CHAPTER VI

THE ORGANIZATION OF HEALTH CARE DELIVERY FOR ELDERLY
IN A POOR COMMUNITY

This chapter explores how a best practice in community based care provision of healthcare meet the needs of a poor elderly in an urban slum setting. It presents a case study where many medical and non medical dimensions of geriatric care are addressed, and in this context examined what are the perceived needs but which are not addressed due to constraints at the organization level, how continuity of geriatric care across levels through referral care and at the community level is established, what challenges they are facing, and the provider perceptions about the key health and healthcare problems faced in this community.

This chapters also presented how the organization of service delivery for the elderly takes place in terms of financial resources, human resource, infrastructure, and range(package) of services. This is presented in the context of the overall mission and vision of the organization which is the driver for design and sustaining of care provision for the elderly in this poor community.

6.1 Sundar Nagari Case Study – The Study of St. Stephen Healthcare Centre (SSCHC) and Prem Chaya

History of SSCHC

SSCHC have been providing access to health services for vulnerable populations in Sundar Nagri, Delhi since the year 1857. The history of St. Stephen’s health contributions started in the year 1857 with the young missionary educationist, Daniel, who was killed in the crossfire during the first revolution in India. Daniel came to India as an educationist for women and children. After Daniel's death, his sister, Priscilla Winter came to Delhi to continue and fulfil her brother’s work. But Priscilla Winter found women health condition and their sufferings more critical though she was not a medical missionary. By gaining some basic skills, she eventually started working as community health worker, and later became quite famous in the community. Later, she realized that there is lack of medical skills to deal with the further complex health problems. She thus contacted England and the women medical missionary workforce and with their help, a
small dispensary was founded in the city as the ‘White Ladies Association’. This later converted into nurses training centre in the year 1876 with the aid provided by Delhi and Panjab government.

At the age of 44, Priscilla Winter died in Delhi, but her work continued. St. Stephens hospital was started in the year 1885 along with six outreach centers. A century later this hospital had become one of the largest and most affordable non-government health care providers of Delhi.

During 1979 when there was “major plan for cleaning Delhi by shifting slums and homeless to the outskirts of the Old Delhi. One such resettlement colony was Sunder Nagari, an urban slum and resettlement colony of most poor and disadvantaged population, which is situated in the north east part of the Delhi. This relocation of the slums was planned without consideration and preparation for healthcare needs of the poor and vulnerable population. In that crisis of fulfilling healthcare of these resettle form of urban slums, the government approached private hospitals to take care or to adopt one of these colonies and provide basic health care services by establishing the primary care unit or centres. In 1981, St. Stephen showed the willingness and compassion, adopted Sundar Nagri to cater the basic medical or health care needs.

Initially, the care delivery in this community started with the mobile clinic, but later the hospital bought the land and the full-fledged St. Stephen community health centre (SSCHC) was developed. Today this center not only caters to elderly care, but also provides services for impoverished children, programmes of temporary shelter and care for homeless, programmes for youth with high health-risks; and various health and social development initiatives.

In particular context to elderly care, the SSCHS made provision of basic health care to the elderly including some referral consultations of the secondary care level and free or subsidized treatment within the same centre. Apart from the health needs, the other prevailing problems of the elderly in this community was also noticed such as poor housing conditions, lack of the open place to sit, undernutrition and malnourishment among the elderly and the ones who were alone, homeless, elderly couples etc. With same compassion and philosophy, the centre made the provision to address the above needs of the elderly by developing the daycare centre for them within the community. In the year 2007, Prem Chaya as a recreational” centre was developed to address the supportive day-care needs of the elderly in the community.
The centre did not stop here in the expansion and reaching the very poor and vulnerable elderly but also gave due consideration for their socio-economic wellbeing. The elderly in this community were poor and illiterate and unaware of their entitlements. The centre started creating awareness about the various entitlements from the government such as old age government pension, subsidized railways reservations etc as well as provide assistance to them in terms of gathering and filling form or applications, arranging documents etc. required to avail the benefits. In addition to that, if they face any form of extreme problems at the family or community level such as fights, conflicts any abuse or ill-treatment, the organization intervenes and offers counselling services.

The SSCHC which is cross-subsidized from hospital earnings, and supplemented by donations, faces shortfalls in terms of financial resources which is directly impacting the human resources it can deploy, thus making it as a challenge for operationalizing and sustaining this elderly day care centre. But despite this, the Prem Chaya center and SSCHC together still supporting a wider range of elderly care for the poor than almost any other programmes -

"It certainly can't do everything for everyone, but at least we do what we can do"

(Ex-HOD, and Senior consultant, SSCHC)

Development and Progress of Prem Chaya Since 2007

The main driver behind opening this center was to create a place a kind of recreational place where the elderly people can come, have some good time, interact with others, enjoy some activities, could share their feelings and thoughts with the people of their own age from their own community and then go back to respective places. From 2009-2015 it expanded as a day care center.

6.2 The organization of services for Elderly

The organization of services at the community level provided by the St. Stephan Hospital through their community health department (CHD) under three components. It includes the outreach programme by the ANMs and other community workers, St. Stephen community health centre (SSCHC) and Prem Chaya daycare centre. The SSCHC is catering the basic health
services and referral care service provision to all the people within Sundar Nagari, in which elderly population are also included.

Through Prem Chaya daycare centre for elderly is providing the recreational aspect of care along with the provision of the food and comfortable space for them to rest and sleep. Prem Chaya was built to accommodate up to 60 persons. However due to resource cuts, currently only 32 are availing the services from this care center. Only those over 60 age, living in this catchment area are enrolled. There is a system of prioritization between them:

“The 60 plus elderly of this community who does not have any support from family or relatives, very poor with no source of income, homeless or disabled or mistreated are usually considered for enrolling in this centre” (Care taker, Prem Chaya)

ANMs who make home visits and doctors seeing referrals could also suggest names for inclusion in PremChaya

Outreach Services: The ANMs associated with the SSCHC are distributed across Sunder Nagari- each assigned a number of households for home visits. These home visits also attend to elderly care needs at home- and only those for whom such visits are not sufficient are brought to the center. The reach of ANMs in the community is really appreciated. All the people in this community listens and trust them and usually pass on or share all sort of information or situation happening in the community. There are social workers who are also actively involved in the outreach programmes who are also providing counselling services within the SSCHC also.

**The care provision for the elderly through the following service component**

- **Basic Medical Care**: Acute minor illnesses are attended to at any time. The elderly can approach any time and day to the centre for the health problem and usually get the free medication for both acute minor illness and chronic illness. This latter can be accessed through an NCD OPD and also the home visits for the NCDs by the ANMs at the centre. Apart from this, there is an annual health checkup for the elderly at the Prem Chay. The centre is also running the outreach mental health programme within this catchment area as well at the centre level.
• **Assistance for entitlements:** Creating awareness about the various government entitlements and provision they can avail and facilitating and assisting these elderly them to access—mainly old age pensions, travel concessions, and public distribution system (ration shops).

• **Food Provision:** Even though, the food provision neither comes under the preview of healthcare or day care needs, looking the severity of the problems in the elderly, the center has made a provision to provide tea and snacks twice a day and ne meal, usually lunch at the center- on all days except Sunday.

• **Rest and Social Interaction:** One important function of the day care centre, is a comfortable space where they can rest – either sleep, watch TV, or read newspapers. There is also space to play cards or sing religious and spiritual songs. There is a provision of organizing the picnic trip per year (previously 2 in 1 year) for them as well as part of their recreational activity. The care taker helps them to undertake some physical exercise and yoga occasionally.

• **Counselling and Psychological Support:** The centre also provides the counselling and mediation role with the help of their social worker whereever required- usually in conflicts or fights and forms of abuse or ill treatment of the elderly. Though this provision is not exclusive for the elderly, they benefited most as they face more ill-treatment or abuse which they report to or ANMs. Apart from this, the centre is also providing the counselling support in the area of alcohol and substance abuse. This is one of major problem the elderly is facing – not so much because of they consuming it- but because their children/caretakers are addicted to it, leading to bad behaviour.

• **Referral care:** The first point of referral for both the home visits and the center is the SSCHC which manages the bulk of medical consultation needs. The SSCHC has further referral hospitals that includes the GTB hospital, General hospital, Rajive Gandhi super specialty hospital which are situated within 1-5 kms, and with the St. Stephen’s hospital which is situated at a distance 15-16 kms. Patients are referred along with a pre-formatted filled in referral letter prescribed by the SSCHC. In this referral letter, there is the column provided for the eligibility for financial concessions also. If any very poor and disadvantaged patient is referred to the SSCHC’s own base hospital (St. Stephen hospital),
they can provide partial or free of cost arrangement for the care. The concession is being reviewed and approved by the HOD of the health center.

- **Health Education and Awareness:** This is another function of both home visits and the Prem Chaya center.

The center is ISO compliant and this has mandated many safety measures one of which is regular attendance maintenance. If the elderly comes and leave and encounter some mishap on the way home or on the way to center, that could happen without anyone knowing. Therefore, elder has to ‘thumb in and out’ of the centre. This helps track for every elderl who visit the centre and helps to report issues if there is unexplained absence which could be due to illness.

The Prem Chaya centre has only two employees – a caretaker and a cook. All its main functions are undertaken by an internal volunteer arrangement within the SSCHC. The functioning of the centre is based on this informal and self-motivated volunteerism. Those volunteering are a doctor, a development assistant, one accounts person, one social worker, the ANMs and the head of department. Their remuneration is based on their designation and work at the SSCHC- and this is seen as additional to it.

**Governance and Financing at the Centre**

The community health centre comes under the community health department (CHD) of the St. Stephen’s Hospital (SSH). All the need based programme or provision at the community usually assess, designed and decided at the community health department (CHD) level, which is subordinate to the governing bodies and hospital administration of SSH for review and approval. This arrangement is effective for identifying the prevailing needs and addressing those needs of the community in optimal manner. Currently, the centre is headed by Dr. Joyce Felicia Vaghela (HOD) and the Deputy Director (Material Management) at St. Stephen Hospital. Dr. Joyce is a trained in public health form John Hopkins and an MD in community medicine, and has a wide interest and understanding of geriatrics. The elderly care programme (Prem Chaya- day care elderly center) was established during the leadership of Dr. Amod Kumar who is currently a senior consultant, but who headed the CHD for more than 20 years. Dr. Amod is the key person
in design and development of the programmes for the elderly. Most of the design of the programme, especially the care that had to be prioritized was done in consultation with the community- and this accounts for many of its unique features. For the purpose of this dissertation it made visible and amplified many aspects of elderly care needs which otherwise could have gone unnoticed.

The SSCHC is financially supported by the St. Stephan hospital directly as well as generated annual funds from the various undertaking CSR projects. In addition, the Prem Chaya center gets a grant of ` 20000/- per month from Department of Social Welfare, Govt. of NCT Delhi basis and 15000/- per month from the St. Stephen’s Hospital Patient Welfare Society. Apart from this, there are occasional donations- mostly in kinds like clothing, one-time food or sweets particularly in the auspicious season or time (like shrad, Navratri). The monetary donations were very rare and uncertain. Due to financial constraints, the sustainability of the day care is becoming a big concern.

**Reach of ANMs and other community workers**

The functions of the Prem Chaya center cannot be seen in isolation. It is part of the services for all the elderly in the community- most of whom are provided care when the ANMs make home visits or when the elderly visits the SSCHC. It is only a sub-set of these elderly who are lacking support or facing special problems who are taken into Prem Chaya.

The role of ANMs and other community level workers are instrumental to the provision of health-related and other support to the elderly and other population in this communities, particularly through home visits. They supported the elderly care by making the elderly people aware about the existing services for them in the CHC and also by identifying the elderly who are destitute or in vulnerable conditions such as immobile, or alone or staying in any form of abusive environment in which case they may require Prem Chaya support.

The local administrative organizations at the CHC level have played an important role in promoting access to health services for the elderly in this communities, including providing transportation and other assistance to the most disadvantaged elderly and health promotion
activities in the communities. On occasion home visit services by health professionals facilitate access of health facilities by the poor elderly.

“Operationlizing the complete aspect of geriatric care in such poor community and with such financial constraints is a challenge; however, the basic and most required needs among the elderly people in such marginalized community can be ensured and addressed to a great extent through the collective understanding by the service provider” (Dr. Amod, Ex HOD, Sr Consultant)

6.3 Geriatric care: Definition and understanding of the SSCHC- Prem Chaya Programme

At the beginning, it was clarified by the current head of the SSCHC that the department is involved in many programmes and elderly care is one of them. However, there is no separate programme or provisioning of elderly care at the SSCHC. They attend the elderly people in a same way as the other group is coming to the SSCHC. Also a part of day care services being provided by Prem Chaya, is not very comprehensive in nature and therefore the institution is nowhere mentioning specifically or claiming that it has any separate elderly care programme.

One of the key informants mentioned: “The idea is that we cannot do everything which will be best and excellent. But it does not mean also that we should not do whatever we can do in given circumstances”

The SSCHC along with its ANM based home visits and the Prem Chaya programme—all taken together are the interventions of the CHD to address the diverse needs of the elderly population with in this community, including a greater affirmative action to meet the needs of the most vulnerable within this group, in the most meaningful and efficient manner possible.

The organization is explicit on the needs of dignity and respect as crucial dimension of geriatric health and care.

“Geriatric care in an umbrella which comprises physical and mental health, social wellbeing, however they need love and care” (HOD, SSCHC)

“Geriatric care means ensuring that person to lead his/her life with optimum health and joy….and of course with complete dignity. Dignity and respect is very important aspect.” (Ex HOD and Sr. Consultant, SSCHC)

The elderly group is usually considered a vulnerable group and the intensity of vulnerability increases, when it compounded by poor socio economic condition, low educational status and poor awareness, poor sanitation, and lower access to basic needs of food, housing and financial
security. In such a population there are gaps not only in access to medical care but also in the social support requires to access basic medical care services. This gap is even more intensified in the very old elderly, the elderly who live alone and the female elderly.

“The current way of envisioning the health care for our elderly around medical needs is not going to help. Most of these programme will be there for name sake or catering to a very limited segment who might be sound in terms of resources. But what about the real problem and needs of these elderly? I don’t know... I am not sure how many will be requiring knee replacement or heart surgery, but I am sure that every one of them require basic care that is compasionate, care with respect and dignity. More such community based care should be facilitated for the elderly who are in need but in crisis to address those needs (HOD, SSCHC)

6.4 Impact of Surrounding and Environment

Impact of Social and Family Environment

While discussing the various problems that these elderly were into, the impact of environment was mentioned. In the elderly care healthcare aspect, the social and family environment they reside it makes a significant impact on the overall health of the elderly person:

“Sometimes the environment or the surrounding the elderly is staying is very supportive. If elderly encounter any issue or problem in such an environment the elderly receives the care they require. But when there is undesirable situation like very low income or no income even though they would like to care for the elderly, they could not due to financial constraints or conflicts or issues within family .... like if son or daughter in law is not bothered, they might leave the elderly alone.”

There is a gender dimension to family support. Males tend to marry a girl who are 5-10 years younger to them, and in later life the male dies early and women are left behind. Also as life expectancy increases, women tend to live more than their male counter parts. The elderly women who are widowed are more vulnerable and have less support.

“Off course if there is male elderly in the family, comparatively there is much better support and care system however with the female elderly this situation is not similar. They might face various forms of abuses, more than male elderly.” Said, HOD, SSCHC

6.5 Practicing Geriatrics for Urban Poor Elderly

While discussing the challenges in operationalizing of geriatric care for the marginalized urban poor elderly, the reasons for low healthcare services utilization them is mainly due to
the concern for their greater priority on own basic existential needs, distance from health facilities, selective and limited care provision at the community level as well as financial and personal barriers. In this community, lack of physical infrastructure is a major deterrent to providing comfort to the aged people. Many elder people need better access to physical infrastructure, both in their own homes and in public spaces.

“When we have started the center initially, there were only the provision of mobile clinic and health center to provide basic medical care for all the population in this community…. later we observed that the elderly in the community need social support and recreational aspect of care along with the basic medical care. There was no place for them sit and rest. Houses are so congested and uncomfortable...there is no sufficient food. We found lack of nutrition among them and that was a point we started working on the concept what today is called our Prem chaya” (Ex HOD, Sr. Consultant)

“We should not compartmentalize the geriatric care as it varies from elderly to elderly and also the social surroundings and conditions in which they are living” (Dr. Shan.)

Communities like this where the people were residing in the most marginalized conditions eventually develop low expectations from the organization to provide the basic care and social support at the community level.

Most geriatric care programmes with a centralized approach fails to address the diverse needs and problems and this limits utilization of healthcare for the elderly.

.“Planning and designing health services that are comprehensive and extend beyond just medical care can be an effective way to support the complex needs of these vulnerable elderly population” (Ex-HOD, Sr. Consultant)

6.6 Health care needs of the elderly: Providers Perspective

Key health problem

According to the health care providers interviewed, the elderly mostly present with the symptomatic condition such fever cough, cold and weakness. They also report that the elderly in this community were vulnerable to develop TB and many of them had a history of the same. This is in contrast to both quanitive data and our interviews with elderly were few reported reported TB as their perceived health problem. Also chronic conditions such as hypertension and diabetes, mental distress (loneliness mostly and depression/anxiety to some extent), generalized pain and bone health (including pain) were the major health issues perceived by providers as affecting the
elderly in this community. Apart from this, vision and physical mobility related disability were also recognized as common problems. Key informants also mentioned undernutrition or malnutrition among the elderly as one of the important concerns in this community.

**Healthcare needs of the elderly in this community**

The health seeking among the elderly participant was mainly for medical consultation for the symptomatic conditions. And for some of the major conditions where they need hospitalization like in case of Dengue, chikungunya, TB, or some injury- usually those in which they were so sick that they could not carry on with daily activity. Apart from this, the elderly was in a need of supportive aids like glasses, hearing aids, walking sticks, which the centre used to assist some time back by collaborating with organization, at very subsidized or free of cost. Apart from this, the elderly main healthcare need is the pain relief and need of physiotherapy. To address this aspect of need, the center has been providing to them a pain reliever oil. Also, there elderly who are having chronic conditions (mostly reported hypertension and diabetes), require medication, which used to be available at the centre free of cost, but which are now available but the subsidized rate.

There is reported lack of sensitivity among the elderly regarding the various health issues, due to which the also healthcare needs either under reported or not accessed. Therefore, there is a need for awareness sessions.

**Main Challenges to access care by the Elderly**

The urban setting is the hub where most of the medical practitioners and facilities are functioning and geographical accessibility is not a major concern for the urban general population. However, when it comes to elderly and when it comes to the poor urban elderly, it is still one of the major barriers. Due to the decline in their physical health and mobility and financial constraints and lack of knowledge.

Selective service provision at the primary level means that much of the care needed by elderly is not available at that level. Most primary care is geared only towards some aspects of care in pregnancy and child health- not towards the needs of the elderly.
Care for the elderly is available only at the public hospital where there are issues of overcrowding, long waiting time and complexed structural process. Private care is more physically accessible but there are financial barriers as private care is usually unaffordable. These are some of the reasons which makes the urban poor elderly fail to access care at both public health facility and private facilities, in spite of geographical proximity. Either they resort to unqualified quacks, or local healers or self-treatment or often take no treatment.

“Poor elderly often faces challenges in accessing care beyond the community. Apart of paying transportation cost to reach facility but also need to accompanying person which furthers adds to the cost which is one of the reason” said, Dr. Shan

According to one of the key informant interview, the most important barrier to accessing health services among older people in this areas, is lack of an escort to visit the health facility, especially for those who live alone and elders who are older (above 80 for example) and for those with mobility problems or other disability issues related to vision and hearing

“Mostly, for the elderly it is difficult to travel to health facilities independently or alone which results in drop in accessing services at the hospital or referral care. This problem is more among poor elderly, particularly who are more than 70 years of age and those who do not live with their adult children or alone,” said, Dr. Shan

“We have a vehicle but it’s on outsourcing arrangement. Stephens is the private hospital referred to. Whatever income we are generating from our private patients in the hospital and the CSR based projects we are utilizing. We usually bear the costs of transportation and arrange the transportation in case of any emergency or complication but every time its not possible. If we get some budget for arraging the transport facility we will be willing and happy to do that” (HOD, SSCHC)

**Choices of the elderly with respect to referral care needs**

For referral care, there were various tertiary care units near the community. However, the base tertiary hospital of this SSCHC and its outreach programmes is almost 15-16 kms. By giving consideration to overall determinants such as the lack of mobility and no accompanying persons, CHD refers the elderly to the nearby government tertiary units so that there is less trouble in terms of travelling time, transportation cost, and familiarity. But, the elderly ask to be referred to the base hospital for the referral (St Stephens hospital) with a mindset that they will be offered transportation, some accompanying person and more personalized care there. In this there is a lack of understanding about the process and criteria at the CHD programmatic level. CHD do
have such provision but that too for the elderly who have extreme vulnerability like homeless, physically immobile with no family support, or vulnerable elderly living with other vulnerable member mostly spouse. Therefore, this gap in understanding among the elderly population often makes them demand for those facility from the CHD centre whenever they get referral

“As a SSCHC family, here in sundar Nagri, we are providing basic healthcare with respect and dignity along with addressing the recreational and nutritonal aspect of need among them” (Dr. A, Sr. Consultant, SSCHC)

All stakeholders agreed that apart from the health services offered by the SSCHC programmes, locally available private providers were approached by elderly often. The dominant reason reported by the stakeholder was better treatment perceived by the elderly in terms of convenience and readily available assistance to them as compared to government or public facilities.

6.7 Summary

This case study helps us understand that there is considerable diversity in the health needs of the elderly in the urban poor and their familiar and social and economic circumstances which influence and impacts their perception of needs and their seeking of health services. Apart from need-base medical care provisioning, geriatric care provisioning at the grassroots level requires serious consideration of social determinant of health. Already the existing scenario and conditions of the urban poor is not appropriate mainly due to the housing and sanitation condition, lack of food and nutrition, poor hygienic and health behavior directly contributing to their poor outcomes. Poor socio-economic condition, illiteracy and dependency makes the elderly urban poor condition even more worsen and complexed. Improving health status of the urban poor elderly by considering the social determinant of health, needs affirmative action on a number of aspects of elderly care that may not be perceived as part of health care, but is nevertheless critical to it. There is a need to re-think the organization of health care services for the geriatric population and integrate it – one one hand with a primary health care approach and on another with many aspects of geriatric care- which go beyond mere health care.