CHAPTER VII

GENERAL CONCLUSIONS
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In the preceding chapters and discussions we have brought the different factors which affect the health status among the old. Major observations on these are as follows:

It has been revealed that in our study as age increases generally there has been a negative opinion of their health condition. A good majority (90.3%) of our sample in the 75 and above age group have the experience that their health condition is bad and a majority (59.5%) in the 60 to 65 age group has felt that their general health condition is good. The higher the age group the higher is the feeling that their health condition is deteriorating. A great majority in the higher age group (91.39%) believe that their health is deteriorating and a major part (69.04%) of lower age group namely does not have such a kind of feeling. Analysis on habit of regular intake of medicines shows that it is decreasing with increase in age. A good majority (92.5%) in the age groups 75 and above not having a regular habit of taking medicines while a major part (83.6) in the lower age group are very regular in the consumption of medicines. The chi-square test also illustrate that the relationship of variables are quite significant.

Further the satisfaction about the care they are getting during illness is higher among the lower age group (78.23%). On analysis of leisure time activities, the
higher age group of (75 years and above) a good majority (77.4%) are spending most of their time for watching TV and while in the lower age group are spending their time for visiting worship places / tourist places / relatives. The study clearly shows that as age increases the feeling of degree of loneliness also increases. It is 74.2% among 75 and above age group and only 47.6% in the 60-65 age group. It has been found that quarrelsome behaviour is higher among the higher age group; it is 89% in the 75 and above age group and only 46.9% in the 60 - 65 age group. It is seen that from the study the memory problem during old age is increasing with age. A great majority (75.26%) in the age group 75 and above are always having the memory problem. On examining the faith in God during illness with respect to different age groups among the old aged, it is clear that as age increases their faith in god among the old aged during illness also increases. In the higher age group (75 and above), 72.04% feel that faith in god helps during illness. On examining the feeling of neglection / rejection by their loved ones, it is clear that the feeling is higher among the higher age group. It is 75.27% in the case of 75 and above age group and only 13.2% in the 60 to 65 age group. Majority (96.1%) of the people have health problem, 91.14% having communicable disease problems and 96.05% having non-communicable problems. The health problems are increasing with an increase in their age. The chances of getting multiple diseases are also increasing with an increase in age. It is 97.8% in the case of 75 and above age group. The
major health problems among the respondents are cardiac / hypertension related conditions (92.8%), it increase with respect to increasing age. The second most prevalent disease is diabetes (91.34%), followed by gastro-intestinal problems (79.03%).

In terms of variation in geriatric health with respect to gender it is seen that females are showing a negative experience in their health conditions. The majority 68.18% of males believe that their health condition is good and it is only 23.35% in the case of females. The case of deterioration of health is also higher among females, 50.12% of females have the opinion that their health is deteriorating very much and only 5.4% of males have the same opinion. Chi-square test also shows that the two variables differ significantly. In the habit of regular medicine intake is more among males (75%) as well as being more punctual. Chi-square test also support the observation. Regarding the satisfaction of care during their illness, the majority (84.8%) of males are more satisfied compared with females. Chi-square test also reveals that the relationship of two variables differ significantly. Our data reveals that for males, the main leisure time activity is going for walks (39.2%) and for females (34.8%) spend most of their time for watching TV. It is clear that females (57.1%) are more prone to the situations of loneliness than males (14.5%). While considering the quarrelsome behaviour, females (76.2%) are more likely to quarrel with others compared to males (45.01%). On an analysis of memory
problems and gender the male respondents are always having memory problems (42.4%) compared to females (19.4%). The study revealed that the ability to adjust in the home are more among males (45.9%). Majority of females (79.66%) experience that feeling of faith in God help them always during their illness. Females also have a higher feeling of rejection / neglection from their loved ones than males. It is (52.8%) in the case of females and (7.07%) in the case of males.

Our data on the relationship between gender and disease clearly confirmed that females are more susceptible (96.9%) to the attack of diseases. But the attack of non - communicable diseases is more prevalent (96.05%) compared to communicable diseases (91.4%). Multiple diseases are also more among females (95.9%) compared to males. The most prevalent disease among males are cardiac / hyper - tension related diseases (92.5%) followed by diabetes (88.1%) gastro - intestinal disorders (75.9%), while in the case of females the most prevalent disease is diabetes (93.7%) followed by cardiac / hypertension related diseases (93.02%).

While considering the family size and general health condition, those who have a smaller family size, higher is the perception about the health condition. It is 69.9% who are having a family size less than 5 and 30.06% who are having a family size 5 and above. It is clear from the study that higher the family size, higher is the
deterioration of health among the aged. It is 19.8% in the lower family size and 80.2% for those who belong to a family size of 5 and above.

Observation on activities during old age and family size reveals that those who belong to the smaller family size less than 5 (37.4%) go for regular walks and only 6.7% are spending their time in conversing with others while those who belong to the large family size of 5 and above 38.3% spend their time mostly for watching TV and 26.4% go to visit worship places / tourist places and relatives. On enquiring about the care during illness during old age with respect to the family size it has been found that the majority (76.2%) of those who belong to the larger family size of 5 and above are getting adequate care during their illness. While examining the influence on the number of family members on the ability to adjust at home it is seen that slightly less than the majority (48.37%) who family size is smaller than 5 are always able to adjust well at home. Only 10.5% among those who are not able to adjust well at home are having a larger family size of 5 and above. The feeling of loneliness is higher (77.5%) among those who are having a smaller family size. Chi-square test also shows that the two variables are significantly related. While assessing the influence of family size on the occurrence of diseases 96.7% having diseases with the smaller family size of under 5 and 95.45% having diseases belong to the larger family size of 5 and above. The communicable diseases are more among the old and those who belong to the larger
family size of above 5 (94.3%). In the smaller family group non communicable diseases are present among 96.7% of the study sample. The prevalence of multiple diseases is more among (94.3%) with those who belong to the larger family size of above 5. In both cases the major health problems present is cardiac / hypertension related followed by diabetes and gastro-intestinal problems. It is 97.2%, 96%, and 90.2% respectively in the case of the sample whose family size of less than 5. It is 88.7%, 87%, and 68.6% respectively in the case of the sample with the larger family size of 5 and above.

On examining the factors marital status and general health conditions it is clear that the self perception of the health status among the old is higher among the married (74.5%) and lower among the widowed / separated / divorced (8.2%). It is seen clearly from the study that more diseases are prevalent among the widowed / separated / divorced (98.7%) and lower percentage among the unmarried (54.16%). While considering the occurrence of communicable and non communicable diseases the prevalence of non – communicable disease is 96.05% and for communicable disease it is 91.4% in total. In both cases widowed / separated / divorced are showing a higher percentage. And the multiple diseases are also more among the same group (95.2%). On closer evaluation between the types of diseases and marital status, widowed / separated / divorced are showing the highest prevalence of all types of health problems except urological problems. In all the 3
groups married, unmarried, widowed / separated / divorced cardiac / hypertension related problems is the main issue (98.7%, 92.3% and 87.6% respectively).

While assessing the influence of monthly income on various factors related to geriatric health has been observed that the level of satisfaction about their care during illness increases with the increase in income. It is 88.3% in the case of the higher income group and 44.8% in the lower income group. On an assessment of the quarrelsome behaviour and monthly income it is seen that it is higher (86.1%) among the lower income group. The occurrence of diseases with respect to their family income reveals that as income increases the chances of getting various diseases also increases. It is 99.3% among the higher income groups. Chi -square test also reveals that monthly income and occurrence of diseases are also related. In both communicable and non-communicable diseases the prevalence increases with increase in income levels. But the percentage is higher in the non-communicable diseases; it is 99.3% in the higher income group. The occurrence of multiple diseases is also display a similar trend. It is 95.4% in the higher income group are prone to diseases. On a detailed assessment on the types of monthly income all diseases show an increasing trend with an increase in income. In the lower income group and in the higher income group the most prevalent disease are cardiac/hypertension problems. It is 85.9% and 98.5% respectively. In the middle income group the main health problem is diabetic (91.23%).
While considering the habit of regular exercise with respect to occupation it is found that the 50.3% of the ministerial / administrative / professional workers regularly partake in exercise compared to the other groups. Satisfaction about the care during illness is also higher among the ministerial / administrative / professional workers (92.8%) compared to other occupational groups. While considering the occurrence of disease with respect to occupation, the diseases are more prevalent among the never worked / unemployed / house wives (99.3%) compared to other groups. Communicable and non – communicable diseases are more prevalent among the never worked / unemployed / house wives compared to the other groups. It is 98.1% and 99.3 % respectively. It is evident from the study that the prevalence of multiple diseases is also more (98.08%) among the same category. It was observed that cardiac / hypertension is the most prevalent disease among the never worked / unemployed / house wives (99.3%). Among the daily labourers / manual workers the most prevalent disease is respiratory problems (82.9%). Among the ministerial / administrative / professional workers diabetes is the main health problem (99.5%).

The enquiry on the habit of doing regular exercise during old age with respect to their educational levels reveals that as educational status increases their habit of doing exercise also increases. The habit is 30.4% among the illiterates and 57.02% among those who belong to the higher education group. Another observation is that
as education levels increase the habit of regular and timely medicinal intake also increases, it is 34.7% among the illiterates and slightly less than $3/4^{\text{th}}$ (72.7%) among the more educated. While considering their satisfaction about their care during illness and their educational levels, it has been found that as educational levels increase their satisfaction about their care also increases, it is 20.9% among the illiterates and 83.8% among the highly educated group. The relationship between the educational status and occurrence of disease shows that higher disease prevalence is among the higher educated group (98.7%). The prevalence of both communicable and non-communicable diseases increases with increase in educational level. In the case of communicable disease it is 95.4% and in the case of non-communicable disease it is 98.7%. The presence of multiple diseases also shows the same trend, as education levels increase the prevalence of multiple diseases also increases. It is 95.4% in the case of the higher educational group and 43.4% in the case of illiterates. In all the three groups except the higher educational group, the greater percentage are suffering from cardiac / hypertension related diseases and the second major health problem they suffer from is diabetes. In the case of those who are having a higher educational status the greater percentage is for diabetes 97.9%, and the second more prevalent disease is cardiac / hypertension related (97.4%).
On an analysis of sleeping habits at night and occurrence of disease it is clear that those who sleep less are more prone to health related problems than those who sleep more. Among 76.9% of those who are having some kind of disease are having only up to 5 hours of sleep at night. Chi-square test also fully supports the observation. The study shows that worries and anxieties place an important role on the occurrence of health problems. Among those who are having diseases (96.05%) the majority (58.2%) are always having worries and anxieties. Chi-square test also reveals that emotional issues like worries / anxieties during life and occurrence of diseases are significantly related. The capacity to adjust well at home and disease occurrence are also related. Among the disease absent respondents (67.8%) have always adjusted well at home. On examining the aspect of doing regular exercise it is clear that those who are not exercising regularly are more prone to the onset of illness. The majority (58.3%) than those who are not doing any exercise are having health problems. On a detailed analysis with respect to diet and disease it is clear that vegetarians (60.7%) are at less risk of getting ill than those who follow a mixed diet pattern (39.3%). Among the sample of male respondents (74.3%) having smoking habits of which (95.2%) having some sort of disease and only 4.7% are free from health problems. Regular consumption of meat and meat products leads to an increase in health problems among those having diseases who follows a mixed diet pattern (63.76%) having diseases. Regular consumption of roots and
tubers invite a higher risk of getting diseases. Among those who are having a
disease (68.9%) regularly consume roots and tubers while 31.1% are occasional
users. Routine habits of eating vegetables are good for maintaining proper health,
where 75% of regular consumers are free from diseases. Chi-square value also
reveals that occurrence of diseases are significantly related with regular
consumption of vegetables.

As a whole, analyzing the various parameters associated to the social behaviour of
individual during old age and the dimensions and trends of geriatric health have
been discussed fully well in foregoing discussions. The observations and findings
at every stage of research have been well brought out in the earlier statements.
Thus the hypotheses formulated in various contexts of the study have been tested
and the results have also shown that the findings support them. In this context the
research studies of Sivaraju.S [2002], Sudha Katyal [1999], Yi.Z et al. [2002],
Hemanalini.V et al. [2002], Bannerjee Mrinmayi et al. [2001], Nath.D.C et al.
[2000], Jayashree [2004], Suresh.K.N [2002] well support our observations in the
study. They well indicate the relevance of the problem in the contemporary health
situations of the old in the society. The dimensions of social determinants have
come to limelight fully well in these analyses.