMA

Meeta Dasgupta wrote this case solely to provide material for class discussion. The author does not intend to illustrate either effective or ineffective handling of a managerial situation. The author may have disguised certain names and other identifying information to protect confidentiality.

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In April 2018, Suryashish Gupta was in a contemplative mood. Care Unlimited, which he had founded three years earlier to reduce the concerns of children living abroad regarding their aging parents, had not met the targets he had set. The set-up provided a bouquet of services designed to meet the special needs of elderly people. Gupta had acquired at least 30 clients who wanted their parents to stay active, engaged, and socially connected. Although the set-up had managed to capture a small share of the early market in Kolkata, India, the concept had yet to achieve wide-scale acceptance. Gupta felt that most people saw his services from the viewpoint of handling emergency situations. Very few realized the importance of elderly people’s day-to-day well-being. He knew that his decision not to provide emergency services had given him clients who were interested in their parents’ well-being and not only in taking care of their parents’ medical emergencies. If the mindset of the majority focused on emergency services, how would he convince them of the value of his proposition? Should he consider adding emergency services? Alternatively, he could continue to drive across the point that, to age successfully, elderly people had needs that went way beyond emergency services.

THE start OF CARE UNLIMITED

Gupta, a software engineer by profession, was at the peak of his career as the practice head in a multinational company when he decided to follow his heart’s calling: helping others. Months of research confirmed what Gupta knew by observing households in his neighbourhood: elderly citizens living alone in urban areas were one of the most vulnerable demographics in society. Their needs were simple, and their demands were few; yet they found themselves alone at times when they needed simple support, and this led to distress in their lives.

Kolkata, a city in West Bengal, India, suffered from a lack of jobs. Capable individuals from the younger generation had left the city in the 1990s. Gupta said, “In my childhood, we were 15–20 kids in the same age group living in this apartment complex. Now only six to seven of our generation stay here. Rest are all in the old age.” Their parents had always lived in joint families[[1]](#footnote-1) and were probably the first to adopt the nuclear family structure. They had instilled in the next generation a desire for global excellence and a drive to travel overseas to pursue their ambitions. Very few, however, had planned for their old age. With their children settled in other cities and countries, all they had to look forward to was their children’s visits. At the same time, their children had limited time to pay social visits to their friends or family and spend quality time with them. Gupta realized that these seniors were struggling to find the right engagement in life. Their social circles had reduced over time, and they tended to move into isolation gradually. He could empathize with their situation—when he was working for the multinational corporation, although he stayed at home with his parents, between working and spending time with his child and wife he barely had adequate time to spend with them.

Although his idea of taking care of the elderly had conceptualized in 2007–08 and he had started planning financially for it, Gupta had no business plan. It took him almost two years to come up with a value proposition. The data points showed him that Kolkata and Chennai were the two cities that had faced the largest exodus, and were where the geriatric proportion of the population was high. He zeroed in on Kolkata for his initiative. Gupta explained:

The choice of city for me was based on constraints. I had stayed all my life in Kolkata, [and] my parents were in Kolkata. There was a need for me to find a commercially viable business opportunity in that social context. Also I did not want to do anything that would take up all my time. I wanted to experiment with other opportunities too. Both urban and rural angles were explored.

Having consolidated his personal finances, in April 2015 Gupta took the leap and quit his job. He set up his dream project, Care Unlimited, with the vision to “change the experience of old age through active aging and meaningful engagement.”

The challenge thereafter was to reach out to the targeted client segment—the children of elderly people who had settled away from their parents. His friends who had settled abroad had seconded his idea of Care Unlimited, and they spread word of it in social gatherings. He reached out to more acquaintances who had settled abroad through personalized emails and phone calls. His initial target was to build a base with 25–30 clients. He decided that it would be a low-investment business. He had saved enough, but he did not want to risk his savings. Also, he was not prepared to take on unnecessary exposure. As he said, “I did not plan having deep pockets.”

GERIATRIC CARE IN the INDIAn MARKET AND COMPETITION

With a decrease in birth rates and an increase in life expectancy, India’s population was aging fast. In 2017, there were 112 million elderly people with a number of physical, economic, psychosocial, and spiritual problems.[[2]](#footnote-2) It was expected that the number of seniors in the country would triple by 2050 and would reach 19 per cent of the total population.[[3]](#footnote-3) The proportion of elderly people within the total population varied across regions and states (see Exhibit 1).[[4]](#footnote-4)

The rapid pace of change in Indian society leading to the breaking up of joint families and the emergence of nuclear families was exposing elderly people to emotional, physical, and financial insecurity.[[5]](#footnote-5) In Indian culture, aging parents traditionally lived with their children; because of time constraints, the younger generation was faced with the dilemma of how to take care of their parents. For many, the idea of putting elderly parents in an assisted-living facility was similar to the concept of deserting them or “dumping” them into the hands of others.[[6]](#footnote-6) While a majority of elderly people lived with their children, about one-fifth lived either alone or with their spouses.[[7]](#footnote-7) Care of the elderly was rapidly emerging as a critical public and private concern.[[8]](#footnote-8) There was a need for geriatric care professionals, and there were not many institutions in the country offering courses on geriatric care where participants could be trained to be mindful and sensitive to the needs of their elders.[[9]](#footnote-9)

In urban areas, the concept of retirement resorts that provided constant assisted-living facilities was growing in poularity. The arrangement involved elderly people staying permanently for monthly charges ranging from US$62[[10]](#footnote-10) to $462, with deposits running into thousands of dollars. This arrangement suited elders who wanted to give space to their children and spend their old age without having to bother with the day-to-day tensions of managing a household. Many older citizens, however, preferred to stay at home as long as possible. Companies such as Portea Medical and ElderAid Wellness Pvt. Ltd. provided different packages of care, from nursing to bill payment, based on the level of support required. There were also organizations like Eldercare India, which was started by retired personnel from the Indian Armed Forces, doctors, and social work specialists to provide home-care services to assist elderly people with health, legal issues, finances, and property.[[11]](#footnote-11) Most of the set-ups combined medical with non-medical personal care.[[12]](#footnote-12) For those who could not afford such services, non-governmental organizations like HelpAge India, Agewell Foundation, and Dignity Foundation provided support but depended on charitable funding to sustain the levels of care.[[13]](#footnote-13)

As luck would have it, before Gupta formalized the idea he had conceived, two big companies—TriBeCa Care Private Limited (TriBeCa) and Deep Probeen Porisheba—began offering similar services in the city. In addition to running elder-care facilities, both organizations provided other health care services, including physiotherapy, psychological counselling, and psychotherapy.[[14]](#footnote-14) They entered the market with a big bang, advertising their services on radio channels and banners. Gupta remarked, “Instead of seeing their entry as a challenge, I took it as an opportunity. I decided to piggyback on them. I did not change my strategy.”

VALUE PROPOSITION

Gupta proposed to offer the services of a “surrogate son or daughter” who was not under any contractual obligation. He knew that, for elderly people, simple chores could become a cause of anxiety. Purchasing groceries, going to the bank, picking up gifts, making bill payments, and managing finances could be a big drain on their health and energy. Nevertheless, he wanted to leverage the emotional quotient rather than be recognized as a means for running errands. As he explained, “Running errands is not the primary offering. I hope to reach their hearts by reducing the headache of mundane tasks.” The proposition was that his set-up would care for seniors much as their children would care for them. Any structured format of services would not serve the purpose.

The dilemma before Gupta was how to offer an unstructured level of service under a commercial structure. He knew that if he executed a relationship-based model of offering services, it would also serve as a differentiator for his set-up.

THE CUSTOMERs

While the majority of the clients of Care Unlimited were sons and daughters, the actual customers were the elderly parents of the clients. In a quest to engage the seniors based on their age, mobility level, and mental ability, Gupta held interactive sessions with seniors of different ages. These interactions prompted him to divide them into four groups: those planning for retirement, in the age group 55–60; those just retired, in the age group 60–65; those enjoying retirement, in the age group 65–75; and super seniors, in the age group 75 and older. Gupta’s focus was on the seniors in the last two groups.

Gupta’s client base grew at a very slow pace in the initial years, when he had just three clients, but it steadily increased in subsequent years. According to Gupta, “Numbers grew at a faster rate when friends saw that I was persistent and was still continuing with the set-up. Most of my clients have come through referrals.”

Clients were satisfied with the services provided by Gupta and his team. As one of the clients said, “They provide personalized care, so true to their name. The employees are respectful, kind and genuine.” Another client added, “I will strongly recommend the service to anyone who wants their parents to be taken care of with love and affection, while they are away.”

SERVICES OFFERED

Gupta decided that he would offer personalized services to seniors, so the way services were provided was not very structured. It was very different from the approach of competitors, who most of the time defined every service up front. He felt his approach would allow him to enter the families of the elderly customers. He elaborated: “One of my elderly customers expressed an interest in painting; I got an artist aligned to him. . . . I aligned a music teacher with another customer who was interested in learning music.”

After much deliberation, he came up with three types of services that would serve the different needs of elderly customers (see Exhibit 2). He remarked, “We have experienced the [maximum benefit] from our ‘Build the Relationship’ service” (see Exhibit 3).

Emergency services and maid services were two areas that were not covered under the range of services offered by Gupta. He explained:

I am operating with a very small team. If I provide emergency services to the 20–30 customers that I have, I will have to make provisions for one or two emergency visits per month. I cannot afford a 24/7 set-up or an ambulance. I do not have a doctor or nurse on the team. It is not cost viable and, apart from being physically present, I will not be adding value.

He believed that proper planning would help overcome this shortcoming.

He encouraged all of his customers to avail of his emergency protocol, which listed all steps to be followed in case of an emergency. He encouraged them to list the names and numbers of family members, preferred hospitals, family physician, ambulances, local contact number, his contact numbers, and the numbers of his team, and keep these in an accessible place—for instance, behind the door of the bedroom. He advised customers to include insurance papers and a copy of prescriptions from their last visit to the doctor. Gupta noted that if “the above protocol is followed, emergency services from my set-up would not add any value.”

Gupta explained further: “I had entered into partnerships for imparting emergency services, but the quality was not satisfactory. I could not continue. The small size of my set-up also limits the partnerships that I can enter into it. Others do not see value in it.”

PRICING

Service charges were based on the number of visits and not on the type of service provided, as Gupta perceived that the type of services required would be driven by the situation. He also felt he was playing with factors that could not be quantified until experienced. There were no charges attached for extra visits. Gupta explained: “It will lead to a lot of calculations and variations. My clients would validate the number of extra visits with their parents. Those calculations would lead to controversies, and be counter-productive to developing a relationship.” He was convinced that if elderly customers knew they could call for help and would not be charged for doing so, he would get an easy opening into their hearts. Calls would not originate if the elderly feared extra charges for every visit. Gupta knew the need was to design a softer aspect, which otherwise would have been quantified.

To start with, Gupta visited seniors to assess their needs and decide on the number of visits required. He and his clients would then agree on the service model. In any month, if he saw the number of visits exceeding the number budgeted, his approach was to absorb three to four extra visits. He then followed up with a discussion with the client to explore if there was a possibility of reducing the number of visits. If the client was not in favour of reducing the number of visits, Gupta would then explore the possibility of moving to the next service plan.

Neither Gupta nor his team charged for visits to the hospital, where elderly customers would be admitted in case of emergency. Gupta knew they often had no relatives nearby to visit them.

Gupta had intentionally kept the charges significantly lower than the market rate (see Exhibits 2 and 4). The clients were, however, told up front that they could expect a hike of 20 per cent every year.

INITIAL CHALLENGES

Based on his research and feedback from friends, Gupta had expected the journey to be easy, but he was proved wrong. He had imagined that high-net-worth clients, due to a lack of social support, would catch on to the idea. As he explained, “My customers might be having a lot of cash, but their price-point is still fixed . . . when they retired. They compare the cost of services with the value of money when they retired. They do not want to spend on themselves. Their social philosophy is, sacrifice is the means to the end.”

The service concept offered by Gupta was unheard of in a country like India, where it was the duty and obligation of a son or daughter to take care of elderly parents. The small scale of his business constrained him from doing any advertising, and he knew that the nature of the business meant there would not be any returns on an investment in advertising. He reached out to people on LinkedIn and through word of mouth. He realized that no one saw value in his offerings until they experienced it.

GUPTA’S TEAM

There were eight people on Gupta’s team: four full-time employees and four part-time employees. They were selected based on certain criteria: applicants had to be university graduates, English speaking, computer literate, and comfortable working on Microsoft Windows and WhatsApp Messenger. They should be able to speak and send emails in English and should like the job of taking care of seniors. They had to be older than 35, and they should have spent time caring for elderly people in their families. Gupta explained, “I am offering [a] surrogate son or daughter to my customers, not grandchildren. My employees should be of an age that my customers could relate to that of their son or daughter.” It was important for the applicants to appreciate how the elderly customers thought and what they were sensitive towards. Gupta had recruited his team mostly through references. The small scale of his business gave him the flexibility to be selective.

Most of his employees started as part-time employees and were gradually promoted to full time if they exhibited passion for their job and were proactive in taking up more clients. This approach also helped Gupta to keep a check on his costs. His selection criteria and the choice to work part time provided opportunities to a number of mothers who wanted to return to work after caring for their children. Gupta noted that “getting a part-time male employee is a challenge.” He had a counsellor on board who was part of the team and who was paid on the basis of the number of visits made. He knew that he could leverage the counsellor to groom his employees, too.

Attrition was very low; most employees stayed loyal to Care Unlimited. They were passionate about what they were doing and were satisfied, as the pay level was higher than the city standard of $184.80 per month. Gupta paid $231.00 per month to full-time employees and $77.00–$123.20 to part-time employees. The manager drew a monthly salary of $385.00.

Hours were flexible and based on employees’ personal needs. Employees were entitled to leaves, on the condition that they informed someone in advance. Gupta treated them as respected individuals—a practice that was not too evident in the small-scale sector. Their suggestions were adhered to, and they had the freedom to plan events for the customers they were responsible for. There were six to eight group events with customers per year, and birthdays were celebrated, leading to a feeling of teamwork and coordination.

PUTTING PROCESSES IN ORDER

Gupta handled the client on-boarding process himself; this involved sending the introductory mail, filling out forms, and receiving the registration cheque. At first, no payment was required at the time of registration, but Gupta soon realized that his clients would shy away from availing of the services at the time of commitment. An agreement defining the terms of service and liability had to be signed by his clients. He made an exception in the case of clients who lived abroad. These clients would initiate the service by sending a formal email and could complete all of the paperwork at the time of visiting their parents. Gupta would make a note of customers’ medical history and areas of interest in a pre-formatted document.

During the first meeting, under Gupta’s supervision, the primary team member who would be interfacing with the customer was introduced. Extra coverage was provided for the first 12 visits. This was critical to building a relationship. Thereafter, the frequency of visits was targeted according to the plan chosen by the client.

After the relationship had stabilized, a back-up team member was introduced, and both the primary and the back-up team member would be part of the visit. Gupta explained: “It was important for the back-up to be introduced without a crisis situation, wherein his entry looks very natural.” The back-up would visit the customer once a month.

Groups were created using the WhatsApp messenger service, which enabled online conversations with more than two people. Each group included Gupta, the manager, the primary team member, the back-up team member, and the children of the customer. Every visit was followed by an update to the group within the next 24 hours. In case of an emergency, an update was provided within five to six hours. Lastly, a monthly update was given, summarizing the month.

Days were fixed for the visits, although these could be rescheduled with advance notice. Every regular visit was followed by an ad-hoc visit. Gupta explained: “In case a regular visit has taken up three to four hours of a team member, one could adjust against an ad-hoc visit. Taking the customer out for a movie usually involves three to four hours, door-to-door.”

All visits were logged in the name of the client, the name of the customer, the person from the team visiting, and the time spent per visit. At the end of the month, data were analyzed to draw a pattern of the frequency of visits, their duration, and the services rendered.

All payments by clients from abroad were done through National Electronics Funds Transfer System (NEFT) into Gupta’s account, usually by the 5th or 6th of the month. Customers in India preferred to pay by personal cheque. Employees were given a travel allowance, and they were expected to manage within that allowance. The manager was reimbursed for telephone calls, and employees were reimbursed for expenses incurred during visits.

DECISIONS AHEAD

Since the conceptualization of Care Unlimited, Gupta had been very clear that he aimed to offer personalized services to his customers. However, continuing to do so might limit his capacity to have a scalable model. Also, he had never aspired to grow the business exponentially, since that would rob him of the opportunity to innovate. Was this the right approach? He was convinced that advertising would not work for this set-up. Gupta knew that elderly people were skeptical and concerned about fraud. Building trust was the only way to enter their lives and gain their confidence. He needed clients who would refer his services, and friends who would vouch for him to build trust and increase his client base.

His “engagement in life” offering differentiated him from other players, but there were very few takers. Gupta had published his idea in a couple of publications through the Indian Medical Association. It was very difficult to convince seniors that they would save on their medical bills if they spent on their well-being and felt happy with what they were doing. Prospective clients were more interested in availing of the services that could be quantified. What approach should he take to meet the expectations of the majority of potential customers?

Building relationships with customers also required a team of individuals who were not only experts in caring for seniors but also sensitive towards their needs. Attracting good people was a challenge, and he needed human resources in order to scale up the business. He tracked revenue and expenses on a monthly basis—his business had never been in the negative, but it was providing him with only the bare minimum in pocket money (see Exhibit 5). Would he be able to sustain the business at this rate? Did he need to be more aggressive with respect to his strategy? Should he explore alternative sources of earning revenue? Did he need to diversify his business? If so, what were the opportunities for diversification?

EXHIBIT 1: PERCENTAGE OF POPULATION over age 60 IN DIFFERENT indian STATES

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| --- | --- |
| **State** | **% of Population**  **Over Age 60** |
| Assam | 6.5 |
| Delhi | 6.5 |
| Jharkhand | 7.1 |
| Madhya Pradesh | 7.1 |
| Uttar Pradesh | 7.1 |
| Bihar | 7.2 |
| West Bengal | 8.5 |
| Maharashtra | 9.0 |
| Andhra Pradesh | 9.1 |
| Karnataka | 9.2 |
| Punjab | 9.7 |
| Himachal Pradesh | 10.3 |
| Tamil Nadu | 11.2 |
| Kerala | 12.3 |

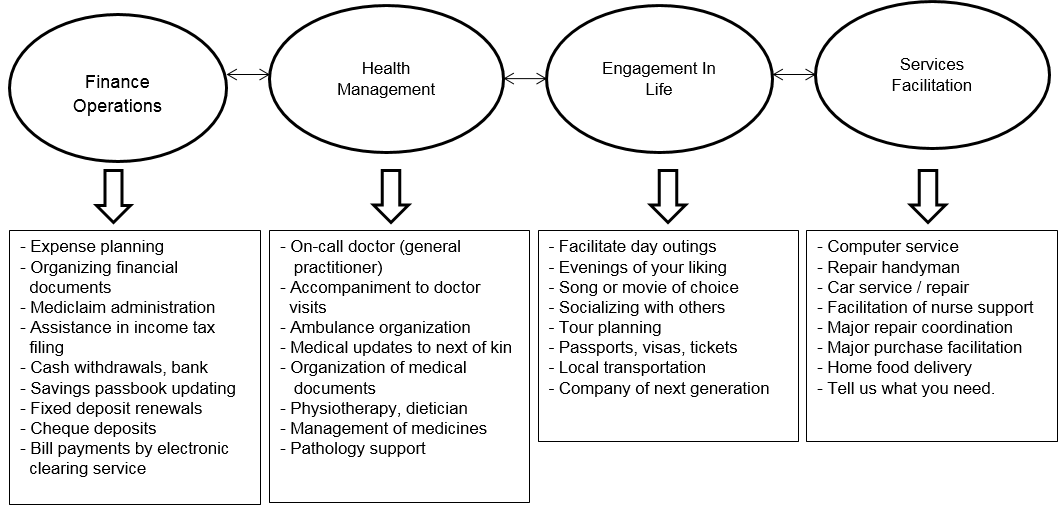
Source: Adapted from United Nations Population Fund, *Caring for Our Elders: Early Responses, India Aging Report – 2017*, accessed May 1, 2018, https://india.unfpa.org/sites/default/files/pub-pdf/India%20Ageing%20Report%20-%202017%20%28Final%20Version%29.pdf.

EXHIBIT 2: SERVICE CHARGE STRUCTURE OF CARE UNLIMITED (In US$)

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| --- | --- | --- | --- |
|  | **Details** | **One-Time Registration Fee** | **Rates** |
| Build a relationship | This service aimed to help the elderly with their day-to-day responsibilities and provided assistance to enjoy life. The personalized support for the elderly living alone looked at building long-term relationships. | $61.60 | * Standard (two visits a week): $123.20 per month (25% surcharge for couple) * Regular (one visit a week): $92.40 per month (25% surcharge for couple) |
| Have a friend | This service involved a caregiver with a background in geriatrics who would visit the elderly person and spend two hours with him or her. The caregiver would advise seniors in areas where they may be facing challenges.  Visits were as per a pre-defined schedule made a week in advance.  Generally, outdoor activities or financial management were not covered under the service. | $30.80 | * $11.55 per session * Those who paid in advance for one month (4 sessions) received a discount of $3.08 (7%) * Those who paid in advance for one month (8 sessions) received a discount of $9.24 (10%) * Those who paid in advance for two months (16 sessions) received a discount of $24.64 (13%) |
| Get an assistant | In this service, one of the support team members would accompany seniors for any outdoor activity. The scope of service would be to be physically present and provide physical assistance to the seniors so that they could confidently execute the outdoor activities on their own.  Visits were as per a pre-defined schedule made a week in advance. | $15.40 | * $7.70 for each three-hour assignment * Extra time needed would be charged based on blocks of three hours each |

Source: Created by the case author based on company documents.

EXHIBIT 3: SERVICE COVERAGE IN BUILDing A RELATIONSHIP



Source: Company documents.

EXHIBIT 4: RATES OF OTHER PLAYERS (in US$)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Eldercare** | | **TriBeCa Care** | | **Deep Probeen Porisheba** |
| Allocation of care/buddy manager  (Weekly home visits) | 3 months: $78.52 (+ applicable taxes) | Aador Package (High ultimate comprehensive care) | Annual registration: $109.34 (inclusive of service tax)  Monthly charges: $109.34 (inclusive of service tax) | Medical services (per session): $10.01  Non-medical services (per session):  $8.47  Physiotherapy (per session): $10.01  Psychological counselling (per session):  from $15.40  General physician (per session): $21.56  Specialist visit (per session): from $30.80 |
| Allocation of care/buddy manager  (Weekly home visits) | 6 months: $153.98 (+ applicable taxes) | Jotno Package  (For elders who love independence)  Companionship visit by care manager four times a month | Annual registration: $78.54  Monthly charges: $49.28 (inclusive of service tax) |
| Allocation of care/buddy manager  (Weekly home visits) | 12 months: $292.58 (+ applicable taxes) | Suraksha Package  (Assistance now and then)  Companionship visit by care manager four times a month | Annual registration: $23.70 Monthly charges: $23.10 |

Source: Compiled by the case author based on data from “Membership Plans,” Eldercare, accessed May 1, 2018, <https://eldercare.co.in/pricing.php>; “Aador Package,” TriBeCa Care, accessed May 1, 2018, <https://www.tribecacare.com/packages/aador-package>; “Jutno Package,” TriBeCa Care, accessed May 1, 2018, <https://www.tribecacare.com/packages/jotno-package>; “Suraksha Package,” TriBeCa Care, accessed May 1, 2018, <https://www.tribecacare.com/packages/suraksha-package>; “Membership Packages,” DPP Elder Care, accessed May 1, 2018, <http://dppindia.com/membership-packages/>.

EXHIBIT 5: Care Unlimited FINANCIALS (in us$)

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| --- | --- | --- | --- |
| **Particulars** | **2015–16** | **2016–17** | **2017–18** |
| **INCOME**  Service Charges and Sales  Other Receipts  Closing Stock | 8,776.18  292.60  166.26 | 15,646.40  0.00  166.26 | 22,339.24  0.00  166.26 |
| **EXPENSES**  Purchases  Salary  Rent  Telephone  Repair and Maintenance  Conveyance  Bank Charges  General Charges  Office Expenses  Depreciation  Service Charge and Honorarium  Taxes  Internet | 312.80  5,470.08  693.00  192.30  150.61  167.94  5.87  328.17  0.00  311.76  0.00  0.00  0.00 | 166.26  7,758.52  924.00  70.61  166.43  575.25  3.39  181.77  419.44  403.16  500.50  41.58  168.12 | 166.26  11,822.58  924.00  106.40  508.20  308.00  3.39  181.77  704.26  403.16  0.00  41.58  0.00 |
| **NET PROFITS** | 1,602.51 | 4,433.94 | 7,335.91 |

Note: In the initial year, the set-up stocked elder enablement gadgets like grab bars, pill boxes, and so on.

Source: Company documents.

1. A joint family was a family unit that included two or more generations of related individuals, either from the paternal or maternal side, residing together. [↑](#footnote-ref-1)
2. Prabha Adhikari. “Geriatic Healthcare in India: Unmet Needs and the Way Forward,” *Archives of Medical and Health Sciences* 5, no. 1 (2017): 112. [↑](#footnote-ref-2)
3. Antara Bhargava, “Elderly Care: Why India is One of the Worst Countries to Grow Old In,” DNA, October 26, 2015, accessed May 1, 2018, www.dnaindia.com/analysis/standpoint-elderly-care-why-india-is-one-of-the-worst-countries-to-grow-old-in-2138686; United Nations Population Fund, *Caring for Our Elders: Early Responses, India Ageing Report – 2017*, accessed May 1, 2018, https://india.unfpa.org/sites/default/files/pub-pdf/India%20Ageing%20Report%20-%202017%20%28Final%20Version%29.pdf. [↑](#footnote-ref-3)
4. United Nations Population Fund, op. cit. [↑](#footnote-ref-4)
5. Abhay B. Mane, “Elderly Care in India: Way Forward,” *Journal of Gerontology and Geriatric Research* 5, no. 5 (2016): 339. [↑](#footnote-ref-5)
6. Reenita Malhotra Hora, “The Cost of Caring for the Elderly,” *The Hindu*, January 1, 2016, accessed May 1, 2018 www.thehindu.com/news/cities/mumbai/business/The-cost-of-caring-for-the-elderly/article13974115.ece. [↑](#footnote-ref-6)
7. United Nations Population Fund, op. cit. [↑](#footnote-ref-7)
8. Abhay B. Mane, op. cit. [↑](#footnote-ref-8)
9. Swati Goel Sharma, “Geriatric Care in India is Still in Its Infancy,” *Hindustan Times*, August 20, 2015, accessed May 1, 2018, https://www.hindustantimes.com/health-and-fitness/geriatric-care-in-india-still-in-its-infancy/story-SsPNcQFSmgPrWwVv8q11MP .html. [↑](#footnote-ref-9)
10. All currency amounts are in U.S. dollars unless otherwise specified. [↑](#footnote-ref-10)
11. “The Concept,” Eldercare, accessed May 1, 2018, https://eldercare.co.in/theconcept.php. [↑](#footnote-ref-11)
12. “Services,” Senior Care India, accessed May 1, 2018, www.seniorcare.in/services.htm. [↑](#footnote-ref-12)
13. Antara Bhargava, op. cit. [↑](#footnote-ref-13)
14. “Our Services,” TriBeCa Care accessed May 1, 2018, <https://www.tribecacare.com/>; “Membership Packages,” DPP Elder Care, accessed May 1, 2018, http://dppindia.com/membership-packages/. [↑](#footnote-ref-14)