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Healthcare Support among Elderly Population

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ABSTRACT

The elderly population is large in general and growing due to advancement of health care education. These people are faced with numerous physical, psychological and social role changes that challenge their sense of self and capacity to live happily. The present study was conducted to assess the relationship of specific satisfaction in biogerontology and social gerontological and medical gerontology. The present study reveals that health supports is positively and highly significantly related to using care services and suffer from disease of aged persons. The main purpose of this research was to find out the mean difference between old age home and residing in their home in suffer from disease and using care services .The total 120 elderly (60 elderly in old age home and 60 residing in their home) of age range 60-80 year. The study was carried out in Lucknow. Multistage sampling technique was fallowed in the present study. The samples of this study were personally and individually contacted and data was obtained through face to face interview. The research tool for hospital anxiety and used the care services and health care scale was used .and the test was applied to check the difference of suffer from disease Asthma, diabetes, cardiovascular disease, stomach /bowel disease and using care services the ANOVA method used to check the difference .Result reveals that significant difference in suffer from disease and using care services–old age with respect to both old age with respect to both old age home and residing in their home .While the difference between suffer from disease and using care services reveals and the elderly people who live in old age home suffer from disease and using care services and residing in their home elderly people live with family and happy and significant difference were found in disease and using care services in old age.

Keywords: *Health support, Suffer from disease, old age, elderly people live in old age home, elderly people live in residing in their home.*

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Healthcare Support among Elderly Population

Aging is not a disease, but the final stage of normal life. “Old age is an incurable disease”. “You do not heal old age”, “You protect it”, “You promote it”, and “you extend it”

Every human being passes through various stages in his life time. Birth infancy childhood adolescence adulthood and old age. This biological transition through different stages has cultural and human overtones. For the individual, age serves as an important base for self perception and role performance in the Indian homes, elderly are regarded as symbols of the divine and given utmost respect. They are considered as the repositories of wisdom, carriers of traditions and transmitters of experience of idea of group living.

Aging is a series of processes that begin with life and continue throughout the life cycle. It represents the closing period in the lifespan, a time when the individual looks back on life, lives on past accomplishments and begins to finish off his life course. Adjusting to the changes that Accompany old age requires that an individual is flexible and develops new coping skills to adapt to the changes that are common to this time in their lives (Warnick, 1995).

The definition of ‘health’ with regard to old age is a subject of debate. There is consensus that health in old age cannot meaningfully be defined as the absence of disease because the prevalence of diagnosable disorders in elderly populations is high. Instead, health is considered to be multifaceted: The diagnosis of disease should be complemented by assessment of discomfort associated with symptoms (e.g., pain), life threat, treatment consequences (e.g., side effects of medication), functional capacity and subjective health evaluations (Borchelt *et al*., 1999). Furthermore, Rowe & Khan (1987) suggested that the health of subgroups of older adults be defined in terms of their status relative to age and cohort norms.

Physical, social and emotional health’s are all important aspects of our overall health and wellbeing. Keeping active in older age is vital for each of these aspects of our wellbeing. This may mean being physically or socially active, or keeping the mind active. Everyone has different interests and activities they like to pursue, and these may change from time to time as circumstances change. However, it is important that we continue to pursue things of interest that give purpose to our lives, regardless of our age or ability. This can help us feel positive and lift our mood when we are feeling flat or low. The aim of this booklet is to assist you to reflect on positive.

The ageing of a population has been defined as an increase in the proportion of the aged vis-à-vis a decrease in the proportion of the young. There have been major occurrences in Asia that have impacted on the situation of the elderly: the decline in fertility that will gather further momentum in the twenty first century coupled with the continuing and steady decline in mortality which has resulted in significant changes in the size and structure of Asian populations. In India, the population of the elderly is growing rapidly and is emerging as a serious area of

concern for the government and the policy planners. Among the population aged 55 and above in Asia, there are about 90 men for every 100 women; for those aged 75 and above, there are only about 70 men for every 100 women (Lee and Mason, 2000).

Old age can be broadly characterized by time-altered changes in an individual's biological, Psychological and health related capabilities and its implications for the consequent changes in the individual's role in the economy and the society (Irudaya Rajan and Mishra, 1995).

The task of looking after the welfare of these citizens, who are in need of physical, financial and emotional care, is a daunting one for a country where the majority of the population is barely able to live above the poverty line. One aspect of this welfare consists in providing affordable and adequate health care for the elderly, by taking into account the pathologies of old age. A second issue is the socio-economic vulnerability of the elderly (in addition to the physical problems of old age).

Old age as such cannot be identified with ill health or disparity, although advancing age tends to bring increased health problems, There is after a gradual decline in physical strength, hearing less, visual improvements, and lower immunities to illness, hardening of blood vessels, respiratory and digestive disorders, heart ailments, arthritis etc.

Psychological problem include Cognitive impairment, Depressions, Dementia, Anxiety Death, Anxiety etc.Aging of the population is the defined as increase in the proportion of population aged 60 year and above. The elderly person is dynodes as a person who has completed 60 year or more. The United Nations generally uses age 60 as the lower limit to define elderly population **(United Nations.1993, 2005).**The national practices, however, vary in defining the aged .In development countries where considerable ageing in population has occurred, and where people are healthier and where life expectancy is very high (75 year and above) the elderly is defined as a person of 65 and over. The censor of India although provides data on aged 60 years and above. India demographer while studying the demographic and socio-economic aspects as an indicator of ageing (visana, 2006 Iruduya Rajan 2008).

Demographers and sociologists sometimes categories the elderly in three groups;

(a) Young old aged 60-69;
(b) Old age 70-79 and
(c) Oldest old aged 80 years and above.

In developed countries the elderly are generally categorised in following age statements:-

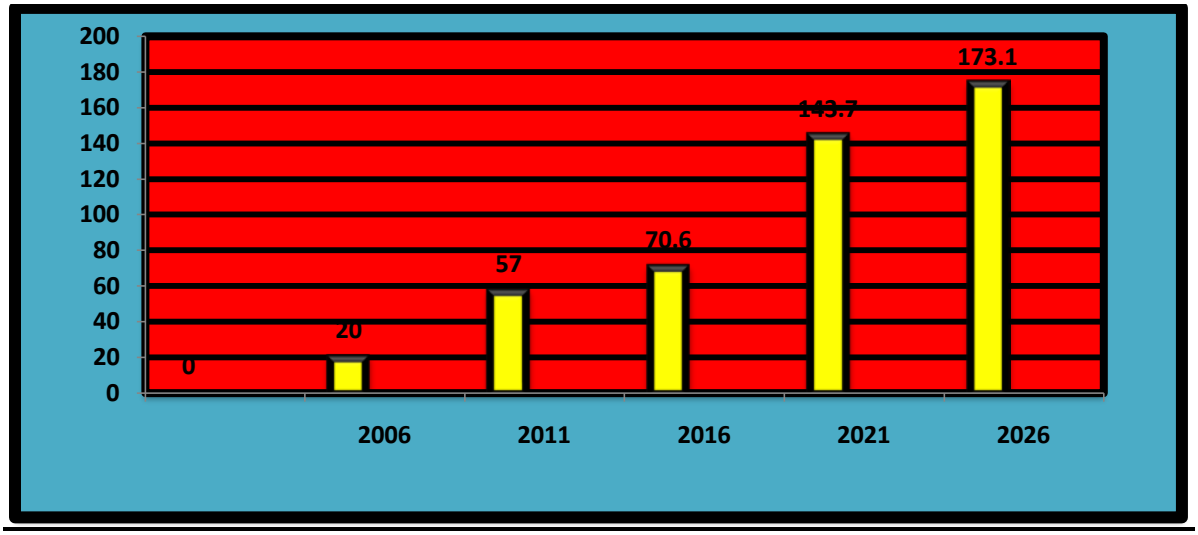
(a) Aged 55-65 as young old.
(b) Aged 60-85 as old and
(c) Aged 85 years and above oldest old

Demographic Transition

As per censes 2001.The number of older persona in 2001 was 70.6million (6.9%) which was projected to be 83.5 million in 2006 (7.5%). As per the projections the percentage of older person will be 94.8 million in 2011 (8.3%).118 million in 2016,(9.3%) 14.37 million in 2021(10.7%) and 173.1 million in 2026 (12.4%).

The growth of population of the elder person snows upward trend.

Population Projection



POPULATION 60+

The world's older population—defined in the present context as those aged 60 years and above—presently stands at around 760 million. Asia accounts for more than half of the total (414 million, including 166 million in China and 92 million in India). Europe is the region with the second largest number of older persons (nearly 161 million), followed by Northern America (65 million), Latin America and the Caribbean (59 million), Africa (55 million) and Oceania (6 million).

According to UN-Reports, the world elderly (60+ year) population in the year 1950 accounted to only 8.12% of the total population it is rapidly increasing and expected to touch of the total population by the year 2025 and 20.69% by the year 2050. Elderly growth rate is reportedly higher among the developing countries. India also and increased to 7.3% in 1990 and it is expected to reach 12.6% of the total population by the year 2020.

Objectives of the Study

- To study about the well-being of older people. (Between the age of 60-80years.)

Hypothesis

- There is no significant relationship between well-being and Health profile of elderly.

MATERIALS AND METHODS

The present study aim at purposive random sampling of wellbeing in old age, health profile social support, from deprived communities like, Education level marital status, working status, age .the practices they follow from as independent variable which affect and alter the dependent variable .therefore the proposed study intends to study the well-being in old age.

Study Area

Lucknow district of Uttar Pradesh was selected as the study area. The urban and semi-urban areas and selected the old age home–Aastha old age home and Sanjeevani Foundation (Charitable) Trust and Seva Sanklap old age home and residing in their home male and female aged group (60-80) year.

- The sample size of the study was restricted up to 120 samples. 30 male and female living in old age home and 30 male and female living residing in their home. Sample technique was purposive random sampling. Multistage sampling technique was followed in the present study.

Tools and techniques:

To carry out the present study, the following tools were used to measure various parameters. The main tools were used in the study was Predesigned questionnaire, Use the scale Care Services And Health Care Use, Multidimensional Scale of Perceived Social Support **(MSPSS).**

- Independent variable was age, Gender, Residing in their home etc.
- Dependent variable was Health domain in older people.

Procedure:

The samples of this study were personally and individually contacted and data was obtained through face-to face interview. The duration of data collection were spread over a period of two months (60 days). The obtained responses were scored and statistically analyzed.

Methods of data collection:

The data for the present research was collected personally through interview method. A pilot study was conducted on 10% of the sample to validate the data collection instrument and requisite changes in the schedule were made. Visits were made to the selected areas in order to establish a rapport and to ensure full co-operation form the identified sample.

RESULT

Table no: 1-Using care services elderly across- Age. (N=120)

S.No	Parameter	60-70 Mean±SD	71-80 Mean±SD	F	P
1.	The problems disappeared	1.43±.500	1.37±.487	.445	.506
2.	The waiting-list was too long	1.14±.348	1.23±.422	1.540	.217
3.	The care services were difficult to contact	1.28±.451	1.27±.450	.000	.984
4.	The care services were not available	1.28±.451	1.35±.482	.856	.357
5.	I did not get an appointment fast enough	1.50±.504	1.50±.504	.444	.506
6.	I had negative experience from previous services	1.48±.504	1.44±.500	.266	.607
7.	I had financial problems	1.21±.409	1.39±.491	4.740	.031
8.	I did not have the time	1.38±.489	1.29±.458	1.059	.305
9.	I did not know who to contact	1.67±.473	1.60±..495	.730	.394

(P<0.05=Level of highly significant)

Result depicted in table no.1-discussed that the difference between age and not using to care services .Data revealed that P-value was found not highly significant (.984) in the table it mean that there is significant difference age of respondent not using of care service. These mean that null hypothesis is accepted. Which mean that not using care services may also very according to the age of the respondent?

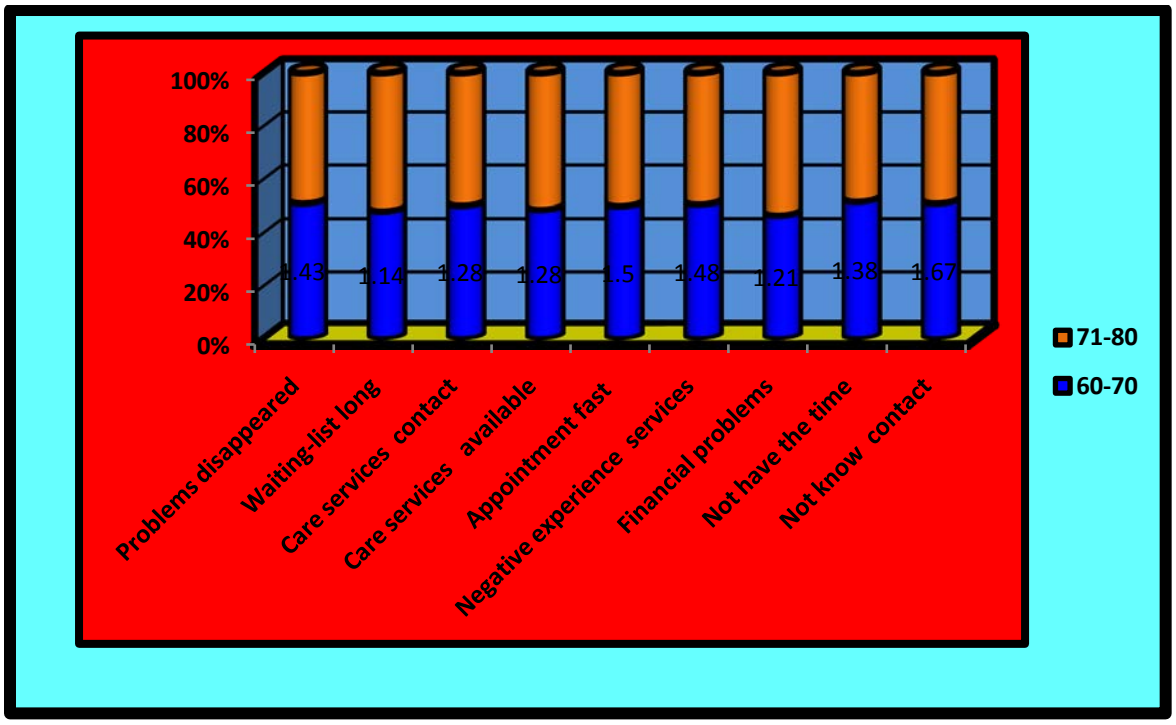


Fig no: 1 Using care services elderly across- Age.

Table no: 2- Using care services elderly across- Gender.

S.No	Parameter	Male Mean±SD	Female Mean±SD	F	P
	The problems disappeared	1.53±.504	1.45±.502	.206	.651
1.	**The waiting-list was too long**	1.39±.491	1.35±.482	.476	.491
2.	**The care services were difficult to contact**	1.51±.504	1.52±.504	.023	.880
3.	**The care services were not available**	1.67±.476	1.63±.487	.726	.396
4.	**I did not get an appointment fast enough**	1.60±.495	1.55±.502	1.031	.312
5.	**I had negative experience from previous services**	1.54±.503	1.65±.482	3.904	.051
6.	**I had financial problems**	1.72±.453	1.60±.495	7.517	.007
7.	**I did not have the time**	1.51±.504	1.53±.503	.188	.665
8.	**I did not know who to contact**	1.56±.501	1.61±.491	1.165	.283

(P<0.05=Level of highly significant)

Result depicted in table no.2-discussed that the difference between male and female not using to care services .Data revealed that P-value was found not highly significant (.880) in the table it mean that there is significant difference age of respondent not using of care service. These mean that null hypothesis is accepted. Which mean that not using care services may also very according to the male and female of the respondent?

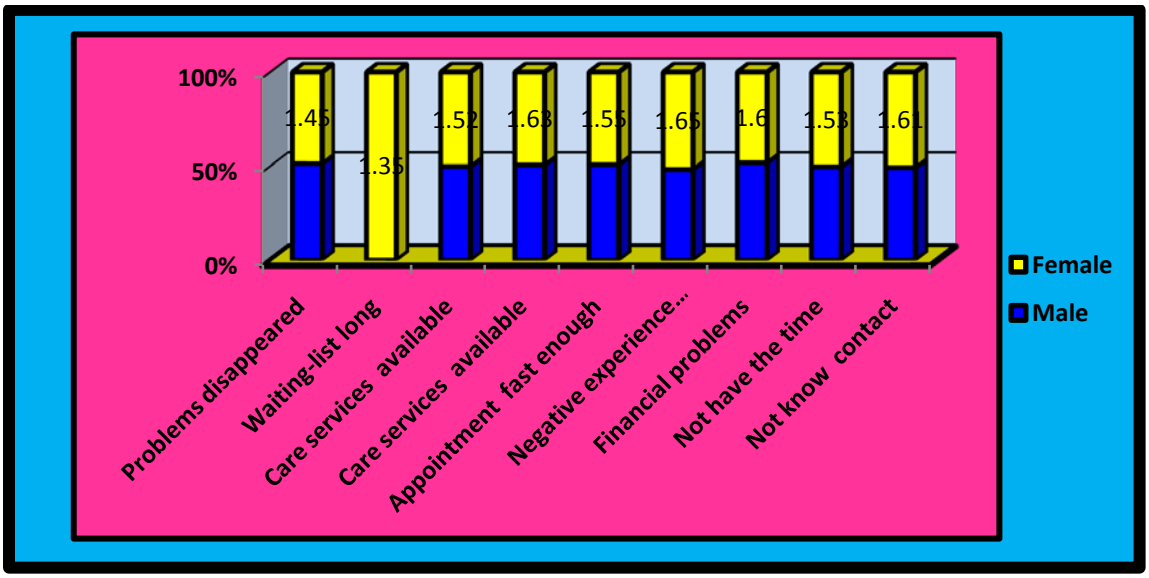


Fig no: 2 Using care services elderly across - Gender.

Table no: 3Awareness and knowledge of elderly suffer from disease across –Gender.

S.No	Parameter	Male Mean±SD	Female Mean±SD	'F'	' P'
1.	**Allergy**	2.37±.780	2.40±.718	.059	.808
2.	**Asthma**	2.28±.761	2.02±.725	3.863*	.002
3.	**Diabetes**	2.50±.770	2.35±.777	.963**	.000
4.	**Eye diseases**	2.85±.404	2.63±.637	.948	.028
5.	**Cardiovascular diseases**	2.10±.602	2.03±.780	.974**	.000
6.	**Liver diseases**	2.43±.698	2.22±.715	2.821	.096
7.	**Stomach/bowel diseases**	2.83±.493	2.70±.619	1.704	.194
8.	**Lung diseases**	1.98±.770	2.25±.680	4.045	.047
9.	**Cancer**	2.07±.252	2.03±.258	.513	.475

(P<0.05=Level of highly significant)

Result depicted in table no- 3 discussed that the difference between male and female elderly suffer from disease. Data revealed that p- value was found highly significant (.000) in the table. It mean that there is significant of respondent are suffer from cardiovascular disease and diabetes disease. These mean that null hypothesis is rejected. Which mean that are mostly males and females suffer from disease.

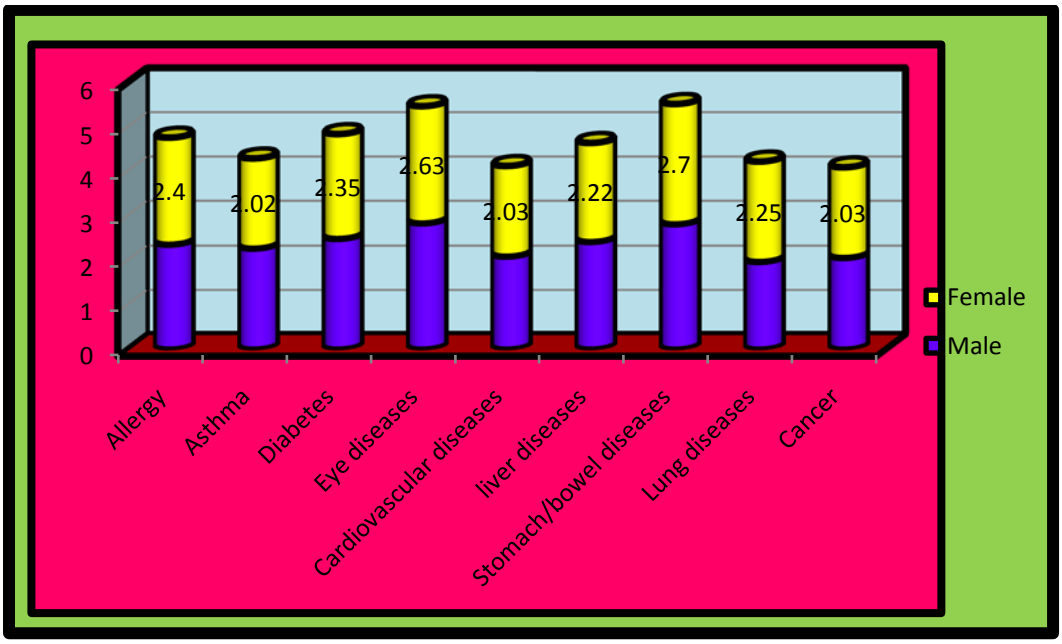


Fig-3 Distribution of the respondent on the basis of suffers from disease across-Gender

CONCLUSION

This study has revealed that majority of the inhabitants in this old age home were elderly suffering disease and majority of respondent using care services. And whose elderly live in with family and social support was good feel happy. More than half of the participant expressed a moderate disease wellbeing as per test scores. In many parts of the developing words, chronological time has little or no importance in the meaning of old age .Other socially constructed meaning of age are more significant such as the role assigned to older people ;in some cases it is the loss of roles accompanying physical decline which is significant in defining old age.

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Conflict of Interests

The author declared no conflict of interests.

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