CHAPTER VIII
DISCUSSION

This chapter of the dissertation presents the discussion of the major findings. It includes the current elderly morbidity status, the trend of morbidity in the elderly in last two decades, and the utilization and health seeking patterns across various physical, social, economic and demographic variables. This will be compared with the understanding of perceived health and healthcare needs of the elderly as emerges from the case studies and qualitative interviews with elderly. Further, we discuss how our findings are similar to, or vary with earlier research work on this theme.

The results of the study are discussed in three sections-
1. Current patterns and morbidity trends and healthcare utilization among elderly – National Perspective
2. Perceived health, healthcare needs, access to care and choice of providers- Community perspective
3. Community-based care provisioning: Barriers and facilitators – Providers perspective

Morbidity and utilization of healthcare among elderly – National Perspective

The findings indicate a significant variation in morbidity rates and patterns in elderly across various demographic, social and economic determinants. Other crucial factors that affect morbidity rates in the elder population are physical mobility, the living arrangement of the elderly (living alone or with company), size of the household in which the elderly are staying and the state of economic dependency.

Our findings of higher morbidity rates in elderly population, and a greater proportion of overall morbidity rates being contributed to by the elderly is well established in published literature. (Dror, Putten-Rademaker, and Koren, 2008). Both policy articulations and programme designs focus on the rapidly growing burden of NCDs in this age group, which is undoubtedly relevant. But our results also show that morbidity rates of communicable diseases, and of disability and injuries are also higher among this segment of the population. In NSSO 71, the pattern of morbidity in the elderly (60 and above age group) is 192 per 1000 for non-communicable
diseases, 47 for communicable disease and 4 per 1000 for injuries and 11 per 1000 for disability. Each of these rates are higher than the rates for these categories in the below 60 age group. The share of injury reported in the elderly is twice as compared to the non-elderly population. There are other studies such as Ingle and Nath, 2008, which have made similar observations.

This study finds that all morbidity in the elderly- in terms of non-communinable diseases, communicable diseases, disabilities and injuries vary considerably across age group, sex, place of residence and economic conditions. This finding too is consistent with published literature. (Gupta and Sankar, 2002; Kumar, 2003; Sudha et al., 2006). Murray and Lopez have pointed out that whereas 90% of the disability conditions arise from NCDs in the developed countrie in developing countries like in India, significant proportion of the disabilities developed due to the injuries and communicable diseases (Murray and Lopez, 1997).

Even within the category of the elderly the morbidity rates and prevalence of each morbidity category are higher among the older (age 70 and above years). The significant variation within the elderly group needs consideration while proposing and designing of the care services for this segment. The highest burden of morbidity on the older cohort of the elderly reflects their frail condition which makes them at risk of developing more health conditions and less access to the treatment. The estimates of morbidity categorized as disability show a J-shaped relationship with disability rates higher in the young adult, less in the older non-elderly and then rising again in the elderly (Medhi et al., 2006).

The study findings of gender differential in reporting morbidity is in contrast with the findings of the other existing studies. Whereas many earlier studies report, a lower self reported morbidity rate in women, and attribute this to a decreased awareness (Iyer, 2000; Kannan et al. 1991; Krishnaswami, 2004), NSSO 71st findings are different. Female elderly reported higher morbidity rates, overall as well as by major morbidity categories as compared to their male counterparts. However, regarding health-seeking behavior, the utilization of healthcare services reported marginally higher among the males as compared to the female’s counterparts, a finding that has been reported earlier in literature (Rajan and Sreerupa, 2008). This finding on gender disparity in morbidity rates could be attributed to a feminization effect of ageing as well as an increased awareness and sensitization among elderly women. Despite this improved perception of morbidity among elderly women, the health service access is still a barrier due to their greater
economic and social reliance on the spouse or children. Previous studies have also concluded that the weaker socio-economic conditions of women make them more vulnerable in particular contexts of demographic and socio-cultural changes (Tout, 1989).

The overall burden of morbidity among the urban elderly was found significantly higher than their rural counterparts both in our study and in published literature (Thakur, Banerjee, and Nikumb, 2013). However, by morbidity type, the rural elderly reported relatively higher communicable diseases than the urban whereas the urban elderly reported significantly higher NCDs than the rural counterparts. The previous studies found a more significant burden among rural populations than in urban ones (Gumber and Kulkarni, 2000; Dilip 2002).

The past pattern of reported morbidity was slightly higher in rural than the urban counterpart in 1995, whereas in 2014, the urban elderly showed higher morbidity than their rural counterpart. Also suggested in other studies also, the current higher rates of morbidity and hospitalization rate in the urban areas could be reflective of better access to healthcare services in urban areas, often at tertiary care sites (Ingle and Nath, 2008). In contrast, the lack of healthcare infrastructure and reach in rural areas is worrisome (Kumari, 2001).

The overall morbidity and the prevalence rate of each morbidity conditions among the elderly varied significantly among different social groups. Elderly from the scheduled tribes reported lower morbidity (PAP) and lower prevalence of ailments than the elderly belonging to SCs who reported less morbidity as compared to other (OBCs and general) social groups. The scheduled tribe communities are mostly concentrated in areas where the availability of healthcare services is minimal, even non-existent. Therefore, lower educational levels, limited exposure to media and lack of health care services may lead to underreporting of ailments among the SC/ST people.

With higher education level and richer economic class, morbidity rates reported were significantly higher. This is at variance with the findings of some earlier studies that show higher prevalence of illness among the poor and less educated. (Dilip, 2002, IIPS and WHO 2006). This could be because in these studies more probing questions or objective measurements of health were additionally used. In the NSSO study, which uses only a single question to probe morbidity, higher morbidity among the rich and educated elderly could be because of a higher level of reported needs and healthcare-seeking behaviour as compared to poor and uneducated elderly population. This disparity in expectation towards health and healthcare among the different
economic-education status has been reported earlier. (Murray and Chen 1992; Subramanian et al., 2009).

The results found that the currently married elderly reported significantly less morbidity compares to the elderly who were living alone due to either of reasons, e.g. who were widowed or divorced or deserted or abandoned by family members. The results of the study accorded with the existing research on the positive impact of the family. (Paul and Verma, 2016). This has implications when we project future trends since more of the elderly are likely to be living alone or only with spouse.

Apart from demographic and socio-economic factors, the logit model result also found that elderly who were completely immobile reported almost double the times of morbidity prevalence as compared to the physically mobile elderly population. Earlier studies too have reported that because the functional limitation is often associated with numerous consequences related to physical deconditioning and reduced levels of social participation, mobility is strongly related to health status and quality of life (Groessl et al., 2007; Metz, 2000; Yeom, Fleury and Keller, 2008).

With increasing age, the need of finances also increases as older populations are more prone to suffer multiple chronic and other forms of health issues. However due to economic dependence on their caregiver, much attention is not paid to their healthcare needs. Banjare, 2016 has described this as a double crisis where the elderly does not have financial security or independence and are more at risk of mix burden of health morbidities. (Banjare, 2016). In the study (Dillon and Gupta, 1992) stated that in the middle class socio-economic community, the elderly relatively healthier and more in control due to the better socio-economic conditions, higher education and better family and social network as compared to the health of elderly in poor socio-economic conditions.

There is less reported morbidity among the elderly who stayed in the larger family (more than five members) as compared to the elderly staying in smaller family size. This pattern has been explained in many contrary ways. Gupta and Pillai see the joint family as contributing to better care for the elderly (Gupta and Pillai, 2002) whereas in another study, this is attributed to morbidity in the the elderly being given less consideration over the health of other young members in the family (Zyzanski et al.,1989).
Various theories have arisen to explain the dynamics of health changes in the older population and the interplay of mortality and morbidity patterns with demographic change (Myers, Lamb, and Agree, 2003). Whereas the morbidity theory of expansion reflects the medical paradox, i.e., with the increase in expected life increases, it entails an increase in morbidity conditions (Gruenberg, 1977). This can help us understand the morbidity pattern in the elderly across states.

Southern states like Kerala, Tamil Nadu, Karnataka, Andhra Pradesh which have made a demographic transition (low fertility, low infant mortality, aging population and increased life expectancy) and have also made significant economic development and attained higher educational status as compared to the rest of the states, have elderly-morbidity rates that are moving upward. This has been reported by other studies also (Dilip, 2007). In Kerala, the morbidity in the form of PAP among elderly population reported increased three times, of which NCDs alone increased by four times in last two decades. Also, communicable diseases among elderly and other condition that included the infectious conditions also showed the significant increase. These souther states also have higher hospitalization rates. Kerala, reported highest utilization of inpatient care hospitalization (189 per 1000) rate in 2014 in the elderly population compare to the other major states. Apart from Kerala, Tamil Nadu and Andhra Pradesh, where both demographic and epidemiologic transition occurred earlier reported higher hospitalization rates compare to the high fertility, high infant mortality states with lower economic development and literacy levels like Bihar, Uttar Pradesh, Orissa, Rajasthan, and Assam also report significant improvement in reporting the elderly morbidity since 1995 to 2014.

But in these states, in contrast to the southerm states there is no corresponding rise in utilization of services as reflected in hospitalization rates. Rates of reported morbidity have risen due to improved awareness but access is limited due to barriers- which could be in physical access, affordability or inadequate health-seeking behaviours. The vulnerability associated with elderly makes the healthcare access a big challenge for the growing elderly population in these states.

Summarizing the changes in self reported morbidity across the two decades we find an 50% increase in morbidity rates, which is more in the older age groups. There is also a significant increase in self-reported morbidity by the elderly females as compared to the male elderly. Till 1995, the results indicated equal morbidity rate among both male and female elderlies. By 2014,
the morbidity reporting by elderly females increase by 50% (201 PAP per 1000 in 1995 to 312 per 1000 in 2014 and showed marginally higher morbidity burden than their male counterparts (201 per 1000 in 1995 to 299 per 1000 in 2014). The results are in conformity with other studies which all show elderly females reporting higher morbidity as compared to men, but a higher proportion of elderly males are hospitalized as compared to elderly females (Ranjan and Sreerupa, 2008).

The increase in hospitalization rates occurs in all sub-groups – by income, by educational level, by physical mobility, by economic dependence, by living alone. The hospitalization rate among the elderly population who were divorced or separated showed the drastic increase from 1995 to 2014. This is converse to the findings in one previous study that stated that living alone did not substantially disadvantage older adults concerning acute sickness and hospitalization. (Ugargol et al., 2016).

An urban advantage in health mostly found when comparing averages between urban and rural areas, but when investigating health indicators within urban areas, significant heterogeneity arises (Rice and Rice, 2009). Due to which, the health status and condition of the urban poor is diluted along with the overall good picture of the urban health. Till date, the urban poor health did not get enough consideration in the government agenda (Shetty, 2011). Given the increasing number of poor urban residents and slum dwellers in cities and towns across India, this leads to our limited understanding of the interconnections between urban deprivation in context to health which makes the study of the issue surrounding elderly health and healthcare essential.

Further quantitative data helps understand morbidity rates change in different sub-groups- but it does not adequately explain how the factors that define these sub-groups- like living alone, economic dependence, physical mobility interact with social contexts and access to lead to changes in utilization. Further even in contrasting sub-groups which are lower in morbidity, the levels of suffering and morbidity are high enough for us to understand mechanisms of deprivation from care that straddles these sub-group boundaries- more so in lower socio-economic groups. Finally, quantitative data from the NSSO surveys does not help us understand the elder people’s perceptions and prioritization of health care needs and how they are coping with them. For all these reasons a set of indepth interviews were carried out. This was combined with a case study where a community health programme was conscious and addressing many of
the supportive needs of elderly care which were part of and needed to accompany geriatric health care- for in such a setting the supportive needs could be seen and articulated better.

The socio-economic profile of the elderly participant in this community reflected the higher illiteracy rate coupled with the deprived environmental, social and economic. Out of 20 elderly participants, half of the participants were widow.2 were deserted female elderly, 8 were female widow and 2 were male widows. Thus more elderly women found live without spousal or family support as compared to the male elderly. The state of family networking and support was also found very poor. The condition is further worsened due to the indulgence of most of the elderly participants’ children (son) into various form of substance abuse, with no formal occupation or job and high rate of illiteracy among them. Most of the elderly women who were living alone expressed their desire to live with their adult children and preferably with the married son. This finding also supported in some of the previous study which found elderly women preference to live with their children during the oldage (Beydoun, and Tohme, 2009) but poverty, lack of social support, personal limitations, and physical locations are some of the important factors that increase the vulnerability among them (Mechanic and Tanner, 2007).

**Perceived Health, Healthcare Needs, and Utilizations- Community/Elderly perspective**

The Anderson and Newman model conceptualizes utilization of health care as based on needs dimension which is influenced by predisposing and enabling factors. The findings of our qualitative study have elucidated the predisposing factors and enabling factors of utilization of healthcare by the elderly in a poor community.

Peoples perceives health and healthcare need influence to a great extent the health-seeking behaviors among the elderly (Kabita et al., 2017). Health-seeking behavior of the elderly people was influenced by a variety of factors such as socioeconomic conditions, age, other basic needs, gender, an authority of the elderly within the family, the financial security of elderly, their perceived health status and illness, type of illness, and access to services (Dey et al., 2012).

One key predisposing factor is the perception of need. Most of the participants of the indepth interviews reported poor health status, but considered only physical health complaints which were mostly symptoms as needs. However, with desirable probes to bring out many related dimensions, we get a more holistic picture of their needs and health status. After the most
reported dimensions of physical health, the next important dimension of wellbeing was the presence of lack of family support mainly from children (son). This could take the form of being left alone or of neglect or even of active ill-treatment. Such conduct resulted in the participant feeling lonely and sad. One particular form of being alone was widowhood, which was reported as the crucial dimension among the elderly female participants as affecting their health. Studies have reinforced that home-based care with family members as primary caregivers was still the first and often the only option for a majority of older adults, and the most common type of living arrangement in India was found to be living with married sons and their families (Devi and Indira 2007; Prakash 1999). Unfortunately, as seen in our study as well as in published literature, demographic shifts are reducing the availability of familial support to India’s older adults (Krishnaswamy et al. 2008; Rajan and Kumar 2003). This is worse in the poor and marginalized.

Physical mobility is another dimension that the elderly considered as limiting their functions and impacting their overall life conditions. But this is closely related to living arrangements in the form of family support and economic independence. Elderly participant except few, all were reported managing their essential expenses on their own, and few of them are continuing to earn modest supplementary amounts. Even though, some of the elderly participants reported staying with the children (son), they were not supported for essential expenses and care and this included mainly providing food, or accompanying them to the health facility, and supporting other financial needs. If physical mobility issues are added onto such a context, it becomes most difficult to manage and leads to much higher levels of morbidity and the lack of wellbeing.

Another important dimension which was considered by almost all the participants for reporting their health as good or bad was the adequacy of access to food. This was recognized as an important need among the elderly by the caregivers of the community geriatrics programme-Prem Chaya- and addressed innovatively. It is only in the presence of such a services, that the necessity of such a support was understood and articulated by the elderly, who otherwise may not mention this in a discussion on health.

Elderly in this community are disadvantaged regarding awareness of their entitlements. Most of the elderly were availing the old age pension with the support of the SSCHC staff who assist in the process and need documentation to get the entitlements. For most the participants, this old
age pension was the only source of income, and since its delivery was often irregular, it was difficult to manage all their essential expenses.

In such a context the elderly may have to choose between food, other essential personal expenses, and health care needs- and in such a context it is the healthcare needs that would have the least priority and be most compromised. The more the problems in access, the more they have to spend for travel to access health care, the more likely that the healthcare needs gets compromised.

On exploring the reported morbidity among the elderly in this community (chapter 7), it was found quite similar to the national estimates reported in chapter 4 and 5. But differences were found between what was reported problems and what were problems addressed. Most of the participants while asking the chronic health conditions, first reported the symptomatic health conditions which were causing them immediate discomfort. These were the generalized pain, pain in knee and back, weakness, stomach discomfort, where fever and cold were reported as the effect of seasonal change and the conditions that are obvious with seasonal change. Generally, they would not report chronic conditions unless asked specifically. There were few participants who reported chronic conditions in the first instance but in these instances it was because their chronic conditions were causing them acute discomfort. On probing, female participants reported most of the chronic diseases such as hypertension, diabetes, asthma as compared to male participants who only reported hypertension and needed further probing for eliciting other conditions. Apart from this, vision-related problems were reported by more than half of the participants, but again only when asked separately. Also as per the provider’s perspective, the elderly in this poor community are considerably more vulnerable to the debilitating health conditions other than the chronic conditions such infections, communicable diseases, undernutrition or malnutrition. Apart from this, due to poor sanitation and environmental conditions, TB is prevalent among the elderly in this community. The main reported conditions included pain, hypertension, Diabetes and vision conditions. Due to their compromised immunity coupled with both age-related as well as poor nutritional conditions often makes them suffer seasonal issues like a cough, cold and fever.
Many of the health conditions either were not recognized as health conditions and often perceived as a normal and perhaps inevitable part of aging. A good example of this, was the condition of urinary incontinence particularly among elderly women. This was often not recognized as an ailment. On exploring specifically, the participants reported it, but even then they were not comfortable discussing it, though some of the elderly showed interest to know about the condition further and the treatment regime.

When reading each of the disease categories in the list, no participant reported depression—though some of them had all the symptoms of it. Moreover, most of the participant reported loneliness and ‘boredom’ while discussing their wellbeing and quality of life. When the condition of depression was assessed using the depression scale (keeping the questions open-ended to get the contextual understanding too), there were participants found with the depressive attributes.

Clearly where there is no realization of the problem or issue, it will direct lead to low healthcare utilization. Currently, in the Indian context, most of the existing data and research on geriatric issues refers to self-reported illness to measure health status and these provide the basis for assumptions which are used for various policy formulation (Idler and Benyamini, 1997; Dilip, 2002; Duriasamy 1995; Murray, 1998).

Perceived Healthcare Needs

When specifically queried about healthcare needs as perceived by the elderly themselves, most of the study participants expressed needs related to social care and support— which is not supposing considering that they are living under poverty and deprivation. What elderly expressed as such supportive health care priorities included Food, safe transportation to the health facility, supportive aids/devices that enhance mobility, and assurance of at least a place to sleep or take rest was the most reported. Requirements which directly associated with the medical care included the provision of medicines for chronic illnesses, timeliness of services, support and assistance within the health facility, language and conduct of the health providers, and feeling respected by the providers.

Among these elderly participants, rationalizing their situation was one form of coping with it. One form of such rationalization was accepting it as a part of the ageing process. Another was
comparing themselves with other peers’ member who were worse off. Food was the most necessary and crucial aspect of needs among these elderly participant, but none of them directly reported the crisis of food, for it was a sensitive topic to reveal. Therefore, they reported more quantity and quality of food available or provision of food in a conducive environment as the main factors as to why they were visiting the Prem Chaya.

There were many coping mechanisms mentioned- reducing the portion or size of the food or the number of meals. Health issues like poor digestion, or edentulousness (partial or full) also impacts also limited their food intake. Most were not forthcoming on the rationing and lack of access to food at the home initially and were sensitive to questioning on this area, more so among women elderly. Apart from household and economic factors, there were beliefs about the food intake and living alone that determined intake.

**Health Seeking and Perceived Barrier to Access Care**

The findings suggested that, irrespective of the availability of the various health services available, the uptake and utilization of such services vary and are often uneven. This study shows that the elderly received health care in an uncoordinated, sporadic manner from a variety of sources for a variety of needs, partly driven by resource constraints and partly by their beliefs and understanding about what would be optimal care in a given context. If the elderly participants were suffering from more than one ailment, a priority setting was done by them on which ailment to attend to first and which to ignore or under-treat. If married elderly, and both had health problems then preference to care seeking could go to the male spouse first, with the female coping with her needs. Symptomatic illnesses were prioritized over asymptomatic illnesses though the latter could be more life threatening.

There was no elderly found who were actively seeking care for any chronic health conditions unless they had a significant discomfort due to that. Part of the reason for this was because illness has passive acceptance as a part of the growing age in this community – and this could be more so in more poor and marginalized communities and the attitude of the elderly reflects this view of the community (Krishnaswamy et al., 2008).

The findings provide an important insight about belief-behavior models among the participant, shedding light on the conflicting findings in the existing literature. Firstly, the demedicalisation
of some of the health conditions where problems are increasingly considered to be non-illnesses and attributed to age factor, and Secondly the perceived acute or symptomatic issues were given more consideration over the chronic conditions until it is causing any immediate discomfort to them, for availing the care. The findings of the quantitative analysis of the NSSO 71st rounds however indicating a significant increase and rate of elderly morbidity but it could be even more which remain unreported or underreported due to such understanding among the elderly.

For chronic diseases, the treatment depends mainly on the availability of the free medication within the easy reach and access by these participants. Due to the cost and traveling factor involved in the process to get free chronic medication, it mostly resulted in the discontinuation of the chronic medication or taking medication as and when they feel any discomfort due to the chronic problem. In this community, the elderly participants reported the higher degree of social care (food, housing, economic hardship, lack of knowledge) over the specialized medical care. A previous study mentioned that immobility, inaccessibility, misconception, and poverty lead to reduced utilization of healthcare services (Kumar, 2003).

In the study, there were no elderly found seeking care for mental health problems. However, few of them found with depressive attributes and one elderly reported the cognition and memory problem. This finding is also supported by a study that found there is usually lack of awareness existed regarding various mental health conditions which are prone to the elderly population (Shaji et al., 2004). In one of the studies in 2001 reported that Dementia and Depression were not addressed and recognize as the health problem to seek care among the elderly population. (Patel and Prince, 2001). Also, these specialized care may not be preferred and approach by this socially and economically marginalized elderly population.

The findings suggested that an essential component of care provision for the elderly population is the availability of the care within easy reach of elderly people since it plays the most crucial part in accessing care. The existing arrangement for the care of the elderly where the elderly has to travel to a healthcare facility is often very challenging especially among the older-oldest segments of the population (70+years and above) where disability, and issues of physical mobility, are also often prevalent.

Traveling alone, fear and difficulty of walking much, the crowded and uncomfortable condition of public transport and lack of accompanying person, apart from the financial barriers all
together make accessing referral care difficult task for them. Therefore; the organization of healthcare requires special affirmative measures for ensuring access, a friendliness to elderly (acceptability) while at the same time keeping it affordable.

The barriers to referral care that we identified can be categorized as structural barriers to accessing health facilities (i.e., transportation, physical barriers, facility accessibility, cost of services) and as process barriers at the health facility (i.e., timeliness of services scheduling of appointments, language, feeling respected, and health provider conduct). The results confirm research in other countries (Aboderin, 2012; Goins et al., 2005; Van Rooy et al., 2012), showing that older adults experience multiple barriers to accessing health care. This makes all access to referral care a challenge among the elderly and emphasizes the need for an accompanying person to help find and negotiate their way. In the current context this leads to a subjective change in choice and preference of provider for healthcare needs that require visiting a secondary or tertiary care site, even if the choice is not the best possible from an objective medical point of view.

**Operationalizing Geriatric Care in the Marginalized Setting:**

Due to the selective service provisioning at the primary care level, geriatric care is absent at the primary care level. In such a context, the perception amongst providers of geriatric care as a super specialty domain is making the access gap even wider. The current organization of health care services for the elderly which emphasizes only curative medical needs leads to creating the dysfunctional and non-holistic approach of addressing the diverse needs of the elderly. Our findings are similar to findings from other studies. The article on unmet needs of the elderly in a rural population of Meerut (Goel et al., 2003) mentioned that 96% had never utilized any geriatric welfare services due to economic dependence, ignorance to the healthcare advice, loneliness, distant government health facilities and lack of awareness as well as utilization of geriatric welfare services. The organization of health services for the elderly in a disadvantaged community should creatively integrate insights about the critical life issues that impact on health and well being- physical mobility, lack of family support, access to food, place for rest, opportunity for social interaction with peers into the organization of care. While the provisioning of the services should take into account the most immediate concern and issues of the elderly, it should also make more senior citizen friendly arrangements for referral consultations and for
regular uninterrupted access to medicines essential for their chronic illness. The quest for the system that responds holistically the needs of this diverse nature is still lacking. Despite various efforts and investments towards strengthening the elderly health, there are still yawning gaps between the nature of service provisioning and the health needs of the elderly population especially those in a poor resource setting.

Elderly in this setting are found to be with low healthcare expectations. Lack of support, low education and awareness levels, and various existing insecurities mainly in the form of financial constraints, access to food, family network and adequacy of housing lower healthcare expectations even further. These needs often overshadow health care needs and are more of a priority than finding treatment for chronic illness. An assumption that a number of illnesses are natural to old age and therefore inadequate health seeking also contributes. Conversations about what an individual believes about healthcare needs and treatment preferences need constant updating and can evolve, dependent upon the individual and social circumstances as well as on availability of services, and increasing knowledge about what is an inevitable part of aging that has to be accepted and what is remediable. What cannot be cured, has to be endured, but a lot of what is being endured can be cured. And an even greater part of it can be prevented.

**8.2 Limitations of the Study**

In the results of the quantitative analysis provides the overview about the current morbidity and healthcare seeking and the emerging patterns of morbidity and healthcare utilization during the span of last two decades from the population-based survey of last three rounds of NSSO. Although, these findings need to be taken in the light of some limitations. It might be possible the reported morbidity of the elderly underreported (Sundararaman and Muraleedharan, 2015) by the marginalized and disadvantaged elderly or could be over reported among the sensitized, educated and economically advanced elderly population.

The overall sample size of the elderly population (60+ age group) in the 52nd round during 1995 to the last 71st round (2014) has considerably declined. As a result, it is likely that the prevalence estimates across various rounds of NSS are affected.
Also, there elderly cohort in 1995 and the elderly cohort during 2014 might have variation regarding education attainment, and better enlightenment and consciousness regarding the morbidity condition might have impacted the reporting pattern. Also, in the morbidity categorization (Appendix 1), there have been slightly mismatch due to the difference in the coding pattern of ailments in 52nd and 71st round. Moreover, there is lack of food, and nutritional aspects have not been examined in these survey data, which have great relevance for the elderly health and morbidity condition particularity for NCDs and communicable and infectious conditions. Despite this limitation, the current pattern and emerging trend of the elderly morbidity and healthcare seeking is useful in providing insights regards the elderly related morbidity burden across the major states and the various demographic, social and economic conditions along with some of the relevant attributes such as physical mobility, living arrangement, and economic dependency. This will provide the direction for the relevant policy change and programmes for managing morbidity of ageing India. The qualitative part of the study also has some limitations. First, the case study and its participants were selected via purposive sampling due to the time constraint and approval issues. This may add the bias in findings, but that was the best possible option present during the study. Second, semi-structured interviews were conducted by the researcher, and not by usual care providers; therefore, elderly subjective needs may have been excessively measured. However, this could be interpreted as having provided the opportunity for potential elderly needs to rise to the surface, whereas elderly might have refrained from expressing them out of consideration of the relationship with their regular care providers. Thirdly, all the elderly study participants were cognitively intact and were able to communicate verbally, application of the results to other older in different socio-economic conditions requires caution. Fourthly, in this study, the family perspective on elderly care was not included which might have potential impact in addressing and understanding needs for geriatric care. Furthermore, this study was exploratory to bring forward the diverse aspects related to health and health care needs of the elderly. The study was intended to explore the composite understanding through provider’s perspective how they perceived the needs of geriatric care provisioning in the community. Some of the dimensions require the further exploration which was not possible due to the time and resource constraints of the study.