

A community based study to determine health care seeking behaviour in elderly population of rural India

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Abstract

Background: The number of elderly is increasing day by day due to demographic transition. In developing countries, elders form a weak group in availing of social benefits. This will result in emergence of new problems related to medical, social and economic rehabilitation of elderly population if a timely initiative in this direction is not taken. **Aims and Objective:** To determine socio-demographic profile and health care seeking behaviour of elderly people in the study population. **Material and Methods:** A community based cross-sectional design was adopted for studying the socio-demographic profile and health seeking behaviour in the elderly population. A two stage sampling technique was used for sample collection. A total of 220 individual ≥ 60 years of age were taken up for the study purpose. **Results:** Out of total 220 subjects, maximum were in the age group of 60-69 years (Males=53.6% & Females = 46.4%). Majority of the subjects were currently married (60%) and nearly 64% were illiterates. 71.3% of the subjects were engaged in household activities. Maximum numbers of subjects (92.7%) were utilizing non-government health care facility and major reason for this was due to long distance from their houses (33.3%). Most of the subjects were utilizing modern Allopathic medicine (93.6%) and mainly dependent on family (70.81%) for source of medical expenses.

Key Word: Community, health care, elderly.

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INTRODUCTION

Ageing is a universal process and it affects every individual, family, community and society. In developing countries, elders form a weaker group in availing of social benefits. The inequalities in elderly based on class, gender and race are expected to influence the parameters of ageing population. Women's issues are extremely important in considering social policies for elder population. Epidemiological transition in developing countries has created necessity for health care transition from systems based on cure to one that highlight

prevention and long time care. Scarcity of resources is prevalent in all developing countries, so making best use of the limited resources by integrating health care for elderly people with established health services, particularly existing primary health care system needs priority.¹ With increase in proportion of aged population number of elderly with ailment is also on rise but health care delivery systems of most developing countries are not equipped to tackle the problem.^{2,3} Care of elderly is an expensive predisposition; hence concept of vulnerable group is important in India where resources are limited. These vulnerable groups are elderly widows, childless elderly and physically disabled elderly, elderly whose children have migrated abroad and elderly in an alien environment. This study is an attempt to study the health care seeking behaviour among the elderly persons residing in the rural areas of Punjab.

AIMS AND OBJECTIVES

To determine socio-demographic profile and health care seeking behaviour of elderly people in the study population

METHODOLOGY

The study was conducted in field practice area of Rural Health and Training Center (RHTC) located at village Pohir, block Dehlon, district Ludhiana, Punjab, India. This Center is an integral part of Department of Community Medicine, Dayanand Medical College and Hospital, Ludhiana. A community based cross-sectional design was adopted for studying socio-demographic profile and health care seeking behaviour in elderly population. The period of study was one year from 1st March, 2007 to 29th February, 2008. The field practice area is composed of ten villages. It covers a total population of 20861, comprising of 2117 elderly. A convenience sample of 10% was taken for the present study. Hence 220 subjects out of total 2117 individuals, 60 years and above were included in the study. The individuals refuse to participate; non-cooperative and inability to participate due to gross physical and mental disability were excluded. A two stage sampling was used for the study. In first stage, equal no of individuals were taken from each village according to quota sampling technique and in the second stage, subjects were stratified on basis of gender and individuals from each gender were decided on the basis of simple random sampling technique. The information was collected on a predesigned and pretested proforma through personal interviews by house to house visits. Each individual was told about the purpose of the study, and confidentiality of the information was assured. If the house was locked or/and subject was not available two attempts were made

to contact the subject. The proforma includes socio-demographic variables viz. age, gender, marital status, education, occupation, family type, past and present illness including information on utilization of health services. A self-designed proforma to enquire about health care seeking behaviour was used. It included health care facility availed when sick, average expenses for one month, source of finance for medical expenses, system of medicine preferred, need for expert medical care in last one year and source of medicine, adherence to pharmacological intervention.

Ethical Consideration

The present study did not impose any financial burden to the patients and informed and written consent was taken from the participants before conducting the study.

Statistical Analysis

The data collected in respect of various variables was statistically analyzed. Mean, range and standard deviation were computed for the variables. The data was analyzed by using statistical package SPSS 16.0.

RESULTS

This community based cross-sectional study was conducted with the objective to determine socio-demographic profile and health care seeking behaviour of elderly people of field practice areas of department of Community Medicine, Dayanand Medical College and Hospital, Ludhiana. A total of 220 subjects including 112 (50.9%) male and 108 (49.1%) females were taken.

Table 1: Distribution according to Socio-Demographic Profile of Participants

Characteristics		Male (%)	Female (%)	Total (%)
Age	60-64	30 (26.8)	32 (29.6)	62 (28.2)
	65-69	30 (26.8)	32 (29.6)	62 (28.2)
	70-74	26 (23.2)	23 (21.4)	49 (22.2)
	≥75	26 (23.2)	21 (19.4)	47 (21.4)
Marital Status	Currently Married	80 (71.4)	52 (48.2)	132 (60.0)
	Unmarried	08 (07.2)	01 (00.9)	09 (04.2)
	Widower/ Widow	23 (20.5)	54 (50.0)	77 (35.0)
	Divorced	00 (00)	01 (00.9)	01 (00.4)
	Living away from spouse	01 (00.9)	00 (00)	01 (00.4)
Education	Illiterate	55 (49.1)	86 (79.7)	141 (64.0)
	Primary	20 (17.8)	14 (12.9)	34 (15.5)
	Middle	18 (16.1)	07 (06.5)	25 (11.4)
	High school	15 (13.4)	01 (00.9)	16 (07.3)
Occupation	Graduate	04 (03.6)	00 (00)	04 (01.8)
	Household work	43 (38.4)	77 (71.3)	120 (54.5)
	Agriculture	28 (25.0)	0	28 (12.7)
	Business	11 (09.8)	01 (00.9)	12 (05.6)
	Service	02 (01.8)	0	02 (00.9)
	Unskilled labour	04 (03.6)	06 (05.6)	10 (04.5)
	Skilled labour	07 (06.2)	01 (00.9)	08 (03.6)
	Professional	00	00	00
	Not working	17 (15.2)	23 (21.3)	40 (18.2)

	Own Income	63 (56.2)	08 (07.4)	71 (32.3)
Source of Livelihood	Government	05 (04.5)	07 (06.5)	12 (05.4)
	Supported by Family	43 (38.4)	93 (86.1)	136 (61.8)
	Destitute	01 (00.9)	00 (00)	01 (00.5)

The table no.1 describe, out of total 220 subjects, maximum were in the age group of 60-69 years (Males=53.6% & Females = 46.4%) respectively. Regarding marital status, majority of the subjects were currently married (60%). In regards to educational status 64% were illiterates (Females=61% & Males=39%) and only 4 (1.8%) of subjects were graduate or had high school education. As far as occupation was concerned, majority (71.3%) of the subjects were engaged in household activities whereas 18.2% were sitting idle. Table further illustrates that 61.8% were supported by family and 32.3% subjects had their own income as far as source of livelihood was concerned.

Table 2: Distribution of Subjects according to Main Source of Health Care Facility Availed

Source of Health Care Facility	Male n=112 (%)	Female n=108 (%)	Total n=220 (%)
Government	12 (10.7)	04 (03.7)	16 (07.3)
Non Government	100 (89.3)	104 (96.3)	204 (92.7)

Majority of the subjects (92.7%) were utilizing non-government health care facility as main source of health care.

Table 3: Distribution of Subjects according to Non-Governmental Health Care Facility Availed

Non Government Health Care Facility	Male N=100	Female N=104	Total N=204
RHTC , Pohir	24 (24.0)	35 (33.7)	59 (28.9)
Private Hospitals	02 (2.0)	03 (2.9)	05 (2.5)
Private Doctor (Qualified)	21 (21.0)	09 (8.6)	30 (14.8)
Private Doctor (Unqualified)	51 (51.0)	57 (54.8)	108 (52.9)
Faith Healer/Religious Person	02 (2.0)	00 (00)	02 (0.9)

Rural Health and Training Center of Dayanand Medical College and Hospital, Ludhiana

Out of the total using non government health care facility 52.9% were going to unqualified doctors, 28.9% going to private hospitals for health care.

Table 4: Distribution of Subjects according to Main Reason for not Utilizing Government Health Care Facility

Reason for Not Utilizing Government Health Care Facility	Male n=100	Female n=104	Total n=204
Lack of doctors	08 (8.0)	14 (13.5)	22 (10.8)
Lack of medicine	23 (23.0)	19 (18.3)	42 (20.6)
Staff not cooperative	15 (15.0)	21 (20.2)	36 (17.7)
Far from home	38 (38.0)	30 (28.8)	68 (33.3)
Not aware	04 (4.0)	05 (4.8)	09 (4.4)
Takes more time	09 (9.0)	13 (12.5)	22 (10.8)
Other	03 (3.0)	02 (1.9)	05 (2.4)

The table no 4 depicts that most common reason for not utilizing government health care facility was long distance from house (33.3%).20.6% said lack of medicine, 17.6% said staff not cooperative, 10.8% said lack of doctors, 10.8% said it takes more time and 4.4% said they were not aware.

Table 5: Distribution of Subjects according to Source of Medical Expense

Source of Medical Expense	Male n=103	Female n=106	Total n=209
Own Income	53 (51.5)	06 (05.7)	59 (28.2)
Family	49 (47.6)	99 (93.4)	148 (70.8)
Re-imburement by Employer or Ex-employer	00 (00)	01(00.9)	01 (00.5)
Third Party (Insurance)	01 (00.9)	00 (00)	01(00.5)

Table 5 shows that in majority (70.8%) of subjects family was source of medical expense. In 93.4% of female subjects, family provided medical expense. In 28.2% of subjects source of medical expense was own income. Only one male subject was having health insurance.

Table 6: Distribution of Subjects according to System of Medicine Preferred

System of Medicine Preferred	Total n=220	Percentages
Modern Medicine	206	93.6
Ayurveda	09	4.1
Homeopathy	04	1.8
Home Remedy	01	0.4

Table 6 depicts that majority (93.6%) of subject's preferred modern medicine as system of medicine while only 4.1% preferred Ayurvedic medicine.

Table 7: Distribution of Subjects according to reason for Medicinal non Adherence

Reason for Medicinal Non adherence	Male n=18	Female n=30	Total n=48
Dependent on Others to Bring Medicine	03 (16.7)	14 (46.7)	17 (35.4)
Ignorance	07 (38.9)	08 (26.7)	15 (31.3)
Cost of Medicine	06 (33.3)	07 (23.3)	13 (27.1)
Supply Not Adequate	02 (11.1)	01 (03.3)	03 (6.3)

According to table no.7 ignorance and being dependant on others to bring medicines accounted for more than 65% of non-adherence to medicines. The cost of medicines leads to 27.1%non-adherencein the study subjects.

DISCUSSION

The present study was a community based cross sectional study carried out over a period of one year i.e. from 1st March, 2007 to 29th February, 2008 conducted in rural field practice areas of the Department of Community Medicine, Dayanand Medical College and Hospital, Ludhiana. The total sample consisted of 220 subjects, 50.9% being male and 41.9% being female. The age wise distribution is in consonance with findings of Goel PK *et al* who reported a similar age distribution in their study on the elderly in rural population of Merrut.⁴ The present study reveals that 60% of the subjects were currently married and 35% of subjects were widow/widowers. The marital status seen in present study is similar to the figures reported in the 2001 Census⁵ In the present study nearly two third of the subjects were illiterate with women (61.0%) far out numbering men (39.0%). This is expected because of very low school enrolment rates that must have existed in rural areas in the pre independence era. The present study shows that more than half of subjects were involved in household work with females (64.2%) outnumbering men (35.8%). 72.7% of subjects were living in joint families. This is expected in a rural setting, where the traditional system is still continuing and may be an important buffer to combat loneliness and promote social support. The present study shows that majority (61.8%) of the subjects were supported by family as far as their source of livelihood was concerned. This is in tune with the findings that 72.7% of the subjects (*vide supra*) were living in the joint family.

HEALTH CARE SEEKING BEHAVIOUR

In our study it was observed that majority (92.7%) of subjects do not generally seek healthcare from government source and the most common reason for not utilizing government facility was long distance (38%). NFHS-3 data⁶ also showed that 72% of household generally do not seek health care from government facility. Among households that do not use government health facilities, the main reasons given for not doing so are poor quality of care (55%), lack of nearby facility (42%), and long waiting times (25%). Similar results were found in a study conducted in Bangladesh⁷ who revealed that more than half the respondents did not avail government facilities because of a lack of proper and /or sympathetic care from the doctors. About one-sixth of the respondents mentioned the distance to be travelled or the long waiting time as deterrents to the use of Government Hospitals. Goel PK *et al*⁸ in their study also found that in 59.2% of cases the distance of government health facilities was more than 3 kms. As far as system of medicine was concerned 93.6% preferred modern medicine as system of choice in our study. Similar

findings were observed by Joshi K in his study in urban and rural area of Chandigarh⁹, WHO reported that most preferred system of medicine was allopathic system in 92.2% of elderly and the rest 7.7% relied on either ayurvedic or homeopathic system of medicine. The major source of medical expenses in our study was from the family as most elderly in our country are dependent on their families. The most common reason given for medicinal non adherence was dependent on others and ignorance.

CONCLUSION

The study among the elderly in the rural area of Punjab has highlighted a rapid expansion in the elderly population of the country. There is an urgent need to develop various schemes and enhance the existing policies for better utilization of services of health care among elderly population all over the country.

RECOMMENDATIONS

- To motivate aged people to utilize government health services.
- Evaluate reasons for failure of government institutions to attract large number of elderly population.
- In order to nullify the effect of inflation on elderly, pension and old age pension needs to be enhanced.

LIMITATIONS OF THE STUDY

Due to lack of time and resources we could not follow up the study. Misreporting and underreporting might increase with age and varies greatly with the disease considered. There are increased chances of recall bias in the study as it deals with elderly population. One possible source of biased reporting of medical conditions may arise from differential access and utilization of health care services by different segments of the population.

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