ABSTRACT

Background: Existing health care systems have the potential to deliver quality care for the elderly, yet a significant proportion of the elderly population are unable to reach and receive even the basic primary medical care. There is a need to understand and address this yawning gap between the growing diverse needs of the elderly in diverse socio-economic settings and the current provisioning of geriatric care. This 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.

Methodology: 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 way.

Results: Our findings show much higher morbidity rates (Proportion of Ailing Persons (PAP) per 1000) of 302 per 1000 in the elderly population, and a greater proportion of overall morbidity rates being contributed to by the elderly. The morbidity rate of 302 per 1000 population is constituted by communicable diseases (47 per 1000), non-communicable diseases (191 per 1000 which includes chronic respiratory disease of 23 per 1000), disability (11 per 1000), injuries (4 per 1000) and others (50 per 1000).

The findings of the trend analysis of three rounds of the NSSO showed a significant increase in morbidity rates (PAP per 1000) over the last two decades across major states as well as variations in increase across various demographic, social and economic determinants. Cross-state comparisons show that both PAP and hospitalization rates are much higher in the more economically developed and literate southern states as compared to the northern states.

The results indicated a significant increase in NCDs over the last two decades, but the prevalence of other morbidities such as communicable disease, injury and disability have also shown a continuous increase and in each of these the rates are relatively higher as compared to the other
non-elderly population. The findings of the primary data analysis also indicated the same pattern of higher rates of chronic conditions. In the providers’ perspective, elderly in poor resource settings are more vulnerable to infectious conditions due to the compromised immunity due to poor nutrition and sanitation condition along with a higher prevalence of various chronic conditions such as hypertension, diabetes and vision-related problems. However, healthcare seeking by the elderly are mostly for pain and discomfort caused by the acute conditions. Morbidity among elderly varies considerably across age group, sex, place of residence and economic conditions.

Elderly in an urban setting with better economic condition and education status also reported a higher level of morbidity. The result of the logit model also found a significant adverse impact of the physical immobility, economic dependence and living alone on the morbidity among elderly. The case study finding, on the other hand, was that where there is greater mobility, greater availability of services and greater support for accessing required services, the reporting of ailments increases. Also, the case study suggested a ‘de-medicalisation’ of some of the health conditions where health problems are increasingly considered to be non-illnesses and attributed to be a normal part of ageing. This indicates that the quantitative data of NSSO is likely to be seriously under-estimating morbidity rates- and it would also explain why states with higher levels of education and development and access to healthcare show higher morbidity rates.

In the last two decades, there was a significant increase in reporting morbidity among female elderly. As per NSSO 71st, there was higher morbidity among females’ elderly as compared to males, but hospitalization is marginally lower among females, though even this has improved significantly in last two decades. The findings directly from the community suggest how the gender differentials in access to health care play out among the elderly at the community level. Though a greater proportion of the poorer quintile seeks ambulatory care in the public facility as compared to higher quintiles, it is noted that even in the poorest quintile close to 59 percent are seeking care from the costlier private sector. The Sundar Nagari case study helps us understand some of the reasons for this. Though in urban areas, distance to the facility is not seen as a problem, for the elderly it is a big barrier. Further long waiting times, and difficulties with accompanying person, finding one’s way in the crowd of the hospital and a lack of relevant public services and suitable timings makes it easier for the elderly to approach to the locally available, often unregistered practitioners' for seeking ambulatory care needs.
**Conclusion**: issues of our times. This increase is seen across all categories of illnesses, and through self-reported surveys bring this out, they underestimate the rates because of methodological issues, that arise from a failure to understand the perceptions of illness in the elderly. Further, in the poor and marginalized community, the other supportive care needs of the elderly often take precedence over the medical care needs. Such supportive needs include food provision, counselling, a space for social interaction and rest, assistance to secure their entitlements and outreach care programmes. Therefore, it calls for a more holistic approach to elderly care where community-based health care is one of the components- but not the only one. Further within the elderly, there is a more vulnerable group who face isolation and loneliness, who lack support or mobility and who have greater financial crisis or disability and such elders need even more affirmative actions. There is an urgent need for integrating geriatric care into primary health care as most of the elderly health concerns and issues could be effectively addressed within a primary care setting. Rising morbidity in an increasingly ageing population is one of the central public health.