Research Article

Perspectives of older person on health problem and health service utilization: A focus group study

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ABSTRACT

Background: The state of well-being is generally involved happiness, autonomy, satisfying social relationships, and self-contentment. Joint pain was the most common morbidity followed by dental and chewing problem and decreased visual acuity. The community needs and perceptions about geriatric health are often ignored. Therefore, this study was conducted to assess the health of geriatric patient and awareness about medical service. **Objectives:** The objectives of the study were (a) to assess the health of the geriatric patient and (b) to obtain a perception of elderly participants about health service. **Materials and Methods:** Three Focus Group Discussions with seven participants in each group were conducted at rural area of Patan after taking permission from the Institutional Ethics Committee. The principal investigator was the moderator and observer noted down the verbatim. Seven to eight questions were prepared to direct the flow of discussion. The discussion lasted from 60 to 90 m. **Results:** Females were seen dominant in the discussions. Majority of participants (81.0%) had at least one disease. Most of them were suffering from aches followed by loss of vision, reducing hearing ability, and loss of teeth. Preserving good mental health, staying alert, and independent were important contributors to the health of elder person. Concept of Self Help Groups was suggested for increasing social participation. Poor economic status, self-rated poor health status, and having no faith in government medicine were obstacle in health-care services utilization. **Conclusion:** Dependency, low social participation and loneliness, negative attitude, no respect to elderly by a family member and ignored in decision-making may adversely affect the health of elderly. There is a need for caregiver support services to improve the health of the elderly.

KEY WORDS: Discussion; Health; Elderly; Utilization; Dependency

INTRODUCTION

The state of well-being is generally involved happiness, autonomy, satisfying social relationships, and self-contentment.[1] The elderly population in India accounted for 8.6% (104 million; 53 million females and 51 million males) in 2011 and has been projected to increase to 19% by the year 2050.[2-4] About 71% of elderly population were living in rural areas. The proportion of physically mobile elderly population declined from 95 to 72% for elderly men. Almost half of the elderly disabled population are suffering from locomotor disability and visual disability. About 5.0% of elderly persons are living alone.[2] Another study from Tamil Nadu revealed that joint pain and joint stiffness (43.4%) were the most common morbidity, followed by dental and chewing problem (42%), decreased visual acuity (57.0%) and hearing impairment (15.4%), hypertension (14.0%), diarrhea (12.0%), heart illness (9.0%), and diabetes (8.1%).[5] It has been reported that a geriatric person takes an average of six prescription drugs and often suffers from adverse drug reactions.[6]

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Reasons for the low utilization of available health service are a lack of transport facilities and dependency to accompany to the health-care facility. Thus, peripheral health workers should be trained to identify elderly patients and refer them for proper treatment.[7] Various programs targeting the geriatric population with a vertical approach where the community needs and perceptions are often ignored. Therefore, this study was conducted to assess the health of geriatric patient and awareness about medical service.

The objectives of our study were to assess felt needs in the care of the elderly and to obtain a perception of elderly participants about health service.

MATERIALS AND METHODS

This present study was conducted at Kungher, rural Health Training Center of GMERS Medical College, Patan during January 2019–March 2019. The permission was obtained from the Institutional Ethics Committee.

Twenty-one participants were selected for focus group discussion (FGD) with using purposive sampling method. Three FGDs were conducted with seven participants each. Elderly who could not speak properly, the primary caregivers of them were included for FGD. After written informed consent, FGD was started with the introduction of all participants. The principal investigator was the moderator and other investigator worked as an observer. Observer noted down the verbatim. An audio recorder was used after permission of participants to ensure completeness of discussion. Seven to eight questions were prepared to direct the flow of discussion. The script was translated into English independently by members of the study team. The participants were ensured confidentiality. The discussion lasted from 60 to 90 m.

Statistical Analysis

Repeated reading of verbatim was done for better understanding and enhanced familiarity with the data. Following the initial stage, coding was carried out through systematic way of organizing and gaining meaningful characteristics of data. Sociogram was formulated to evaluate the participation of participants.

RESULTS

Characteristics of Participants [Table 1]

A total of 21 participants were included in the present study. Seven participants were in each group. The mean age was 66.2 ± 5.4 years. Only male was included in Group A and only female was included in Group B. There were three male and four female participants in Group C. Illiteracy rate was

Table 1: Profile of participants (*n*=21)

Characteristics	Group A (*n*=7)	Group B (*n*=7)	Group C (*n*=7)	Total (*n*=21)
Age (Mean±SD)	64.2±4.5	69.3±5.4	65.2±6.3	66.2±5.4
Gender				
Male	7 (100.0)	0 (0.0)	3 (42.9)	10 (47.6)
Female	0 (0.0)	7 (100.0)	4 (57.1)	11 (52.3)
Education				
Illiterate	2 (28.6)	4 (57.1)	3 (42.9)	9 (42.9)
Primary	2 (28.6)	1 (14.3)	2 (28.6)	5 (23.8)
Secondary	1 (14.3)	1 (14.3)	2 (28.6)	4 (19.0)
Higher secondary	1 (14.3)	1 (14.3)	0 (0.0)	2 (9.5)
Graduate	1 (14.3)	0 (0.0)	0 (0.0)	1 (4.8)
Postgraduate	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Marital status				
Married	5 (71.4)	2 (28.6)	4 (57.1)	11 (52.4)
Unmarried	1 (14.3)	1 (14.3)	0 (0.0)	2 (9.5)
Widow	1 (14.3)	3 (42.9)	3 (42.9)	7 (33.3)
Living status				
With family	5 (71.4)	3 (42.9)	4 (57.1)	12 (57.1)
Alone	2 (28.6)	4 (57.1)	3 (42.9)	9 (42.9)
Addiction				
Yes	3 (42.9)	4 (57.1)	2 (28.6)	9 (42.9)
Tobacco	2 (28.6)	2 (28.6)	1 (14.3)	5 (23.8)
Cigarette/Bidi	0 (0.0)	1 (14.3)	1 (14.3)	2 (9.5)
Alcohol	1 (14.3)	1 (14.3)	0 (0.0)	2 (9.5)
Chhikani	1 (14.3)	1 (14.3)	1 (14.3)	3 (14.3)
Disease				
Yes	5 (71.4)	6 (85.7)	6 (85.7)	17 (81.0)
No	2 (28.6)	1 (14.3)	1 (14.3)	4 (19.0)
>1 disease	3 (42.9)	4 (57.1)	3 (42.9)	10 (47.6)
Diabetes	3 (42.9)	2 (28.6)	4 (57.1)	9 (42.9)
Hypertension	2 (28.6)	3 (42.9)	1 (14.3)	6 (28.6)
Stroke	1 (14.3)	2 (28.6)	2 (28.6)	5 (23.8)
Osteoarthritis	2 (28.6)	2 (28.6)	2 (28.6)	6 (28.6)
Asthma	1 (14.3)	2 (28.6)	0 (0.0)	3 (14.3)
Using assistive aid				
Glasses	4 (57.1)	3 (42.9)	5 (71.4)	12 (57.1)
Walking aid	1 (14.3)	0 (0.0)	1 (14.3)	2 (9.5)
Able to take care of yourself ?				
Yes	6 (85.7)	4 (57.1)	5 (71.4)	15 (71.4)
Sleep hours (h)				
<8	5 (71.4)	4 (57.1)	3 (42.9)	12 (57.1)
>8	2 (28.6)	3 (42.9)	4 (57.1)	9 (42.9)
Self-rated fitness				
Poor	1 (14.3)	3 (42.9)	2 (28.6)	6 (28.6)
Average	3 (42.9)	2 (28.6)	3 (42.9)	8 (38.1)
Good	2 (28.6)	2 (28.6)	1 (14.3)	5 (23.8)
Very good	1 (14.3)	0 (0.0)	1 (14.3)	2 (9.5)

SD: Standard deviation

42.9%. Two participants were single and one-third participant (7,33.3%) was widow. Nine participants (42.9%) had at least one form of addiction. Twelve participants require assistive aid. Majority of participants (17,81.0%) had at least one disease and nearly half of the participants (47.6%) had >1 chronic disease. Six participants rated poor health.

Health of Elder Person Perceived by the Community

Physical health

Most of the participants were suffering from "aches." Other symptoms were loss of vision, reducing hearing ability, loss of teeth, loss of appetite, abdominal discomfort, and joint pain. They had diabetes, hypertension, and stroke, and osteoarthritis. According to participants, free from disease, staying active, healthy eating habits contributed to good physical health.

Some common responses related to physical health:
- "I cannot watch television continuously due to backache."
- "After osteoarthritis, I cannot work like before."
- "I eat fruit every alternate which keep me healthy."
- "I live alone but I do all work by myself, so I am active and healthy."

Mental health

Reduced memory and decreased sleep were most common symptoms listed by participants. The other psychological symptoms are irritability, childishness, short temperedness, insecurity feeling, and distrust. Spiritual factors such as having faith and trust in God and learning new things were also contributed to positive mental health. Most of the participants were not aware of specific symptom of mental illness.

Some common response related to mental health:
- "I get frustrated when I did not remember simple things."
- "There is so much positive atmosphere in 'Swadhyay video kendra' (Learning about Bhagavad Gita), I attend every Monday."
- "My grandson downloaded bhakti songs in my phone, listening to these give me mental peace."
- "At this age, I learn new many things from young which keep me mentally and physically healthy."

Social health

The major social problems, according to participants, were a dependency on others, less income, loneliness, and elderly abuse. Fifteen participants stated that financial status played a big role in their life. Having good neighbors and friends, participation in social and community events was pointed by some participants to stay socially active. Majority of the participants (80.9%) stated that dispute with in-laws interfered with caregiving. Fifteen participants pointed out that modern society showed disrespect toward them.

Some common response related to social health:
- "Half our problems will be solved if we have personal income."
- "My neighbor beat his elderly mother once in a week because of her medical expenses."
- "I am social active person and I have good friend circle so I am not filling that much loneliness."

Health service utilization

Married couples or living with the supportive family were utilizing more health-care services. Most of them believed in the traditional healing system and few of them had no trust in government health facility and cost of private health service was high. They ignored to visit health facilities until they were seriously sick. They required a home nurse with an affordable cost. They suggested the formation of self-help elderly groups who would support each other for activities such as hospital visits, shopping, and banking related work.

Some common statement related to health service utilization.
- "I am living alone and no one accompany me to reach the clinic."
- "District civil hospital is so far from my home."
- "Private medicine is better than government but we cannot afford medicine."

DISCUSSION

Happiness, self-contentment, social relationships, and independence are primary characteristics of the well-being of the elder person.[1] In the present study, females were seen as dominant in the discussions. The medical specialty of geriatrics was not known to the majority of participants. Health promotion and disease primary prevention were ignored in young age, and lifestyle modifications were considered as an intervention to be started in old age. The participants reflected that they should not be ignored at this age because being isolated impacted adversely on health. Majority of participants (81.0%) had at least one disease. Most of them were suffering from aches, followed by loss of vision, reducing hearing ability, and loss of teeth. The most common disease was diabetes, hypertension, and stroke. Participants discussed that free from disease, staying active, healthy eating habits contributed to good physical health and also preserving good mental health, staying alert, and independent were important contributors to the health of an elder person. Participants of the present study pointed out that spiritual merit, praying, having faith, and trust in God gave a more positive attitude. When the elderly were not respected and ignored in decision-making, conflicts occur. Concept of self-help group was suggested for increasing social participation. The present study revealed that poor economic status, self-rated poor health status, having no faith in government medicine was an obstacle in health-care services utilization.

Various studies came out with similar findings. It was reported that dependency, low social participation, and loneliness were significant risk factors for the ill health of the elderly.[8] Staying independent was viewed as a major trait for aging well.[9,10] They were more fatigue and undernourished than older adults who do not live lonely.[10,11] The World Health Organization surveyed that proportion of widows in rural areas was more than widowers.[12] The best health status expected in old age was their independence in activities of daily living. In Rowe and Kahn's model, it was maintaining high cognitive and physical function.[13] Other study reported that participants with chronic diseases had a lower level of physical activity.[14] This was also supported by study of Japanese elder population for aging well.[15] It was concluded that health problems of the elderly may be ignored until they become severe. In the Indian communities, ill health is passively accepted as part of aging.[16] Laditka *et al*.[9] revealed that maintaining good cognitive health was associated with social engagement, independence, and physically active lifestyle. Positive attitudes were associated with lower levels of anxiety, depression, and higher level of satisfaction in older adults.[17] Different studies supported this finding.[9,15] A study from Karnataka revealed that >½ of elderly (52.0%) felt that their importance in the family has been affected by old age and 35.0% felt that they were ignored in decisions-making.[18] Elderly are prone for abuse in families as verbal abuses were the most common followed by financial abuse and physical abuse.[19] A previous study pointed out that immobility, misconception, inaccessibility, high cost of medicine family nuclearization, and poverty were associated with poor utilization of health-care services.[20]

Strength and Limitation

In the present study, FGD method has been used, which is better than a quantitative method to collect the views and experiences of elderly on geriatrics health topic through dynamic interaction. Therefore, better insight into perceptions and experiences were elicited. In the present study, the moderator had little experience to conduct FGD. Therefore, sometimes, discussion was diverted from the main topic. Geriatric Health problems of elderly residing at rural area might be different from elderly from an urban area, and we conducted a study in a rural area, so views of elderly from urban area and old age home were not covered in the present study.

CONCLUSION

Dependency, low social participation and loneliness, negative attitude, no respect to elderly by family member and ignored in decision-making may adversely affect the health of the elderly. Health promotion and disease primary prevention are considered as an intervention to be started in old age. Most common complain at old age is aches, followed by loss of vision, reducing hearing ability, and loss of teeth. Poor economic status, self-rated poor health status, having no faith in government medicine was associated with poor health-care services utilization. There is a need for caregiver support services to improve the health of the elderly. Structured health education to raise awareness about health problems in old age and behavior change communication for lifestyle factors should be initiated.

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