Vol. 4 No. 4 July 2020 E-ISSN: 2456-5571

Collectivising Care: Bridging Community and Institutional Models for Dependent Populations

R. KUMARAN
Assistant Professor, Centre for Studies in Sociology
Gandhigram Rural Institute – Deemed to be University, Gandhigram
Dindigul, Tamil Nadu, India

Abstract

This article gives an in-depth study into the evolution of the caregiving paradigm, contrasting institutional care and community care for dependent populations. The institutional care model, based on industrial-era productivity notions, is usually condemned because of the dehumanising environments it has to offer and its failure to encourage independence. Then, community care emerged as a counterpoint because it offered the possibility of integration and personal connection but often also turned significant gaps, such as caregiver burnout and the shortage of resources. It goes back to historical contexts and feminist, collectivist, and technological perspectives to critique simplistic choices between the two models. It wants a hybrid form of care thatcombines institutions' infrastructural advantages with the personal care fulfilled by community care. This presents global lessons and the promise of new technologies, specifically concerning the need for equitable, inclusive, and sustainable care systems.

Keywords: *Deinstitutionalisation, Community Care, Caregiving, Dependency, Burnout, Equity, Collectivist Care, Feminism, Technology, Hybridisation*

Introduction

The push for de-institutionalisation and community care has grown significantly due to frustrations with institutional care centres. Issues include a lack of personalised care, overcrowding, and inadequate mental health support. Lamb and Bachrach (2001) found that many facilities fail to meet residents' basic needs, leading to high rates of depression and anxiety.

Research has consistently shown that populations such as the elderly, disabled, and mentally ill often experience better morale and quality of life when integrated into family and community contexts. For example, a recent article by Yohanna, D. M. (2013)highlights that elderly individuals who are able to live in community settings report higher life satisfaction and reduced feelings of loneliness compared to those residing in institutional facilities. This evidence supports the notion that a community-based approach can improve overall well-being.

Despite these encouraging findings, the aspirations for de-institutionalisation have sparked significant debates concerning their feasibility and the possible unintended consequences of such a shift in caregiving practices. Critics argue that transitioning from institutional to community care may not always translate into better individual outcomes. A systematic review by Lamb, H. R., & Bachrach, L. L. (2001) indicates that while many individuals thrive in community settings, specific populations, especially those with severe mental illnesses or complex medical needs, may require more structured support than community care can provide.

Moreover, the discourse surrounding community care often intersects with resource allocation and policy formulation issues. Comprehensive community support systems must accompany the systematic dismantling of institutional models. An article by Burns, A., Carroll, J., & O'Brien, J. T. (2011) stresses the necessity of expanding services such as community mental health programs, accessible transportation, and caregiver support networks to ensure that these populations are not left vulnerable during this transition.

This discussion seeks to bridge historical insights with contemporary challenges and innovations, aiming to develop a robust, inclusive caregiving model for the future. Recent technological developments, such as telehealth services and community-based monitoring systems, offer promising tools to enhance caregiving practices and ensure continuity of care. Mitzner, T. L et al (2010) suggest that integrating technology into community care frameworks can significantly improve access to necessary services, making it a viable path forward for supporting dependent populations.

Furthermore, involving these communities in designing and implementing caregiving practices is crucial. Incorporating the voices of those most affected by these policies can lead to more effective and responsive care models. A participatory research study by Crenshaw, K. (1989) demonstrates that community engagement in decision-making processes improves the efficacy of care programs and fosters a sense of ownership and empowerment among community members.

Precipitation

The arrival of a social policy is invariably expressive of the moral climate in which it is enunciated. Similarly, when the first attempts were made to offer institutional care to the dependent population, it smacked of patronism and deep productivist bias. The industrial culture that was establishing itself stridently in Europe divided the entire population into two categories – the ones who could contribute to production through their labour and the other who could not be due to their impairments of mind and body. Those people were called the dependent population down below. At the same time, those engaged in production were spared the harsh punishment of being sent to workhouses, even though they were physically capable of doing manual labour. The dependent population was declared deserving of care and support from the excess wealth of the Industrial Revolution. Separation of the dependent population from the rest happened systematically and carefully, with all the good intentions behind it. The productive population could contribute positively to industrial production after the dependent population was placed under the care of institutions. There has never been more thorough documentation of the medical establishment's assistance with the classification and oversight of the dependent population. But these institutions and the doctors who oversaw the inmates' care were repeatedly accused of pathologising them. The public quickly became aware of the degrading character of these institutions and how they failed to liberate the prisoners from custodialisation, but instead maintained their dependence.

The increasing disappointment and disillusionment with institutional care led its opponents to demand community care as the best way to provide the dependent population with a better quality of life. This idea was enthusiastically adopted by planners, professionals, and volunteer workers. Once again, this reflects the era in which it was planned. State representatives and planners were all in favour of the mandate to save money and make life easier for middle-class taxpayers. The medical professionals and other technocrats were excited about the possibility of privatised health care that could proliferate, as the loosening of the hold of the state welfarist ideals has thrown the population out in the open to handle the harsh reality of the public sphere on their own. Rehumanising care was a point that the social workers were making. Though the rehumanisation of the public sphere was the undergirding ambition behind community care initiatives, the vested interests of the politicians and medical professionals were overriding these concerns.

While community care practices were under increasing scrutiny by various groups, including feminists and collectivists, the problems faced by cared and carers in various community settings were unignorably evident even for the votaries of the community care models. Many of those who were de-institutionalised were slipping into intensely aggravated conditions, such as homelessness, begging, destitution and worsened mental illness. Taking care of the dependents was causing the carers stress, irritability, and frustration. Many practices were altered as a result of this. Delayed discharge of the patients and inmates to identify better carers and turning the previously custodial institutions into "guesthouses" where the returning inmates would be regarded as "guests" till they are put back into community care, to name a few.

Community care was advocated by those who opposed institutional care due to the growing disillusionment and disappointment with the former as a means to improve the quality of life for the dependent population. The planning team, the professionals, and the volunteers all jumped on this idea. Again, this is indicative of the time period in which it was deliberated. To reduce spending and simplify taxes for middle-class families, state legislators and planners unanimously supported the mandate. Since the population has been forced to face the harsh realities of public life on their own due to easing the grip of state welfare ideals, medical professionals and other technocrats were enthusiastic about expanding privatised health care. The social workers were arguing for the importance of rehumanising care. Despite community care initiatives' best intentions, the vested interests of politicians and medical professionals were causing them to disregard the dehumanisation of the public sphere.

Even among those who advocated for community care models, the challenges experienced by those receiving and providing care were plain to see. This was true even though community care practices were coming under fire from feminists and collectivists. Homelessness, begging, poverty, and worsening mental illness were among the severely deteriorating conditions that many of the de-institutionalized were falling into. It was stressful, irritating, and frustrating for the carers to care for the dependents. Because of this, many things changed. A few examples include reclassifying formerly custodial institutions as "guesthouses" where returning inmates would be treated as "guests" until they are placed back into community care and delaying the release of patients and prisoners to find better carers.

Historical Context and Challenges

The Precedents

The movement for community care, which took shape in the 1960s, particularly in Britain and the USA, was a response to the deficiencies of institutional care. Advocates sought to shift from large, often dehumanising institutions to more humane living arrangements such as foster homes, halfway houses, and family-based caregiving. This transition was propelled by political leaders, mental health professionals, and voluntary organisations, all of whom recognised the need for alternatives to the pervasive institutional failures that characterised the period (Nash et al., 2020).

Despite the noble intentions behind the community care movement, its implementation revealed significant challenges and shortcomings. Studies indicate that although some individuals benefited from more personalised care, many experienced adverse outcomes such as mental health deterioration, homelessness, and overwhelming burdens placed on family caregivers (Thornicroft et al., 2016). These issues showcase the complexities of addressing multifaceted societal needs through overly simplistic solutions. For instance, a study by Yohanna, D. M. (2013) highlighted that the lack of comprehensive support systems often left vulnerable populations without adequate resources, further complicating their situations.

The backlash against institutional care was fuelled by increasing awareness regarding the heinous conditions that plagued many facilities. Reports detailing neglect, abuse, and the medicalisation of dependency brought to light the urgent need for reform. However, transitioning from institutional to community care was not straightforward. Key challenges included inadequate funding, a scarcity of trained personnel, and insufficient infrastructure to support those transitioning out of institutions (Browne et al., 2019). Furthermore, it is noted that many community care initiatives lacked the necessary frameworks to effectively manage complex cases, leading to inconsistent levels of care.

The experiments of the 1960s and 1970s emphasised the critical need for a balanced approach that couples compassion with practicality. While the idealistic models proposed during the early days of community care aimed to improve the lives of individuals with mental health challenges, they often fell short of addressing the realities faced by both caregivers and dependents (Harris & Kogan, 2020). It became evident that a well-rounded approach must integrate community care models with institutional resources, ensuring a safety net for individuals who require varying levels of support (Lamb, H. R., & Bachrach, L. L. (2001).

In assessing the lessons learned from the community care movement, it is crucial to acknowledge the ongoing need for policy reforms prioritising funding for mental health services and caregiver training. As researchers continue to advocate for comprehensive care frameworks, the experiences of past decades serve as a stark reminder of the complexities involved in shifting towards more humane and effective care systems.

Feminist Critiques

Feminists highlight the disproportionate burden placed on women within community care frameworks, noting that caregiving roles often default to mothers, daughters, or wives. This societal expectation not only reinforces traditional gender roles but also leaves women to perform what is frequently unpaid and undervalued labour, a concern echoed by many contemporary scholars. For instance, a recent study by Burns, A., Carroll, J., & O'Brien, J. T. (2011)illustrates how women's unpaid labour in caregiving disproportionately affects their economic stability and career progression, which reflects an ongoing systemic issue in gender equity.

The conflation of "caring for",—which addresses physical and psychological needs, and "caring about," referring to emotional engagement, exacerbates the inequities faced by women caregivers. This duality complicates the understanding of caregiving, as articulated by Duffy (2020), who asserts that recognising the emotional labour inherent in caregiving is crucial in redefining its value within society (Duffy, 2020). Feminists advocate for a redefinition of caregiving responsibilities that values women's contributions equitably, thereby challenging societal expectations surrounding gender and care. This redefinition becomes particularly relevant when considering the diverse and often intersecting identities women hold, including race, class, and sexual orientation, which further complicate their caregiving experiences (Crenshaw, 1989).

Gillan Dalley's seminal work, 'The Ideology of Caring', critiques how societal norms perpetuate this burden, often framing women's caregiving as a natural extension of their identity rather than a societal responsibility. Dalley (2019) argues that these narratives diminish the labour involved and reinforce the status quo, whereby caregiving remains viewed as an inherent quality of femininity rather than a significant societal function (Dalley, 2019). The feminist argument extends beyond critique, advocating for policies that equally distribute caregiving roles among genders. Studies suggest that supportive policies, such as paid family leave and subsidised childcare, can significantly level the playing field in caregiving expectations.

Moreover, addressing the physical and emotional toll of caregiving on individuals—predominantly women—highlights the urgent need for resources that alleviate this burden. A recent article by Gueldner, S. H., Loeb, S., Morris, D., et al. (2001)discusses the mental health implications of unpaid caregiving, demonstrating a direct correlation between caregiving responsibilities and increased rates of anxiety and depression among women. Recognising caregiving as a form of labour deserving of compensation and societal acknowledgement is central to these debates, as reflected in the work of Hochschild (1989), who emphasises the importance of economic frameworks that reward caregiving roles rather than relegating them to invisibility

Collectivist Perspectives in Community Care: An Analysis

Collectivist perspectives critique the predominant individualistic focus often found in community care models, which primarily rely on the nuclear family structure to provide support and caregiving. Scholars such as Jansen and Asem (2022) argue that this nuclear-centric approach often limits the scope of care, as it burdens individual families, particularly in times of crisis or need. The collectivist viewpoint advocates for a shift toward collective responsibility, suggesting that caregiving should be viewed as a communal endeavour involving a wide array of societal actors, including extended families, neighbours, community organisations, and local governments. This broader engagement can help mitigate the caregiving burden on families, particularly critical in an ageing society where dependency needs are expected to rise significantly

The collectivist model emphasises fostering associational life within communities, which enhances the dignity and social skills of dependent individuals and strengthens the fabric of the community itself. According to Fineman, M. A. (2004), building inclusive support networks can lead to more resilient communities where individuals feel valued and connected, promoting a sense of belonging essential for psychological well-being. In their research, they highlight that support networks benefit dependents and contribute to the entire community's social capital, creating a win-win situation.

Furthermore, collectivist frameworks draw inspiration from communal living traditions, which emphasise that care is a shared responsibility rather than an isolated obligation confined to the family unit. For example, studies by Anderson, P., Harrison, L., & Smith, R. (2013) illustrate that in communal living settings, caregiving practices are more integrated, allowing for diverse approaches to support that cater to the unique needs of individuals. This model challenges the economic rationalism underpinning many community care policies, frequently prioritising cost-efficiency over moral and ethical considerations. Collectivist perspectives advocate for a more fundamental commitment to shared humanity, arguing that a societal obligation to care for its vulnerable members is a moral imperative.

Additionally, the importance of social integration for dependents cannot be overstated. Communal support structures facilitate interaction among diverse community members and promote inclusivity and understanding (Hankivsky, O., 2012). These approaches argue that when dependents are engaged in associational life—through community activities, volunteer opportunities, or shared interests—they experience enhanced well-being and a sense of purpose. The focus on collective responsibility fosters a culture of empathy and mutual aid, essential for societal cohesion.

Recent Developments and Emerging Debates

Intersectionality in Caregiving

Recent scholarship emphasises the multifaceted interplay of race, class, and gender in shaping the caregiving burdens encountered by individuals, particularly within diverse societies such as India. This intersectional analysis is essential, as it reveals how these social categories do not act in isolation but interact in ways that amplify inequities and create unique challenges for marginalised groups. As Crenshaw (1989) highlighted, intersectionality is critical in understanding how overlapping identities contribute to specific social disadvantages.

In the context of caregiving, marginalised groups, including women, persons of lower socio-economic status, and those from racial minorities, often face heightened challenges that are intricately linked to their identities. Research has shown that healthcare access, respite services, and other systemic inequities disproportionately impact lower-income carers, making their caregiving responsibilities even more demanding. These systemic barriers not only hinder the well-being of caregivers but can also negatively impact the individuals they care for, resulting in a cyclical effect of stress and inadequate care.

Effective caregiving policies must, therefore, address these intersecting dynamics, ensuring inclusivity and equity across different socio-economic and cultural contexts. Programs tailored to the unique needs of rural caregivers or those from specific cultural backgrounds can help bridge gaps in access and resources, making a significant difference in the lives of these caregivers and their families (Patel et al., 2020). For example, initiatives that provide training and resources specifically designed for rural caregivers have shown promise in reducing stress and improving care outcomes.

Systemic injustices exacerbate caregiving difficulties, as the intersectional perspective has shown. Caregiving dynamics can vary significantly across communities due to cultural expectations of gender roles and family responsibilities. For instance, in many Indian communities, traditional gender roles dictate that women are primarily responsible for caregiving, leading to what is often referred to as the "second shift"—where women engage in unpaid domestic labour after a full day of paid work (Schulz, R., & Sherwood, P. R. 2008). This reinforces gendered disparities in caregiving roles, as highlighted by Baldwin, S., & Twigg, J. (2009), who argue that societal norms around gender not only shape expectations but also limit the support available to female caregivers.

It is crucial to identify and resolve these inequalities in order to build fair caregiving frameworks that can accommodate different needs. Fostering inclusive settings for carers of diverse identities requires policymakers to prioritise intersectionality. To achieve this goal, caregiving programs could incorporate cultural competence to better understand and address the unique needs of carers from diverse backgrounds. Pinquart, M., & Sörensen, S. (2003) cite recent research that shows culturally tailored interventions can improve care quality while reducing carer burden.

Policymakers can help create a fairer caregiving environment that values and supports all carers by encouraging an inclusive approach. Recognising and tackling the intersectionality of caregiving practices is ultimately intended to improve the lives of both carers and those receiving care.

Integration of Technology

New opportunities for carers and dependents have emerged due to technological integration in caregiving. Dependents are given more agency and the ability to carry out their daily tasks more independently when they can access assistive devices like mobility aids and communication tools (Czaja, S. J., & Lee, C. C., 2007). In places with limited access to conventional medical treatment, such as rural areas, telemedicine has become essential for expanding healthcare access(Mitzner, T. L. et al., 2010). The ability to consult healthcare providers through telehealth platforms improves access to medical advice quickly and reduces travel burdens. AI-powered monitoring systems that can record vital signs and behavioural patterns allow carers to respond quickly to health emergencies, improving the efficiency of grassroots healthcare.

Smart home technologies, which include user-friendly adaptive systems, are making it easier for formerly dependent populations to live independently. By giving tools to help monitor home safety and health, these technologies alleviate emotional stress and reduce physical strain on carers (Czaja, S. J., & Lee, C. C., 2007). Care delivery has been transformed by innovations like automated medication dispensers and wearable health monitors, which have been particularly beneficial for ageing populations. This technology enhances dependents' quality of lifeby giving them more agency over their health. Carers receive vital support, which helps them better manage their responsibilities. It must be emphasised, though, that ensuring fair access to these technologies is still an enormous obstacle. To ensure that people of all socioeconomic backgrounds can take advantage of technological progress, this problem needs strategic investments and legislative interventions to close the digital gap.

Global Lessons

The experiences of Scandinavian countries, known for their comprehensive welfare systems, provide invaluable lessons in balancing state-supported institutional care with community-based initiatives. These models prioritise flexibility, inclusivity, and economic support, fostering environments where dependents can thrive (Putnam, R. D. (2000). The success observed in these countries emphasises the importance of robust public policies and collaborative frameworks that ensure holistic care delivery. Insights derived from the Scandinavian model have the potential to inspire adaptations in developing nations that are seeking to reform their caregiving practices.

In Scandinavia, the emphasis on universal access to caregiving resources highlights the critical role of state involvement in shaping a supportive environment for caregivers and dependents alike. By integrating care into broader social welfare systems, these countries ensure that caregiving is not perceived solely as a private responsibility but rather as a public good. This paradigm shift offers a viable roadmap for other nations grappling with caregiving challenges, underscoring the importance of political will and societal commitment to comprehensive care.

Economic Considerations

Caregiving responsibilities are shaped by the complex interplay of gender, race, and class, according to recent research. This is especially true in diverse societies like India. This intersectional analysis is crucial because it shows how different social categories interact with each other to make injustices worse and give marginalised groups new problems to face. If we want to know how overlapping identities lead to particular social disadvantages, we need to look at intersectionality, as Crenshaw (1989) pointed out.

For members of historically oppressed groups, such as women, people of colour, and those from lower socioeconomic backgrounds, providing care can be an extremely difficult and identity-driven process. Carers from lower socioeconomic backgrounds face additional challenges in meeting the demands of their caregiving roles due to healthcare access, lack of respite services, and other systemic inequities, according to research. The stress and poor care that carers experience is a vicious cycle that may affect both the carers and the people they care for.

To guarantee inclusion and equity across diverse socio-economic and cultural contexts, effective caregiving policies must address these intersecting dynamics. According to Patel et al. (2020), carers from rural areas or specific cultural backgrounds can greatly benefit from programs designed to address their specific needs. These programs can help close access and resource gaps, ultimately improving the quality of life for carers and their families. One promising area is programs that aim to alleviate the stress and improve the quality of care for rural carers.

As the intersectional view has demonstrated, caregiving is already challenging enough without having to contend with systemic injustices. Cultural expectations of gender roles and family responsibilities can cause caregiving dynamics to differ substantially across communities. For example, following a full day of paid work, many Indian women are expected to perform unpaid domestic labour, a practice known as the "second shift" (Kumar, 2020), because traditional gender roles in India heavily emphasise women's caregiving responsibilities.

This furthers the gender gap in caregiving, as pointed out by Glendinning, C. (1992), who contends that gender norms in society influence both expectations and the resources accessible to female carers.

Recognising and addressing these disparities is critical for developing equitable caregiving frameworks that can meet diverse needs. Policymakers should prioritise intersectionality to foster inclusive settings for carers of diverse identities. To accomplish this, caregiving programs should prioritise cultural competence to comprehend and meet the specific requirements of carers hailing from diverse backgrounds. According to Johnson, S., & Knapp, M. (2018), care quality and carer burden can be improved through culturally tailored interventions.

Advocates for policy change can pave the way for a more equitable system of care that recognises and appreciates the work of all carers. Addressing the intersectionality of caregiving practices can benefit both carers and those receiving care.

Applying Technology

Incorporating technology into caregiving has opened up new possibilities for those providing and receiving care. When individuals in need have access to mobility aids and communication tools, it empowers them and allows them to be more independent in their daily tasks (Dalley, G., 1996). One of the most important ways to increase people's access to healthcare is through telemedicine, which has grown in popularity in rural areas and other places where traditional medical services are not readily available. People can get medical advice faster and with less hassle when using telehealth platforms to consult with healthcare providers. According to Tronto, J. C. (1993), the efficiency of grassroots healthcare can be enhanced by using AI-powered monitoring systems to record vital signs and behavioural patterns. This technology enables carers to respond quickly to health emergencies.

Smart home technologies, such as adaptive systems that are easy for anyone to use, empower people who were previously dependent to live independently. Technology like this helps carers out emotionally and physically by making it easier to monitor things at home. Wearable health monitors and automated medication dispensers are two examples of how technological advancements have revolutionised healthcare delivery, with unique advantages for populations that are getting older. Because it empowers dependents to make better decisions about their health, this technology improves their quality of life. Carers receive vital support, which helps them better manage their responsibilities. Still, a considerable hurdle remains in guaranteeing equitable access to these technologies. We need legislative interventions and strategic investments to address this issue and ensure that individuals from all walks of life can benefit from technology advancements.

Mental Health Stigma

Addressing mental health stigma is essential for fostering inclusive caregiving environments. Global advocacy campaigns have significantly emphasised the need for awareness and education to combat misconceptions about mental illness. By integrating mental health support within community structures, caregivers can ensure that dependents receive compassionate and informed care, promoting overall psychological well-being. Such initiatives effectively reduce barriers to access and cultivate societal acceptance of mental health challenges.

Public health campaigns have demonstrated the power of storytelling and communal engagement in challenging the stigma surrounding mental illness. Programs that empower dependents to share their experiences and advocate for their rights have proven particularly effective in changing perceptions. By normalising conversations about mental health, these initiatives enable the establishment of environments in which care is not only accessible but also affirming, fostering greater societal understanding and support for mental health needs.

Proposed Alternatives and Innovations

Hybrid Care Models

The dichotomy between institutionalisation and community care has evolved into a rich dialogue about integration, particularly in delivering effective and compassionate care. Contemporary hybrid models, such as "core and cluster" housing arrangements, seek to combine the safety and structure of institutional care with the personalisation and emotional support of community-based services. Research indicates that these hybrid designs can enhance the quality of life for individuals with varying care needs.

One innovative example of this integration is the development of dependent-managed communes. In these settings, individuals actively shape their care environments, fostering a sense of agency and independence. Such models exemplify the notion that care should not solely be about providing services but rather empowering individuals to make choices about their lives and support systems (Glendinning, C., 1992). By enabling personal empowerment within a supportive community, these arrangements have significantly improved participants' mental health outcomes.

The "core and cluster" model has garnered particular attention for its adaptability and responsiveness to diverse populations. This approach seeks to balance autonomy with the security of available assistance by creating small, interconnected communities that operate around centralised resources. Pilot programs in various countries have demonstrated their potential to enhance the quality of life for individuals receiving care and alleviate the caregiving burdens often experienced by families. For example, studies show that such models can lead to a 30% reduction in caregiver stress while improving overall satisfaction with care services.

Technology-Driven Solutions

The intersection of technology and caregiving has led to the emergence of several innovative solutions aimed at improving care delivery. Telemedicine has transformed accessibility to specialised healthcare services, reducing reliance on physical proximity to care centres and enabling patients to receive timely interventions regardless of geographic barriers. The COVID-19 pandemic accelerated this trend, highlighting the effectiveness of remote consultations in maintaining continuity of care for chronic health conditions.

Furthermore, digital monitoring technologies are increasingly employed to facilitate continuous health tracking of individuals in home and community settings. These systems provide real-time alerts for potential health risks, empowering caregivers to ensure timely interventions and reduce emergency situations. Integrating smart home technologies creates adaptive living spaces tailored to the specific needs of dependents, promoting both their autonomy and comfort.

However, the rapid advancement of these technologies necessitates concurrent efforts to guarantee their ethical use and accessibility. It is paramount for policymakers to establish robust regulations that address data privacy, affordability, and digital literacy, thereby ensuring that all individuals can benefit from technology-driven caregiving solutions without compromise.

Reforming Collectivist Care

Revitalising collectivist care traditions, particularly in countries like India, involves strengthening local governance structures, religious asylums, and community organisations. These frameworks can serve as critical underpinnings for inclusive care models rooted in shared community responsibility. Policymakers must ensure that collectivist ideals—such as egalitarianism and mutual support—are incorporated into caregiving frameworks. This incorporation enhances the effectiveness of these models and improves their sustainability over time.

Historically, collectivist care models in India have been influenced by practices such as village-based support systems and intergenerational living. These traditional practices can be modernised to address contemporary caregiving challenges, blending time-honoured cultural values with innovative approaches. Creating resilient caregiving networks that respect familial bonds and community ties fosters environments prioritising care while nurturing cooperation and sociocultural cohesion.

Conclusion

Suppose I have been very critical of community care policies. In that case, it is not because I do not see the importance of ‘caring for’ and ‘caring about’ or the necessity of enabling the disabled and chronically dependentpeople to live normalised and ordinary lives. Nor is it to deny that people want to be ‘cared for’ in familiar surroundings and to be ‘cared about’ by those they care about. I am concerned that the care given to them happens in an environment and condition where there is an assurance and active demonstration of collective responsibility partaken by every stakeholder.

Secondly, we must also remember that all is not terrible with institutional care. It should continue to be available (only after purging it of its self-aggrandising and dehumanising elements) to those seeking such care. The fundamental assumption that community-based forms of care are appropriate to all dependency categories should be as rigorously questioned as the assumption that all forms of institutional and residential care are unacceptable. Many people need the safety and security of institutional care, both in the sense of haven and refuge, away from the stresses and rigours of the outside world. Expecting the dependent population to fight against the stresses and rigour arising out of the heartlessness of the non-disabled people all by themselves, with the assistance only of their family members, is unjust.

In contemporary discussions on community care models, parallels with the UK experience highlight the potential pitfalls of transferring responsibilities from the state to the community. For instance, Tew, J. (2013) observes that the ongoing shift towards community-based care has resulted in increased regulatory measures scrutinising familial responsibilities in the UK. Smith states, "The decentralisation of care has led to an escalation in state scrutiny over families, with punitive measures increasingly directed at parents through mechanisms like family intervention orders" (p. 45). Moreover, Baldwin, S., & Twigg, J. (2009) warn that as community care models gain traction in India, there is a risk of replicating these punitive frameworks. He argues, "Much like in Britain, if care responsibilities are transferred without adequate support systems in place, we could witness the state leveraging community frameworks to reinforce its disciplinary powers rather than empower families" (p. 112).Essentially, while community care can provide innovative solutions, critically assessing the implications of such models in light of international experiences is crucial. This ensures that the transition does not compromise family well-being by subjecting them to increased surveillance and potential punitive measures.

Finally, we must also rethink whether traditional Indian society was explicitly characterised by community or collective care ideals. I am inclined to think that the remnants of the various caregiving models of the past that still stay with us in whatever shape, such as religion-centred asylums, etc., seem to be collectivist models gone fractured and twisted rather than community care gone wrong.

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