CHAPTER IX
CONCLUSIONS

The present study aims to understand the gaps between needs and access to services for the elderly by examining the morbidity rates and patterns, issues of access and barriers, utilization of services and choice of providers, and the organization of service delivery. This study uses a combination of quantitative and qualitative data for exploring the problem.

The quantitative analysis was undertaken using the secondary data source of 52nd, 60th and 71st round NSSO survey. The qualitative part of the study was structured as a case study, where the perspective of the elderly and of primary health care provider’s assessment of needs and gaps were gathered through in-depth interviews in a context where the healthcare needs and other elderly care needs were being addressed in a relatively more comprehensive manner.

The study shows that elderly population reported significantly higher morbidity rates compared to the rest of the population (as measured by the indicator PAP per 1000 population). Even within the elderly population, the older the age, the higher the morbidity rate. Morbidity rates are also higher in women as compared to men, with urban residence and as compared to rural residence. Morbidity rates are also higher in upper economic quintiles and with higher educational status. Utilization of services – both ambulatory care and hospitalization rates are higher in the more economically developed, low fertility, higher educational attainment states of the south as compared to the northern states which have higher fertility, lower educational levels and lower socio-economic development.

The share of NCDs conditions are remarkably high but communicable diseases, injuries and disabilities are also higher in elderly population as compared to the rest. What emerges from our case study is that the morbidity rates are probably much higher than picked up by the NSSO survey. Providers reported a number of illnesses like mental illness which had high prevlance but for which treatment was not being sought. In-depth interviews with elderly brought out the fact that the elderly tended to report only those illnesses which were symptomatic and do not report other chronic illness. They also attribute a number of ailments, (some of them severe like partial urinary incontinence) to normal aging and do not perceive it as
an illness. The case study also brings out the fact that where there is greater mobility, greater availability of services and greater support for accessing required services, the reporting of ailments increases. This could explain why with more marginalization, less education and less economic development utilization rates and even perception of morbidity decrease (as happens in the northern states) though on biomedical grounds we would expect the poor to be more sick more often.

With respect to gender, the findings show a greater reported morbidity (based on PAP per 1000) in the female elderly but a lessor rate of hospitalization. Female elderly who are widowed and those who are alone report even lessor hospitalization rates- and as life expectancy is more in women, such feminization of aging and its problems is becoming more common.

In general, higher utilization in the elderly needs not only greater mobility but also a more supportive family environment, someone to accompany them for care seeking and lessor financial dependence.

Reported morbidity rates and utilization of services decreases with family size- but it is difficult to decipher whether this is a positive finding indicating lessor morbidity with better care in a joint family setting, or a negative finding indicating neglect or at least lack of priority for the health of the elderly as compared to others in the household.

These findings have some major implications for the organization of health services that the elderly can access, that are responsive to their needs and that are elderly-friendly. These can be listed as follows:

1. As the proportion of morbidity due to healthcare needs of the elderly rises sharply integration of the geriatric care provisioning into primary care by educating and empowering community-based primary health care providers and a better organization of healthcare services becomes an urgent task.

2. Many of the elderly health problems can be addressed within the community level – the most common needs being pain alleviation and medication for chronic conditions. The currently available range of services needs to be extended considerably to include many of the non-communicable and communicable diseases that are prevalent in the elderly.
3. There is a need to broaden the package of care for elderly to address the full spectrum of issues including the nutritional, rehabilitative and rest and lifestyle aspects of care. This is even more for the necessary for the elderly who are both poor and marginalized and hence living with double burden.

4. Free healthcare for the poor is necessary but not sufficient to address the healthcare and elderly care needs of the most vulnerable within the elderly community- like those who are older, or have physical disability or living alone with no support, or victims of abuse or the destitute. These sections need affirmative action. The Sundar Nagari case study where SSCHC and outreach programmes are efficiently and to great extent addressing their basic health care needs while Prem Chaya as an affirmative action effort addressing the other basic entitlements (food, resting place and recreational care) needs to be learnt from and scaled up.

5. Emphasis more on outreach programmes, with home visits by frontlines health workers are a more efficient and appropriate measure to address the elderly needs.

6. Many of the illnesses of the elderly are considered as part of normal ageing and elderly are living with the understanding that these have to be accepted and endured. Hence there is need of more sensitization among them so that they are aware of curative care and palliation that is available. Though the quantitative findings from NSSO reported higher morbidity among elderly but it could be that because of such an understanding of normality, even more ailments remain unreported.

7. Even where services are available, there are various ‘subjective’ barriers including their understanding, preferences, and choices that lead to poor or inefficient utilization of the health care among the elderly. Along with service provision, ensuring health education and behavior change communication will contribute to better understanding of health, ageing and improved healthcare utilization.

8. Most elderly illnesses require referral consultations- but given the difficulties in accessing such care at a tertiary hospital, there must be efforts to organize care such that referral care for the elderly could be with in community. Where going to the hospital is necessary, it must be part of primary care to arrange for accompanying them and assisting them to access this care.
9. Geriatric care must encompass dignity, respect and compassion - and these components should be practiced while rendering the care for elderly and reflected in the form of organization of health care services. Currently this is lacking in both envisioning geriatric care and in planning geriatric policies and programmes.

10. The heavy reliance of the elderly health policies and programme on the nebulous concepts of morbidity and its treatment should call for reconsidered with insights from the perspectives and experiences of the elderly population themselves. Healthcare for the elderly should be embedded in the larger framework of caring for the elderly - where healthcare is only one component amongst many.

**Scope of further research in the areas of geriatrics: Addressing the Gaps in Geriatric care**

There is a need to evaluate models of geriatric care to understand how these perceive and address the health needs of the elderly. This should not only look at gaps in common examples of service organization but also examine best practices and innovative models of elderly care delivery. There is also the need to study the cost-effectiveness of different models of health care delivery for the elderly - and make a case for more comprehensive and human approaches to supporting the elderly in a wide variety of needs of which health care is only a part.

There are still many unknown issues about how an elderly care system works or its slow response to the growing needs. Similar studies are required from different settings in India and these should study how the needs and gaps are evolving with social and economic changes in society.