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Health Problems of the Elderly People in Tuticorin District

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ABSTRACT

India is transitory through industrial, social, cultural and demographic change. Accordingly growth in awareness of health care among the people took place, which led to the development in the quality of health care facility. The present study is an attempt to examine how elderly people facing social economic and health problems in their day today life. The study is both descriptive and analytical based on primary and secondary sources. This study has highlighted that the elderly suffers from multiple illnesses, which they often attribute to ageing. The elderly should be encouraged to undergo periodic medical checks at a clinic for routine appraisal of their health status, so as to allow early detection and treatment of their morbidities. These services should be accessible and affordable to them.

Keywords: Medicare, physical, mental, Morbidity, arthritis stroke, cataract

INTRODUCTION

The ageing of population is on the growth world over in modern times. Progression in Medicare, development in living conditions and the general quality of life and effective measures for birth control could be recognized to this developing worldwide occurrence. The problems which are associated with age and the care of elderly are not exclusively the problems of social and economic ramifications, rather they include health and medical problems also the affect the life of a community as well (Vijay Kumar, 1998).

Elderly or old age consists of ages nearing or surpassing the average life span of human beings. The boundary of old age cannot be defined exactly because it does not have the same meaning in all societies. According to The World Health Organization (WHO), "Health as a state of physical, mental and social wellbeing and not merely absence of diseases or infirmity" Life expectancy of an average Indian has increased from 24 years in 1900 to 65.4 years in 2004. This results in an increasing numbers of elderly persons which contributes to 7% of India's population (Dr. P.C. Bhatala, 1999).

Government of India adopted National Policy on Older Persons in January 1999. The policy defines senior citizen or elderly population (aged 60 years or above) account for 7.4% of total population in 200. Both the share and size of elderly population is increasing over time. From 5.6% in 1961 it is projected to rise to 12.4% of population by the year 2026 (Central Statistics office, 2011). Illness increases with age. All else being equal, an older population has greater needs for health care, this logic has led to dire predictions of skyrocketing costs-"apocalyptic demography" (Smith et al. 2000).

Most diseases in aged are chronic in nature-cardiovascular, arthritis stroke, cataract, chronic infections and cancer etc., disease process are usually multiple (Vinod Kumar, 1996). Morbidity is the extent of illness (disease) injury, or disability in a defined population. Particularly in circumstances of low mortality such as exist now in the industrialised nations; morbidity data give a fuller description of the physical wellbeing of a population than do mortality date (John A. Ross, 1982). This study was undertaken to understand the health status of elderly people in Tuticorin district.

OBJECTIVES

The main objectives of the study are as below.

- To study the socio-economic status of the rural elderly.
- To examine living conditions of the aged.
- To understand the health problems faced by the rural elderly persons.
- To find access to health care facilities
- To know the reasons for feeling insecure of elderly persons
- To examine the satisfaction of access to health care facilities among the sample respondents

METHODOLOGY

The study is both descriptive and analytical based on primary and secondary sources. The present study conducted in rural areas of Tuticorin district. The sample respondents were selected by simple random sampling teaching the total 250 that is 190 male and 60 female old age respondents were selected from 5 blocks of Tuticorin district selected for the present study. A structural interview scheduled was prepared for relevant information collection from elderly person who belong the age group above 60+. This study discusses the socio-economic background of the selected elderly persons living in the families in Tuticorin district. It is purely a descriptive study. The primary data relates to the month of December 2017. Secondary facts have collected from books, journals, newspapers, internet and bulletins. Percentage, standard deviation, Garret ranking method, t test, chi-square test, and probability analysis used.

LITERATURE REVIEW

Rao et al., (2003) in a study of health status of the rural aged in Andhra Pradesh, found that health problems tend to increase with advancing age and very often the problems aggravate due to neglect, poor economic status, social deprivation and inappropriate dietary intake. A high proportion of the total respondents stated that they were suffering from illness seriously. Lack of medical facilities in the village and poor economic conditions might be responsible for the low health status of the villagers.

Ketshukietuo Dzuvichu (2005) mentioned that health is not only a biological or medical concern but also a significant personal and social concern. In general with declining health,

individuals can lose their independence, lose social roles, become isolated, experience economic hardship, be labelled or stigmatized, change their self-perception and some of them may even be institutionalized.

Achir (1998), showed changes are good indicators of development, dilemma for support capacity of the family towards the elderly are inevitable. With many women entering the work force, available support for the elderly has significantly reduced. As a consequence, the International Year of the Family has appealed to the world to maintain, strengthen and protect the family to ensure continuity of its vital role in preserving dignity, status and security of its ageing members.

Pappathi et al. (2005) showed that the psycho-social perspectives and problems and strategies to welfare of the rural female aged found that a majority suffer from joint pain, blood pressure and chest pain. A few complaint of asthma, piles, loss of weight, diabetes and skin diseases, only 30 per cent among the rural aged where in good health.

Vasantha (1998), found that the rural aged suffered from nutritional, psychological and other problems, when compare to urban aged. The aged employed privately and those self-employed had more of health problems then not gainfully employed person. In general, the male members were found to be literate, economically independent and had less physiological and nutritional problem when compare to the female counter parts, when literacy level, income level and employment status improve, they seem to have better health.

Table 1

Sex-Wise Analysis of the Respondents

SL.No	Sex	No. of Respondents	Percentage
1	Male	190	76.0
2	Female	60	24.0
	Total	250	100

Source: Survey Data

From the table it has been inferred that out of 250 respondents in the Thoothukudi district, the majority of 190 (76.0 percent) are male and rest 60 (24.0 percent) is female respectively.

Table 2

Educational Qualification of the Respondents

SI.No	Education	No. of Respondents	Percentage
1	Illiterate	29	11.6
2.	Primary	43	17.2
3.	High school	124	49.6
4.	College	38	15.2
5.	Technical	16	6.4
	Total	250	100

Source: survey data

Out of the 250 respondents, 29 persons (11.6%) are illiterate, 43 respondents (17.2) are completed their primary school level. 124 persons (49.6%) have completed their high school education, 38 persons (15.2%) have finished a degree and 16 people (6.4%) have finished technical level education.

Table 3

Distribution of Sample Respondents according to the Type of Family

Sl.no	Type of family	No. of Respondents	Percentage
1	Joint family	107	42.8
2	Nuclear family	130	52.0
3	Separated	13	5.2
	Total	250	100

Source: survey data

The table reveals that out of 250 sample respondents, 107 (42.8%) have a joint family system, 130 (52.0%) have a nuclear family system and 13 (5.2%) belonged separated. It reveals that majority of respondents belonged from a nuclear family.

Table 4

Family Size of Respondents

Sl. No.	Family Size	Respondents	Percentage
1.	Below 2	57	22.8
2.	2-3	114	45.6
3.	3-4	60	24.0
4.	4 and above	19	7.6
Total		250	100

Source: Survey data.

A maximum of 114 (45.6 percent) of respondents have a family size of 2- 3 members, followed by 60 (24.0 percent) having a family size of 3 - 4 members. 57 (22.8 percent) have a family size of below 2; and only nineteen (7.6 percent) having a family size of 4 and above. It is observed from Table 4.8 that majority of them have a family size of 2- 3 members. The average size of the family worked out to be 2.67.

Table 5

Distribution of Sample Respondents according to their Housing Condition

Sl.No.	Ownership of the House	No. of Respondents	Percentage
1.	Owned	122	48.8
2.	Leased	39	15.6
3.	Rented	89	35.6
	Total	250	100

. Source: Survey data.

The table shows that 48.8 percent of the respondents have own houses, whereas 15.6 percent and 35.6 percent respondents have leased and rented houses respectively.

Table 6

Earning Members per Family of the Households

Sl.No	Earning Members Per Family	No. of Respondents	Percentage
1.	One	96	38.4
2.	Two	65	26.0
3.	Three	47	18.8
4.	Four	28	11.2
5.	More than four	14	5.6
	Total	250	100

Source: Survey data.

From table it has been revealed that a majority of 96 (38.4 percent) of the respondents have only one earning member per family, followed by 65 (26.0 percent) respondents with two earning members per family, 47 (18.8 percent) respondents have three earning members per family and 28 (11.2 percent) of the respondents have four earning members per family. Only 14 (5.6 percent) of the respondents have more than four earning members per family. The mean earning members per family of the households worked out to be 2.19.

Table 7

Family Income

Sl.No.	Family Income	No. of Respondents	Percentage
1.	Below Rs. 7000	29	11.6
2.	Rs.7001 – Rs.9000	36	14.4
3.	Rs.9001 - Rs.11000	68	27.2
4.	Rs.11001 – Rs. 13000	88	35.2
5.	Above - Rs.13001	29	11.6
Total		250	100

Source: survey data

The above table exhibits that 11.6 percent of the respondents had a monthly family income of less than Rs.7000, 14.4 percent, 27.2 percent, 35.2 and 11.6 percent of the respondents had a monthly family income of Rs.7001 to 9000, Rs.9001 to 11000, Rs.11001 to 13000 and above Rs.13001 respectively. The mean monthly family income worked out to be Rs. 8880.5.

Table 8

Gender Wise Distribution of Respondents by their Health Problems

Sl. No.	Disease	Male Percentage	Female Percentage
1.	Skin diseases	27.33	21.33
2.	Sugar complaints	81.33	68.67
3.	Weakness	24.00	36.00
4.	Urinary problems	48.00	15.33
5.	Tuberculosis	14.00	8.67
6.	Heart complaints	45.33	18.00
7.	Joint pains	27.33	63.33
8.	Asthma	20.67	12.00
9.	Nervous disorders	33.33	9.33
10.	Others	11.33	39.33

Source: Compiled from Primary Data

The table indicate that more than half of the elderly represented by a slightly (more number of women than men) reported various physical problems. The problem of skin diseases is common for both men and women. However, it is evident that the male elderly having sugar complaints form 81.33 per cent to the total. It was found that 45.33 per cent of the male elderly in the study area had heart complaints, followed by nervous disorders (33.33 per cent) whereas general weakness and joint pains is found to report mostly by women. Disorders relating to chest like tuberculosis and asthma, nervous disorders and problems relating to urinary tract infection are more common in men. The urinary problems percentage was higher among male elderly (48.00 per cent) than among female elderly (15.33 per cent) respectively.

Table 9

Reasons for Feeling Insecure

Sl. No.	Reasons	*Mean Score*	Rank
1.	Careless son	59.37	III
2.	Poverty	67.31	I
3.	Bachelor son	41.09	VI
4.	Unmarried daughter	47.53	V
5.	Consistent illness	62.19	II
6.	Illness of partner	54.82	IV

Source: Compiled from Primary Data

It is found from Table that majority of the respondents revealed for reasons for feeling insecure as poverty was ranked first followed by consistent illness. Careless son was ranked third, illness of partner ranked fourth. Unmarried daughter and bachelor son was ranked fifth and sixth respectively.

Table 10

Significant differences in satisfaction of access to health care facilities among the sample respondents based on sex

Sex	N	Mean	S.D	't'Value	Interpretation
Male	190	48.26	21.92	0.6391	Not Significant
Female	60	21.53	8.17		

Source: Computed from Primary Data

In order to find out the significant difference in satisfaction of access to health care facilities among the sample respondents based on sex, the 't' value was calculated and the calculated 't' value was found to be 0.6391 which is lower than the table value 1.97 which is

significant at 0.05 level. Therefore, the null hypothesis is accepted and concluded that there is no significant difference in satisfaction of access to health care facilities among the respondents between male and female.

Table 11

The Summary of Opinion of the respondents

Factors	Chi-Square Value	Result
Sex	18.61	Significant**
Educational Qualification	14.38	Significant**
Family Size	5.03	Not Significant
Family type	13.69	Significant*
Earning Members Per Family	8.13	Not Significant
Monthly family income	15.72	Significant*
Ownership of the house	4.86	Not Significant

Source: Compiled from Primary Data

The opinion of the respondents and socio-economic characters relationship applied to chi-square test. The selected variables only applied in this model. The table reveals that the summary of the respondents. The chi-square analysis reveals that the factors are sex and education are significant at 1% level. Family type and monthly family income are significant at 5% level of significance. The outstanding factors are not significant at 5% level.

CONCLUSION

This study has highlighted that the elderly suffers from multiple illnesses, which they often attribute to ageing. It requires the strengthening of elderly health care services in accordance with the common existing problems in the community. The elderly should be encouraged to undergo periodic medical checks at a clinic for routine appraisal of their health

status, so as to allow early detection and treatment of their morbidities. These services should be accessible & affordable to them.

SUGGESTIONS AND RECOMMENDATIONS

- There is a great need for an in depth study of age old in rural areas.
- Every one individual to take social security by family and community.
- Health facilities and free medical care should be provided in rural areas.
- The school and college students should be trained to meet the needy age old in rural areas.
- The awareness is needed among illiterate age old about government policies and programmes.

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