Original Article

Assessment of Morbidity Profile and Health-Seeking Behaviour of Older Adults in a Rural Field Practice Area of a Tertiary Health Care Centre of Western Maharashtra

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Abstract

Background: The diseases prevalent in the older adults need to be identified and their early diagnosis and treatment is facilitated by a good health seeking behaviour. The present study was conducted with the objective of assessing the morbidity profile and health-seeking behaviour of older adults residing in the rural field practice area of a tertiary health care centre of Western Maharashtra.

Methods: In the present cross-sectional study, 660 older adults were selected from the study population using systematic random sampling with population proportionate to sample size and assessed using a predesigned and pretested questionnaire and clinical examination. Data entry and analysis was done in Microsoft Excel.

Conclusion: The major co-morbidities found in these older people were hypertension (49.4%), diabetes mellitus (43.3%), anaemia (26.1%) and cataract (15.6%). 13.0%study participants had symptoms like fever, cough, diarrhoea, joint pain, etc. and out of these, 26 participants were not getting treatment. Health education regarding the importance of getting treatment during times of illness is necessary to bring about a change in their health-seeking behaviour.

Keywords: Morbidity, health-seeking behaviour, older adults.

Introduction

Ageing is a process of deterioration of the functional capacity of a person that is caused as a result of the structural changes that occur with increase in age. In India, people aged 60 years and above are considered as elderly.[1] In 1950, the elderly population of the world was 7% of the global population, it increased to 11% in 2007 and it is estimated that it will rise to 22% by 2050. By the year 2050, the total population of the elderly individuals in the world will be 1.9 billion. The highest proportion of older persons is in Italy and Japan (about 24 percent and 16 percent respectively).[2] The improvement and provision of good health services and preventive care has further raised the life expectancy of the people.[3] In India, the life expectancy has steadily increased from 32 years

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at the time of Independence to over 63 in 2001.[4]The elderly individuals are very valuable to a country as their wisdom and life experience contribute to the progress of the nation. Indian elderly population is the second largest in the world, and is undergoing rapid demographic transition.

In India, the estimates for the year 2010 showed that 8 percent of the total population was above the age of 60 years. The growth of the elderly population in India is comparatively faster than the other countries and it is estimated that it will be doubled by the year 2026 (173 million) compared to the year 2006 (83.6 million). By the year 2050, the population of the elderly citizens in India will be 19 percent of the country's total population. This profound increase in India's older adults brings with it many social, economic and healthcare policy challenges.[5]

Medical problems like visual impairment, hearing loss, musculoskeletal problems, cardiovascular problems, etc. and psychosocial problems like depression, impaired memory, irritability, rigidity of thoughts, etc. are commonly present in the elderly. Aging should not be looked upon as a process of adding years to life, but as a process of adding life to years. In the year 2012, the World Health Organization (WHO) theme was "Good health adds life to years". It focused on the fact that good health throughout one's life can help the person when they grow old to lead a productive life and be self-dependent.[6]

A decision taken by an individual to maintain, attain or regain good health and to prevent any illness is called Health Seeking Behaviour.[7] This has an influence over the elderly people in choosing a particular health service. Some may do home remedies or some might not take any type of medication when they are ill mainly due to rigidity of thoughts and stubborn nature. Delay in receiving proper health care can cause worsening of their health condition.

The present study was conducted with the objective of assessing the morbidity profile and health-seeking behavior of older adults residing in the study area.

Materials and Methods

The present community-based descriptive cross-sectional study was conducted in the rural field practice area of a tertiary health care centre of Western Maharashtra from October 2020 to December 2022. The RHTC (Rural Health Training Centre) is situated at a distance of 30 km from the medical college and the headquarters of the RHTC is situated at tahshil/taluka place and provides OPD (Out-patient Department) sevices, dental OPD services, immunization services and laboratory diagnostic services to the people residing in the taluka and also to the people residing in all the villages at the periphery. The population of this headquarters is 40,700 and there are 20 wards. Hence this population is considered as urban population and for administrative purpose and for ease, the older adults above 60 years of age were selected from this population as the study population for the present study.Thus total number of older adults in this population was 3,132.

Prevalence of common morbidities in the older adults residing in the study area was assumed to be 50%as it gives maximum sample size. By considering the confidence level as 95%, and adding additional 10 percent more fornon-responses, the final sample size came out to be 660.The sample was selected from a total of 20 wards of the study area according to population proportionate to size of the ward. From the voters list, the people residing in a ward who were above 60 years of age were marked and from the list of these people, every 5th person was selected. Before conducting the study, ethical approval was obtained from the Institutional Ethics Committee. The purpose of the study was explained to the study participants and their verbal consent was obtained. Those older people who were unwilling to participate in the study due to being seriously ill or due to some other reasons and those who were not traceable even after three successive visits were excluded from the study.

Sociodemographic information was noted and clinical examination was carried out. Clinical examination of female participants was carried out in the presence of a female attendant, for example, ASHA (Accredited Social Health Activist) worker or ANM (Auxiliary Nurse Midwife).

Past history was taken and participants who were already diagnosed with diseases like diabetes mellitus, hypertension, cataract, glaucoma, osteoarthritis, bronchitis, etc. and taking medications for the same were noted based on the investigations

done before. History of any major surgery was also noted. Information regarding health services utilization[8] was also noted.

Modified Kuppuswamy scale of socioeconomic status classification for the year 2022 was used to classify the study participants according to their socioeconomic status.[9]

Statistical analysis: Data entry and analysis was done in Microsoft Excel.

Results

Table 1: Distribution of study participants according to sociodemographic variables (n=660).

	MALES		FEMALES		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
AGE GROUP (YEARS)						
60 to 64	127	19.24	111	16.81	238	36.05
65 to 69	86	13.03	85	12.88	171	25.90
70 to 74	73	11.06	115	17.42	188	28.48
75 to 79	25	3.79	29	4.39	54	8.18
80 and above	4	0.60	5	0.76	9	1.36
MARITAL STATUS						
Married	299	45.30	306	46.36	605	92
Widow/Widower	16	2.42	39	5.91	55	8
EDUCATIONAL STATUS						
Illiterate	25	3.79	173	26.21	198	30
Primary school	49	7.42	105	15.91	154	23.33
Middle school	17	2.57	19	2.88	36	5.45
High school	168	25.45	48	7.27	216	32.72
Graduate	32	4.85	0	0	32	4.85
Postgraduate	24	3.63	0	0	24	3.63
SOCIOECONOMIC STATUS						
Upper class I	27	4.09	0	0	27	4.09
Upper middle class II	83	12.57	37	5.60	120	18.18
Lower middle class III	78	11.82	73	11.06	151	22.87
Upper lower class IV	127	19.24	235	35.60	362	54.84
Lower class V	0	0	0	0	0	0

Out of the total 660 study participants, there were total 315 males and 345 females. The mean age of all the participants was 67.73 5.17 years. The highest age was 84 years and lowest age was 60 years. According to the modified Kuppuswamy classification, majority of the study participants i.e., 362 (54.84%) belonged to the upper lower class IV while only 27 (4.09%) of them belonged to upper class I.

Table 2: Distribution study participants according to symptoms and comorbidities (n=660).

	MALES		FEMALES		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
SYMPTOMS						
Fever	8	1.21	15	2.27	23	3.50
Cough	17	2.57	9	1.36	26	3.94
Cold	2	0.30	4	0.60	6	0.91

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Loss of appetite	0	0	8	1.21	8	1.21
Sleep disturbance	5	0.76	7	1.06	12	1.82
Diarrhoea	5	0.76	8	1.21	13	1.97
Constipation	3	0.45	6	0.91	9	1.36
Increased micturition	2	0.30	2	0.30	4	0.60
Headache	2	0.30	6	0.91	8	1.21
Body ache	25	3.80	37	5.60	62	9.40
Generalized weakness	8	1.21	26	3.94	34	5.15
Joint pain	6	0.91	48	7.27	54	8.20
Backache	3	0.45	2	0.30	5	0.76
Knee pain	3	0.45	6	0.91	9	1.36
COMORBIDITIES						
Anaemia	8	1.21	164	24.84	172	26.06
Hypertension	197	30	129	19.54	326	49.39
Diabetes Mellitus	150	22.72	136	20.60	286	43.33
Cataract	43	6.51	60	9.10	103	15.60
Glaucoma	3	0.45	0	0	3	0.45
Hearing loss	13	1.97	14	2.12	27	4.10
Osteoarthritis	15	2.27	45	6.82	60	9.10
Rheumatoid arthritis	0	0	2	0.30	2	0.30
Past history of MI	5	0.76	0	0	5	0.76
Chronic bronchitis	6	0.91	0	0	6	0.91
Varicose veins	3	0.45	0	0	3	0.45
H/O major surgery	5	0.76	11	1.67	16	2.42

Out of the 660 study participants, there were 86 (13.03%) study participants who had some sort of signs and symptoms during the interview. The main symptoms were body ache (9.40%), joint pain (8.20%) and generalized weakness (5.15%). A higher number of females had these symptoms.

The major co-morbidities found in the study population were hypertension (49.39%), diabetes mellitus (43.33%), anaemia (26.06%) and cataract (15.60%). 197 (30%) males were hypertensive while 129 (19.54%) females were hypertensive.

Table 3: Distribution of study population according to health-seeking behaviour (n=660).

	Males		Females		Total	
	Number	Percent	Number	Percent	Number	Percent
ACTION TAKEN DURING ILLNESS						
No treatment	16	2.42	10	1.51	26	3.94
Home remedies	57	8.63	12	1.82	69	10.45
Self-medication	15	2.27	0	0	15	2.27
Govt. health services	287	43.50	315	47.73	602	91.21
Pvt. health services	298	45.15	326	49.40	624	94.54
REASON FOR SEEKING MEDICAL CARE						
Have knowledge of symptoms	302	45.76	324	49.10	626	94.85
Request by family or friends	4	0.61	11	1.67	15	2.30
Afraid of complications of disease	6	0.91	3	0.45	9	1.36

In the present study, 86 (13.03%) study participants had some form of illness and symptoms like fever, cough, diarrhoea, joint pain, etc. during the time of the interview. Out of these, 60 study participants were getting treatment for their illness, 38 of them from government health services and 22 from private practitioners. Out of those taking treatment from government health services, 16 went to a primary health centre, 8 to a subcentre and 14 to a rural hospital. There were 26 study participants who were not taking any form of treatment for their illness because 5 (19.23%) of them stayed far away from the nearest hospital, 4 (15.38%) of them did not have enough money for getting medical care, 6 (23.07%) participants did not have any person in their family to accompany them to the hospital, 8 (30.77%) were afraid of adverse effects of medicines and 3 (11.54%) were afraid of needles, invasive procedures and surgery.

Discussion

In the present study, there were about 198 (30%) participants who were illiterate and 24 (3.63%) of them had a postgraduate qualification.

Similar to the present study, there were more number of illiterate participants than literates seen by a study conducted by Ramesh D. Pawar et al. in which 192 (66.21%) participants were illiterate while 98 (33.79%) participants were literate.[3]

In the present study, the major co-morbidities found in the study population were hypertension (49.39%), diabetes mellitus (43.33%), anaemia (26.06%), cataract (15.60%) and osteoarthritis (9.10%).

Similar findings were found by the study conducted by Mohammed Ubaidulla et al., in which the major co-morbidities were visual disturbances (62%), hypertension (43%), osteoarthritis (28%) and diabetes mellitus (15.5%).[4]

In the present study, 602 (91.21%) participants got treatment from Government health services while 624 (94.54%) participants got treatment from private health services. Out of the 86 (13.03%) study participants that had illness, 60 study participants were getting treatment for their illness, 38 of them from government health services and 22 from private practitioners. There were 26 study participants who were not taking treatment for their illness because 5 (19.23%) of them stayed far away from the nearest hospital, 4 (15.38%) of them did not have enough money for getting medical care, 6 (23.07%) participants did not have any person in their family to accompany them to the hospital, 8 (30.77%) were afraid of adverse effects of medicines and 3 (11.54%) were afraid of needles, invasive procedures and surgery. These were the reasons that sometimes led them not to seek medical care during illness.

In comparison with the present study, the number of study participants that got treatment from government health services was lower in a study conducted by P Ray Karmakar et al. in which it was found that majority of the study participants (86.9%) were having chronic diseases, and out of those having chronic diseases, 71.78% sought treatment. Majority (53.37%) availed modern method of treatment and more than one fourth (28.22%) sought no treatment. Only 13.88% sought treatment from government health facility due to fixed outdoor timing.[10]

Conclusion

The major co-morbidities found in the study population were hypertension, diabetes mellitus, anaemia and cataract. Early diagnosis and treatment of the diseases that are prevalent in the older adults through periodic screening, health check-ups, proper counselling and follow up is necessary to maintain good health, improve their quality of life and prevent complications due to the disease in the future. Health education of the older adults, their family members and the community in which they live regarding self-care and home monitoring of weight, blood pressure and blood sugar levels is equally important.

Majority of the participants got treatment from government as well as private health services.Since a majority of the study participants (70%) were educated, 61.5% of them having received education from primary school to middle school, and 8.5% of them having completed their graduation and postgraduation, the health seeking behaviour was good which was indicated by the fact that they would go to a doctor for follow up visits as advised by the doctor and during times of illness. A lesser percentage of the participants did not take any treatment during illness, the most common reason for

which is the rigidity of outlook and stubborn nature that is present commonly in people as age advances. Health education regarding the importance of getting treatment during times of illness, to solve all the doubts that are there in the minds of those people regarding health care is necessary to bring about a change in their health-seeking behaviour.

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