Chapter-IX

CONCLUSIONS AND SUGGESTIONS
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Ageing is the continuous process beginning with conception and ending with death, by which organisms mature and decline (Aiken, Lewis R. 1995). It is a normal process and the aged should equip them to cope with it when it comes. Getting old is neither a social problem nor are the aged a problem creating group. According to Gross (1987) negative perceptions of old age are based on the decrement model where ageing is viewed as a process of biological, psychological and sociological decline. Old age is a fact of life in all human societies. All societies have some arrangements for dealing with it; but they differ from one society to another. Most people think of ageing as basically uncontrollable biological process, but it is also influenced by social factors, including culture and social organizations. The manner in which someone ages depends on heredity, physical health, nutrition, mental and some other hitherto unknown factors. There are not strict or well defined criteria to define or classify people as older persons; but, for practical purpose the chronological age of 60 years is taken as onset of old age. Old age is not a disease, a little care and caution can prevent or delay many diseases and disabilities.

The entire thesis is summed up in the following way. As regards to the summary, we have taken into consideration the morbidity profile of the rural elderly. We have divided the entire thesis in nine chapters. Each chapter focuses on different categories. The first chapter deals with introduction, concept of ageing, definitions of ageing, four aspects of ageing, the meaning and definitions of health, dimensions of health, determinants of health, conceptual framework among health status of the elderly, health and disability among elderly, health challenges of elderly, concept and
definitions of morbidity, health and morbidity, how to find morbidity, problems of elderly, health problems, global trends of population ageing, ageing-world perspective, population ageing in India, age structure of the population, sex ratio of elderly population, trends, and theories pertaining to the morbidity profile of the elderly.

Second chapter contains methodology, statement of the problem, the objectives of the study, hypothesis, limitations of the study, justification of the study and area sample, method of study, review of literature, pilot study etc.,

Third chapter deals with the setting of Gudalgudda town of Bagalkot District of Karnataka State, general background of the study area, geographical features, historical background, demographic features, physiographic, rainfall, climate, language structure, religious structure, political structure, economic structure, educational structure, transport and medical facilities etc.,

Fourth chapter deals with respondents socio-economic profile; like, age, sex of the respondents, mother tongue, religion, of the respondents, caste, marital status of the respondents, age at marriage, educational background of the respondents, source for daily living, primary occupation, household pattern and facilities available of the respondents, economic aspects among elderly and support provided to economically dependent elderly.

In the fifth chapter morbidity profile of the aged, difference between morbidity and mortality, type of physical disabilities among elderly, pattern of eye check-up, activities of daily living among elderly, ailments of the respondents, usage of physical aids of the respondents, mental health problems among elderly, psychological aspects, intensity of loneliness among the respondents, hospitalization among the elderly,
respondents preferences of medicine, present health problems of the elderly, percentage wise health and education of the respondents, surgery details of the respondents, arthritis problems among respondents, transmitted diseases, and morbidity profile are studied in detail.

In the sixth chapter determinants of morbidity, food and nutrition, food intake, facilities of drinking water, cleaning hands before taking food, category and cleaning up of hands before taking food the respondents, measure taken to avoid mosquitos, prevalent of addiction patterns (tobacco smoking, alcoholic addiction) of the rural elderly are discussed.

The seventh chapter deals with disease patterns and support systems. Acute and chronic diseases among elderly, expectations of the respondents, receiving health care facilities from government, care taker of the elderly during illness, age and care taker wise distribution of the respondents and relatives and neighbours visits are discussed.

In the eighth chapter deals with preventive and curative aspects of the rural aged persons. Available facilities, measures taken to prevent Arthritis, paralysis, kidney disease, cancer, dysentery, asthma and anaemia disease etc.,

In the last chapter, contains the main findings, conclusion and suggestions. The conclusion deals with the major findings of the thesis.

**Main Findings of the Study:**

Present study attempted to understand the morbidity profile of the rural elderly, from a sociological point out view. The data was obtained on various significant questions such as socio-economic background of the respondents, household characteristics and economic characteristics etc., Data was collected on
these aspects through Interview Schedule administered to the 350 respondents. SPSS package was used to analysis the data. Chi-square test was used to explain the association between variables. The main findings of the study are listed follows;

**Socio-economic background:**

The socio-economic background of the characteristics such as age, sex, religion, caste, marital status, age at marriage, educational status and living arrangement are etc., discussed in this section.

In the study, it was found that majority 48.00 percent of the respondents belong to the age group of 60-69 years. Sex wise distribution was an important considerations in the present study found that majority of the respondents are 62.00% females.

Religion wise distribution shows that majority 96.00 percent of the respondents belong to Hindus religion. Present study shows that majority of the respondents 68.86 percent belong to Other Backward Classes (OBCs) category.

As far as the marital status of the respondents is concerned, our study reveals that majority of the respondents 64.00 percent are their widows or widowers. Age at marriage is also an important factor. In the study, it was found that majority of the 65.43 percent of the respondents are married between the ages of 15-20 years. Our study reveals that 66.00 percent of the respondents are illiterates.

Source for daily living of the respondents revealed that, 64.86 percent obtain their income from Agriculture. Majority of the respondents (92.00%) live with their families. As far as, the occupation of the respondents is concerned majority of the respondents were agricultural labours. It was found that these engage in household work, weaving and multiple occupations.
Majority of the respondents 60.00 percent belong to Nuclear Family. Majority of the respondents (74.00 %) have own house.

More number of male elderly were engaged in agricultural labour and more number of female elderly were confined to their house. This indicates the traditional gender roles of males going out of the house for earning and females taking care of the household activities and children.

Majority of the elderly males reported that the source of their income was occupation, as opposed to the elderly females whose income source was their children. This reveals the close association of elderly females with children, grandchildren, and household activities.

Most of the elderly males were independent as opposed to most of the elderly females who were partially dependent. This reveals the existence of traditional predominance of men handling money and important properties more so than women.

Majority of the respondents 54.00 percent are not dependent on economic support providers. 24.00 percent of the respondents fully dependent.

**Morbidity Profile of the elderly:**

Morbidity profile of the rural elderly is the main focus of the study. Out of 350, elderly that majority of them i.e., 52.00 percent are suffering from visual disabilities. Majority of the respondents, 56.90 percent are suffering from hearing disability.

In the present study 16.85 percent are suffering from speech disability, 21.42 percent are suffering from locomotors disability, 36.90 percent of the respondents are bed-ridden since one month and suffering from ailments. 66.30 percent of the respondents depend on children for their daily activities.
In the study, activities of daily living that 12.00 percent are dependent on others for feeding, 12.30 percent are dependent on others for bathing, 12.85 percent are dependent on others for dressing, 10.00 percent are dependent on others for going to toilet, and 56.00 percent are totally dependent on others for washing the cloths.

Majority of the respondents 48.00 percent are complained about the problems associated with digestive system. Majority of them i.e., 42.00 percent are using spectacles. Majority of the respondents 95.70 percent receive help from family members during illness. In the study, our reveals that 32.00 percent of the respondents are not suffering from loneliness.

**Morbidity Pattern of the Study:**

In the study revealed that there is an implicit assumption that disease and deterioration of health are inevitably associated with chronological ageing. However, physical decline in health among old age is not always identical in all those in a particular age group. Some elderly people are sick and others maintain good health status even in advanced age.

In the present study, common illnesses reported were joint pain (46.00%), knee pain (42.30%), fever (37.70%), loss of memory (35.70%) bleeding (33.42%) cough (22.30%) and other self reported morbidities were hypertension (40.28%), diabetes (28.00%), jaundice (14.28%), and kidney stones (10.00%) etc., Old age is occupational by a few health complaints such as hypertension, diabetes, asthma, and anaemia etc., with these problems like joint plan. Blindness deficiency and hearing and blood pressure also. Because of lack of awareness and poor economic condition they are unable to afford good traditional for their problems. Majority of the rural aged facing the health problems like hypertension, diabetes, asthma and anaemia.
Lack of awareness about good nutritious food and sanitation they face the health problems.

**Treatment Seeking Behaviour:**

Treatment seeking was less common in rural area compared to urban area. High number of morbidities was due to low level of treatment seeking behaviour in rural area and also due to low level of literacy and health consciousness, poverty and poor access to health care services.

In the present study, 42.00% were seeking treatment from Private Hospitals, (24.00%) from herbal medicine, and 10.00% from Government hospitals. Most commonly preferred system of medicine was Allopathic (52.00%) and rest 24.00% preferred homeopathic. A study conducted in Northern India showed that system of medicine preferred was Allopathic 92.2%, and Ayurvedic/Homeopathic 7.7% and 90.00% of them consulted doctor only when they were sick (Joshi K. et al. 2003). Most of them i.e. (48.00%) would recent consult with doctor more than five months.

**Morbidity and Health Care:**

Health status is also an important issue, affecting situation and quality life of elderly. In the study, seventy two percent of the respondents are suffering from some kind of health problems.

Majority of the respondents (89.14%) are taking variety of fruits, 96.00% of the respondents consume vegetarian food for their daily intake. Majority of the respondents (56.30%) use water from bore well or hand pump.

In the present study, majority of the respondents (59.10 %) used neem’s smoke to avoid from mosquitoes. Tobacco smoking habit is prevalent among 60.00% of the respondents, for 12.30% respondents consume alcohol.
Out of 350, respondents that 71.70 percent of the respondents are feel lonely. Most of the respondents 90.00 percent have taken some or other benefits from the state government. Our study reveals that 43.40 percent respondents spend Rs/- 501 and above for medical treatment.

Majority of the respondents were 90.00 percent are beneficiaries of old age pension. It was found that 84.30 percent are getting regular monthly pension. 52.60 percent are getting widow pension. 42.00 percent are use spectacles to correct their vision.

In the present study respondents have followed various preventive steps to tackle the illness. Like follow doctors suggestion, taking timely doing exercise-yoga, taking less carbohydrate and more fiber rich foods. Most of the elderly males lived with their spouses, and most of the elderly females lived with their children especially son. This implies the gender role that the grandmothers are more closely associated with the family members, especially daughters and grandchildren, than the grandfathers who mostly feel comfortable with grandmothers.

In the present study almost all elderly had reported to have one or the other health problems. The overall health status of elderly significantly associated with education, marital status and family income. The health status of elderly assessed based on the self reported health problems. Generally the elderly people suffer from various diseases such as diabetes, bronchitis, paralysis, arthritis, bone disorder, urination problems, reduced eyesight, diseases of skin and joints, nervous disorder, sleeplessness, loss of memory power etc,. It is seen that most of the respondents had more than one health problem. Arthritis was found to be more common among females while other health problems were almost similar among both the genders.
Suggestions:

While the 21st century may be considered as the Century of Older Persons par excellence, this century will also experience the phenomenon of “aging of the aged”, i.e., if we take the elderly as a district demographic sub groups the 60-69, 70-79 and the 80+. In the present study half of the respondents are in the first age group i.e., 60-69. Due to feminization of ageing more number of females is being included in the study. It is therefore suggested that in formulating policies and programmes for the elderly, the present approach of treating all the old as a homogeneous group should be discontinued and the oldest old should be treated as a distinct group within the old, requiring welfare policies and programmes geared to their special needs and concerns. In short, there is need for a paradigm shift in policy making for the elderly.

The researcher held a view that the family should be the best and most appropriate place for persons of 60+ years to spend the last segment of his/her life and as such every support should be provided to the family to keep them happy. Provision should also be made to ensure that the oldest old are integrated with the family. Many of the oldest old will be frail, some may have limited activity, some may be bedridden or with limited mobility and some with debilitating diseases. Even those who are active will find their circle of friends and sphere of activity dwindling rather drastically and many of them will be moving towards a stage of dependence both physically and otherwise. Even under the best of circumstances a family may not be always considerate in dispensing care to its old unproductive kin, and this is more so when he/she is a liability in physical and medical terms. Policy on this category of the old therefore should aim at making them acceptable to the entire family in spite of the physical strain and financial burden and other inconveniences. This
needs expert counseling of all members of the family including the oldest old. In this study found that overwhelming majority of the old desire to live with children and very less number of respondents stay away with litigation with their children, childlessness and widowhood this needs further counseling with their family members.

Most countries have instituted old age pension and usually this is a flat amount that never changes during the life time of the pensioner. Since, one's expenses increase as one become older due to the need for special care and medicines etc, it is suggested that the amount of pension be calibrated to their requirements. One way is to increase the pension amount progressively after every ten years starting with 60. An alternative to this is to divide pension into two slabs-one for those below 80 years and higher amount for those 80 years and above. Researcher suggests that the persons who are above 60 plus that do not have any old age pension schemes should be included by the government. A major problem of the old is inability and helplessness in managing one's own finances. Most of the 60 plus may not have any property or proper savings but even those who do have assets are not in a position to manage them for reasons relating to their advanced age. They are often obliged to depend on their kin many of whom, as studies have revealed, use the income for their own betterment, spending little on the kin. Owning property or assets in this case does not benefit the elderly owner. The total dependence of the victim on the family for all his/her requirements in the last years of life makes him/her to stoically bear all the privations even when financially viable. In this regard again the Senior Citizens' Club can come to the rescue of the victim and pressurize the offender.

Health statistic regarding the 60 plus though scanty reveal that at least 80 percent of them will be having single or multiple illnesses, many of which are chronic
and some of them imposing some restriction on the individual on diet, movement, daily routine, etc. About 20 percent will have physical disability problems with performing the activities of daily living including problems of extended mobility and taking care of daily chores. Around 30 percent will be home-bound and another 20 percent will be bed-ridden and 15 to 20 percent will be having some form of dementia. The number in each category will rise as age increases.

Old age treatment at times is a gamble, by the wrong doctor giving the wrong treatment, with the result that not only the cost of health care increases but it causes avoidable agony and pain and offers little relief to patients. The Health Care Unit of the village can direct the patient to the right doctor who will give better treatment at affordable cost. This also takes out much of the burden of care-giving from the family. The elder care center and senior citizens’ club can assist/supplement in follow-up matters.

Deficiencies in geriatric care have been observed in most countries not only because there is an acute shortage of trained medical personnel but also because most diseases of old age have no cure. They are called “terminal diseases” implying that there is no cure except palliative care. Also, medical ethics is getting increasingly eroded and the profession is in the grip of commercialization. The resultant victims are mostly among the oldest old.

Health care of all the 60+ should made free or at least free for all the destitute 60+ and heavily subsidized for the rest and further that their state should take the responsibility for training more doctors in the treatment of old age illnesses. The medical profession should evolve appropriate ethics and codes of conduct for the doctors handling terminally ill patients, with the government acting vigil on the whole practice- medical practitioners, hospitals and
pharmaceutical and medical equipment manufacturing companies. Opening up of free geriatric hospitals, geriatric homes and geriatric clinics for the entire 60 plus is yet another suggestion.

It was noted that women constituted the overwhelming majority among the old and their problems differed from those of men due to biological and cultural factors. The research identified three areas where the problem is conspicuous—support system, health care and living arrangement. Since women live longer than men and since the extended period of life is spent more or less in morbidity and neglect and is crowned with widowhood, they (those women) should be treated as a preferred category in healthcare and social support. It is also suggested that the amount of old age pension should be higher for women than for men and the difference should be maintained when the amount is increased at every slab of ten years after attaining 60 years.

Counselors at the Elder Health Care Centers should entrusted with special responsibility for ensuring justice to elderly women and for enhancing their self esteem and self confidence. The senior Citizens’ Club also should take up the cause of the 60+ women as special cases needing special attention. All services for the 60+ should have special unites for catering to the needs of the old women. The helpline at the Elder Care Center should attend to calls relating to the old women on an urgent and priority basis.

Surveys conducted by NSSO and NAS concluded that 45 percent of the elderly in urban and rural areas as suffering from chronic diseases and about 5.4 percent are found to be physically immobile. Studies on health say that majority of the deaths among the elderly are due to heart problems, cancer and stroke. Alzheimer’s disease is probably the fourth leading cause of death. Apart from these death causing
diseases, about 45 percent of the elderly are suffering from Arthritis and Parkinson's disease (Shah 1996, Habibulla 1996, Vinod Kumar 1995). Depression is another important and common problem of majority of the elderly.

Among communicable diseases, diarrhoeal disease accounted for the largest share of ailment cases for both rural and urban areas. Whooping cough is widely prevalent in both rural and urban areas. People in the rural areas are more affected by malaria and Tuberculosis than their urban counterparts. Among the ailments, fevers of unknown origin are the most predominant. Hypertension, diabetes and heart disease are the most widely prevalent non communicable diseases in the urban areas. The prevalence of hypertension is higher among females but the prevalence of heart disease is higher among males. Both rural and urban populations suffer from respiratory diseases. Gastritis, Bronchial asthma, disorder of joints and bones, neurological disorders, diseases of skin, diseases of kidney and urinary system, cataract and cancer were more prevalent in both rural and urban areas. Among the non communicable diseases, fevers of unknown origin invariably affected the rural and urban people.

Old age homes are not only a phenomenon of the developed countries anymore; they are mushrooming in developing countries to cater to the needs of the growing elderly population. Most old age homes do not provide for the extra needs of those who are in advanced ages and with chronic diseases. To cater to the needs of the 60+, geriatric institutions rather than general old age homes may be established. They should have counseling and medical facilities which most existing old age homes currently lack. Instead of being custodial in structure and nature, they should imbibe the spirit of a "home away from home". To keep up with the trend, old age homes may be re-designated as "Senior Citizens' Homes" or merely

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“seniors’ Homes”. There is also need for better supervision and regulation of old age homes to ensure that they indeed deliver the services expected of them to ensure the proper handling of the special needs and concerns of the old in these institutions, local Senior Citizens’ Clubs should act as watchdogs of these institutions. Elder Care Centers should establish Visiting Committees on old age/geriatric homes in their locality and ensure standards in supplies and services. It is also recommended that old age homes should be provided from the different government agencies to overcome the situations.