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Determinants of Right to Health for Elderly People

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ABSTRACT

Old age is a natural part of the life-cycle. All living organisms, including man, go through the process from conception to infancy, childhood, puberty, maturity and senescence. It is considered as the closing period in the life-span. Many believe that it is an incremental phase in the life-cycle while others associate it with health problems or disease. This rapid growth of ageing population has become a serious challenge to public health globally. Even though, the life expectancy has been increasing and it is a welcoming trend, on the other side, it increases the dependency ratio to the household. Without any increase in additional income, but proportion of enjoyment in the household will not give any positive impact. The results of this study showed that a major proportion of the elderly were getting zero income, partially or totally dependent on others, and suffering or affected by health problems of the elderly. There is a growing need for interventions to ensure the health of this vulnerable group and to create a policy to meet the care and needs of the disabled elderly.

Keywords: Old age and ageing, Health problem, Right to health

INTRODUCTION

Old age is a natural part of the life-cycle. All living organisms, including man, go through the process from conception to infancy, childhood, puberty, maturity and senescence. It is considered as the closing period in the life-span. Many believe that it is an incremental phase in the life-cycle while others associate it with health problems or disease. This debate aside, ageing is a universal phenomenon. However, at the collective level, old age poses a challenge to policy-makers in developing as well as developed countries. In modern times, this challenge is further accentuated, interestingly enough, by the rapid growth of science and technology. Better nutrition, sanitation and health facilities have decreased mortality rates and increased expectancy of life. Denoting a demographic transition, it has radically altered age-structure of the population. As a result, the population is moving towards a rectangular survival curve, in which fewer persons die from disease and most live until the very near end of the maximum life-span. And thus, many countries are found face-to-face with what is popularly termed as "greying of the nation".

Aged people are called senior citizens or golden agers. Apart from economic problems they face in the life the common diseases like ortho, visual, mental, deafness, etc. Some face grave diseases relating to heart and blood also. Hence, a separate branch of medicine dealing with the diseases and care of the old people has come which is famously called Geriatrics and the scientific study of old age and the process of growing old is called Gerontology.

DEMOGRAPHY OF AGEING

Studies on ageing of human population are of quite recent origin. The phenomenon of ageing being conceived in terms of chronological measurement became an area of demographic research in the initial years of gerontological research. With the ongoing rapid social and economic changes, it is expected to have serious implications on the circumstances under which the future elderly will live. These socioeconomic changes comprise emergence of nuclear families, smaller number of children per couple, greater longevity, physical separation of parents from adult children as a result of

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rapid urbanisation and age-selective rural–urban migration, together with the changing values of younger generations against the older ones.

The ageing of a population is obvious consequence of the process of demographic transition. Being ahead in this process, the developed regions of the world have experienced its consequences and the developing world is well on its way to facing a similar scene.

Though the proportion of elderly persons (defined in terms of those aged 60 and above in a population) seems to be low in some of the developing countries, they have more elderly persons in absolute terms because of their large population base. A recent emphasis is on studies pertaining to the elderly in the developing conditions. When their increasing number is attributed to demographic transition, their deteriorating condition is considered as the end result of the fast eroding traditional family system in the wake of rapid modernisation and urbanisation. As neither of the circumstances is avoidable, the reasons seem to be the lack of adequate preparedness. However, the available studies have addressed multiple dimensions of the situation of the elderly by projecting their future size and composition, assessing their needs and difficulties with regard to health, social adjustment in old age, etc.

With the background of fertility and mortality trends, it is worthwhile to preface our discussion with an account of the structure and magnitude of the elderly. The number of elderly in the developing countries has been growing at a phenomenal rate to the extent that in 1990, the population of aged 60 years and above in the developing countries exceeded that in the developed countries (estimated world total of 490 million). By 2030, this number is expected to triple at 1.4 billion. Most of this growth will take place in developing countries and over half of it in Asia (World Bank, 1994). Obviously, the two major population giants of Asia, namely India and China, will share a significant proportion of this growing elderly in future. Hence, there arises a need to understand the socioeconomic as well as demographic dynamics of the elderly population in general.

AGEING IN SELECTED COUNTRIES

In the previous pages, countries have been classified on the basis of developed and less developed regions to indicate the trends in the ageing of populations. The data given in Table 1 shows that by 2050, most countries in both the regions are projected to have more than 20 percent of persons aged 60 years and above in the total population. In the world as a whole, almost one-third of the population is projected to be 60 years of age and above in 2050. Among different continents, Africa will have the lowest percentage (10.1 percent) and Europe the highest percentage (35.1) in 2050, which is almost three and a half times. Asia is projected to have 23 percent of persons aged 60 years and above in 2050. Japan, Korea, Thailand and Singapore are projected to have more than 37 percent persons aged 60 years and above. In 2050, Japan will be the highest (42.4 percent), followed by Italy (46.6 percent). India is projected to have one-fifth of the population aged 60 years and above in 2050. This will be lower than the percentage in Japan in 1995.

Among different continents, Asia will occupy the centre stage in providing residence to more than half of the global population aged 60 years and above. In 2000, Asia had 53.1 percent of the world's total population aged 60 years and above. In 2050, it is projected to have 62.4 percent of the global population.

In 2000, India had 12.7 percent of the world's population aged 60 years and above. Projections for 2050 indicate that India is likely to have 16.2 percent of the world's population aged 60 years and above. China, in 2000, had 21.2 percent of the world's population aged 60 years and above. Projections for 2050 indicate that China will be inhabited by 21.9 percent of the global population aged 60 years and above. These two countries, together, in 2050, are projected to have 38.1 percent of the global population aged 60 and above. In numbers, it will mean about 1.84 times the population aged 60 years and above in the more developed regions.

REVIEW OF LITERATURE

Bhat (1992) expected rise in the proportion of old age population is modest in the near future, the increased survival chance to older ages are likely to induce workers to save more for the welfare of the elderly. Therefore

Table 1: Percentage of population aged 60 years and above in selected countries (2000 to 2050)

Region Country	2000	2010	2020	2025	2030	2040	2050
World	19.4	21.8	25.8	27.7	29.1	31.0	32.3
Europe	20.2	22.1	26.2	28.4	30.2	33.0	35.1
North America	16.2	18.3	22.4	24.1	25.0	25.4	26.1
South America	8.3	9.9	13.0	14.9	16.7	20.4	26.1
Asia	8.8	10.1	12.9	14.7	16.8	19.9	22.8
Africa	5.0	5.3	6.0	6.4	6.7	8.0	10.1
Japan	23.3	30.2	34.0	35.5	37.3	41.6	42.4
Italy	24.1	27.2	30.8	33.7	36.9	41.0	40.6
Korea	11.0	14.7	21.1	25.0	28.8	34.5	38.9
Thailand	8.4	10.6	14.7	17.2	19.8	24.6	37.6
Singapore	10.5	15.7	26.0	31.1	34.7	36.8	37.4
Germany	23.2	25.7	28.3	32.1	34.5	34.4	34.5
Sweden	22.3	26.3	28.9	30.4	31.9	32.9	33.6
France	20.5	22.8	26.6	28.4	29.9	31.6	32.3
Canada	16.7	20.4	26.0	28.7	30.1	31.4	32.2
Denmark	20.0	23.8	27.2	29.0	30.7	31.7	30.6
Bangladesh	5.0	5.5	7.3	8.5	9.8	12.7	16.6
China	10.1	12.3	16.8	19.8	23.6	27.6	30.0
Australia	16.4	19.4	23.5	25.4	26.7	28.7	29.9
UK	20.7	22.5	24.5	26.2	27.6	28.8	29.8
Sri Lanka	9.8	12.1	16.3	18.9	21.2	25.3	29.3
USA	16.1	18.1	22.0	23.6	24.4	24.8	25.5
Indonesia	7.8	8.8	11.2	12.8	14.9	19.2	23.1
Malaysia	6.5	8.1	11.5	13.2	14.8	17.9	21.1
India	**7.5**	**8.6**	**10.8**	**12.2**	**13.8**	**16.7**	**20.1**
Philippines	5.5	6.7	8.9	10.2	11.8	15.4	19.8
Pakistan	5.7	5.9	6.8	7.3	7.8	9.5	12.6

Note: For countries, a descending order has been followed as per the projected percentage in 2050

Source: World Population Prospectus, (United Nations Population Division).

a phenomenal rise in the demand for geriatric medicine and inpatient hospital care is anticipated.

Da Vanzo and Angelique Chan (1994) used senior sample of the Second Malaysian Family Life Survey (MFLS-2) data to investigate which "seniors" (persons age 60 or older) live in this way. The analysis generally supports the notion that coresidence is influenced by the benefits, costs, opportunities, and preferences for coresidence versus separate living arrangements.

Yadave *et al.* (1997) examined the prevalence of age-related diseases in different socioeconomic and demographic groups. Various socio-behavioral factors are found to play a significant role in determining the health conditions of aged people. Also, illiteracy and poverty are found to have their own impact on health during aging. It is also noted that due to adverse familial relationships, many stress-related disorders occur which may result in the poor health of the elderly. Demands for old age pensions were made by most of the elderly people in the sample.

Elango (1998) found out major health problems and associated social problems prevalent among these study population. Main causes of illness were found to be

arthritis, cataract, bronchitis, skin diseases and malnutrition.

De Vos and Holden (1988) explained measures comparing living arrangements of the elderly. Nevertheless, some argue against this, asserting that cohabitation does not necessarily signify an equal distribution of resources among all members. However, the theory that sharing physical space is strongly associated with the distribution of resources holds strong.

Jamuna (2003) focused on dwindling of the joint family, the rise of dual-career families, a possible shift in filial piety values, the increasing life expectancy with greater chances of a prolonged old age characterized by poverty, degeneration, more empty-nest years, and dependency, have all added to the seriousness of the problem and made the elderly more susceptible than ever to abusive treatment. This paper examined these issues as well as the issue of elder abuse in light of available data and suggests some strategies to meet the problem. Also discussed are the problems, stresses, and strains of caregivers of the elderly. A greater role is envisaged for Non-Governmental Organizations (NGOs) than the state in the care of the elderly, particularly in providing support services to family caregivers.

PROBLEM SETTING

The mortality rate has been declining in developing countries, raising the average life span from around 41 years in 1950 to almost 62 years in 1990. Ageing population has been occurring much faster in developing countries, due to rapid fertility decline and increasing life span through medical interventions, providing effective treatment and prevention of diseases that used to be fatal. This rapid growth of ageing population has become a serious challenge to public health globally. Even though, the life expectancy has been increasing and it is a welcoming trend, on the other side, it increases the dependency ratio to the household. Without any increase in additional income, but proportion of enjoyment in the household will not give any positive impact. Similarly, the access to basic needs to the

unproductive age group namely elders are also less. Hence an attempt has been made to study the health problem of elderly in the sample area.

This Study was conducted with the following objective:

❖ To explore the health problems and right to health supported by family to the elderly people.

MATERIALS AND METHODS

The study is subjected to elderly men and women aged 60 years and above. This study is based on the primary and secondary data. The primary data have been collected through interview schedule method in Mettur block of Salem District. Of which, 80 elderly people have been randomly selected for this exercise. The data collected was tabulated and analysed using the Statistical Package SPSS. Findings were described using simple average, percentages and regression analysis.

RESULTS AND DISCUSSION

The following table shows the preliminary information of the sample respondents in respect to gender distribution, occupational category, type and size of the family and also income.

Table 2: Socioeconomic background of the respondents

Variable	No. of members	Percent
Gender (Male)	60	75.0
Occupational (Own business)	22	27.5
Monthly income (No-income)	28	35.0
Joint family	48	60.0
Family members(3 to 6)	42	52.5

Source: *Primary data*

The above table shows the socioeconomic background of respondents in the study area. The majority of the respondents (75%) were male category. Next of this, more than one-fourth (27.5%) were running own business such as grocer, weaver and broker. More than one-third (35%) of the respondents were in the setting of zero income due to the fact that the respondents may be either non-workers or homemakers. A joint family system was seen among majority of the (60%)

respondents. More than half the sample respondent households consist of three to six members and also the average size of the family was around four members which shows the average size of the Indian family system.

Table 3: Types of diseases

	No. of members	Percentage
Skin problem	10	12.5
Diabetics	30	37.5
Earache	14	17.5
Rheumatism	12	15.0
Other problem	14	17.5
Total	**80**	**100**

Source: *Primary data*

The analysis presented in the Table 3 revealed that all the elderly people were affected by any one of the diseases during the reference period. The common being skin problem, diabetes, earache, rheumatism, and others include cancer and heart problem. It is seen that most of the respondents (37.5%) had diabetes problem. Next of this, 17.5% respondents were affected by earache and other health problems such as cancer and heart problem. The rest of the respondents were affected by skin problem (12.5%) and rheumatism (15%) respectively.

Table 3 displays the Family Care Index (FCI) of the elderly people. It was revealed from the table that a majority of the elderly (41.3%) were in medium FCI ranging from 9 to 12. Next of this (35%) of them were ranging from less than 9 which falls under the category of low family care. Only 23.8 percent of them were in high FCI which is above 12 points.

Factor Determining Right to Health and Support from Family

Based on the FCI, an attempt has been made to identify the factors influencing the right to health of the elderly and how best the family members support the elderly people to have better health care facility. The following table gives brief information about the variables which are determining the right to health variable and the expected sign is also given.

Table 4: Family Care Index (FCI) of the respondents

Variable(s)	Score
1. Problem of health	Yes = 1; No = 0
2. Going to hospital	Yes = 1; No = 0
3. Family member interest to go hospital	Yes = 1; No = 0
4. Type of hospital	Yes = 1; No = 0
5. Members accompanied with elders.	Own = 1 Friends = 2 Family members = 3
6. Family member help	Yes = 1; No = 2
7. Special diet	Yes = 1; No = 0
8. Regular medical checkup	Yes = 1; No = 0
9. Mode of transport	Walk = 1 Motor cycle = 2 Bus = 3 Call taxi = 4
10. Family members care on health	Yes = 1; No = 0
Family care Index	**Score range 6 to 15**
Categories of FCI and Range	**No. of members (%)**
Low FCI(<9)	28(35.0)
Medium FCI care (9to12)	33(41.3)
High care FCI(>12)	19(23.8)
Total	**80(100)**

Source: *Primary data*

It is explained from the regression analysis table, the relationship between the dependent and independent variables which were statistically significant. It could be interpreted from the R^2 value given in Table-6 that the endogenous variables were explained by the exogenous variables by 70 percent, and the model is statistically significant.

The **age** of the elderly did not emerge as an influencing factor for determining the elderly health care.

The **sex** of the elderly influenced at 1 percent level of significance. When compared to male members, the female members do not have any right to health and also no support from the family members due to the fact that the male members have more earning capacity than the female members. Hence, the family members may have the interest of financial support of male elderly people.

With regards to the **occupational category** of non-working elderly people, the non-worker has negatively

Table 5: Variables included and expected sign

Code of variable(s)	Variable types	Expansion of the code	Expected sign
AG	Q	Age of the elderly	+
SX	D	Sex of the elderly Male = 1 Otherwise = 0	+
OC2	D	Agricultural labour = 1 Otherwise = 0	+
OC3	D	Retired government servant = 1 Otherwise = 0	+
OC4	D	Non – working person = 1 Otherwise = 0	–
INC	Q	Monthly income of elderly	+
TF	D	Type of family Joint family = 1 Otherwise = 0	+
HP1	D	Health problem of elderly Skin problem = 1 Otherwise = 0	+
HP2	D	Heart problem = 1 Otherwise = 0	+
HP3	D	Ear ach problem = 1 Otherwise = 0	+
HP4	D	Rheumatism problem = 1 Otherwise = 0	+
HP5	D	Diabetes = 1 Otherwise = 0	+
OHP	D	Other problems =1 Otherwise = 0	+
DH	Q	Distance the hospital	–
MS	Q	Monthly spent of hospital by elderly	+

Source: *primary data;* **Note:** D = Dummy variable,
Q = Quantitative variable

influenced the dependent variable at 10 percent level of significance which shows that the younger people think that, there is no use of the people those who are sitting idle in the family. Hence there is no monetary benefit from them.

The type of the family was a significant variable in elderly health problem. This variable had emerged as a significant factor at 1 percent level of significance. It was mainly due to the reason that joint family has more members to take care of the elders in the family.

Of the **health problems** of the elderly, the skin problem

of elderly influenced at 5 percent level of significance. Sugar problem of elderly influenced at 1 percent level of significance. This shows that wherever the elders are suffering or affected by the dangerous diseases like heart problem and others, obviously the elders should be taken care of.

The **distance to the hospital** influenced at 5 percent level of significance. The family members are willing to take elderly to the hospital if the distance is less.

Monthly expenditure on health for elderly influenced at 5 percent level of significance because the elders are suffering from different diseases. Hence there is a positive relationship between the type of health problem and monthly expenditure on health for the elderly people in the household.

Table 6: Factors determining the right to health of elderly people

code of variable	Variable type	Expansion of the code constant	Co-efficient	Std. Error
AG	Q	Age of the elderly	-.002	.017
SX	D	Sex of the elderly	**.947***	.266
OC2	D	Agricultural labour = 1 Otherwise = 0	.121	.265
OC3	D	Retired government officer = 1 Otherwise = 0	.121	.274
OC4	D	Non – working person = 1 Otherwise = 0	**-.690***	.389
IN	Q	Monthly income of elderly	.136	.142
TF	D	Type of familyJoint family = 1 Otherwise =0	**-1.535***	.232
HP1	D	Health problem of elderly Skin problem = 1 Otherwise =0	**.957****	.310
HP2	D	Heart problem = 1 Otherwise = 0	**1.047***	.274
HP3	D	Ear ach problem = 1 Otherwise = 0	-.216	.369
HP4	D	Rheumatism problem = 1 Otherwise = 0	-.041	.349
HP5	D	Diabetes problem = 1 Otherwise = 0	.556	.371
OHP	D	Other problem = 1 Otherwise = 0	**.955****	.399
DH	Q	Distances of the hospital	**.192****	.085
MS	Q	Monthly expenditure on health	**.435****	.146

Source: *primary data;* **Note:** *1% level of significant; **5% level of significant; ***10% level of significant

CONCLUSION

In the light of the above discussion, it is high time to change our attitudes and ways of modern life. Joint families where elderly also contribute as a useful member are welcome. The generation gap has to be reduced if not removed. The results of this study showed that a major proportion of the elderly were getting zero income, partially or totally dependent on others, and suffering or affected by health problems of the elderly. There is a growing need for interventions to ensure the health of this vulnerable group and to create a policy to meet the care and needs of the disabled elderly.

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