CHAPTER-7

HEALTH AND ILLNESS AMONG THE ELDERLY: ROLE OF HOSPITALS AND NGO'S

"In youth we run in to difficulties, in old age difficulties run in to us"- Beverly Sills

Introduction

In India, the elderly people suffer from both communicable as well as non-communicable diseases. This is further compounded by impairment of special sensory functions like vision and hearing. A decline in immunity as well as age-related physiological changes leads to an increased burden of communicable diseases in the elderly (Ingle, 2008, pp. 214-18). Elderly people are also highly prone to mental morbidities due to ageing of the brain, problems associated with physical health; cerebral pathology; socio-economic factors such as breakdown of the family support systems; and decrease in economic independence. The mental disorders that are frequently encountered include dementia and mood disorders. Ensuring good quality geriatric health care services at the primary level would greatly help in improving the utilization rates of the available health services. Health care services should be based on the "felt needs" of the elderly population in the area. This would involve a comprehensive baseline morbidity survey and functional assessment in health areas that are perceived to be important to them. This should be transformed into a community database that would help to prioritize interventions and allocate finances accordingly. The felt needs should vary depending upon gender; socio-economic status as well as rural and urban areas (ibid).

7.1 Accessibility to Affordable and Good Health Care

In Gujarat state there are 24 District Hospitals, 30 Sub-District Hospitals, 300 Community Health Centres and 1208 Primary Health Centres spread across. As per the table below published by the National Health Mission under the Ministry of Health and Family Welfare there is a visible lag in infrastructure and manpower in the health sector.

Particulars	Required	In Position	Shortfall
Sub-centre	9156	7274	1882
Primary Health Centre	1433	1158	275
Community Health Centre	358	318	40
Health worker (Female)/ANM at Sub Centres & PHCs	8432	6431	2001
Health Worker (Male) at Sub Centres	7274	4874	2400
Health Assistant (Female)/LHV at PHCs	1158	875	283
Health Assistant (Male) at PHCs	1158	758	400
Doctor at PHCs	1158	778	380
Obstetricians & Gynaecologists' at CHCs	318	9	309
Paediatricians' at CHCs	318	3	315
Total specialists at CHCs	1272	76	1196
Radiographers at CHCs	318	168	150
Pharmacist at PHCs & CHCs	1476	1428	48
Laboratory Technicians at PHCs & CHCs	1476	1365	111
Nursing Staff at PHCs & CHCs	3384	2705	679

[Source: Ministry of Health and Family Welfare Gujarat (2014)]

Table 7.1

As evident from the (Table 7.1) the actual requirement of good and affordable health care is not met by the state government resulting to the mushrooming of private health care centres which function with a motive of maximum profit.

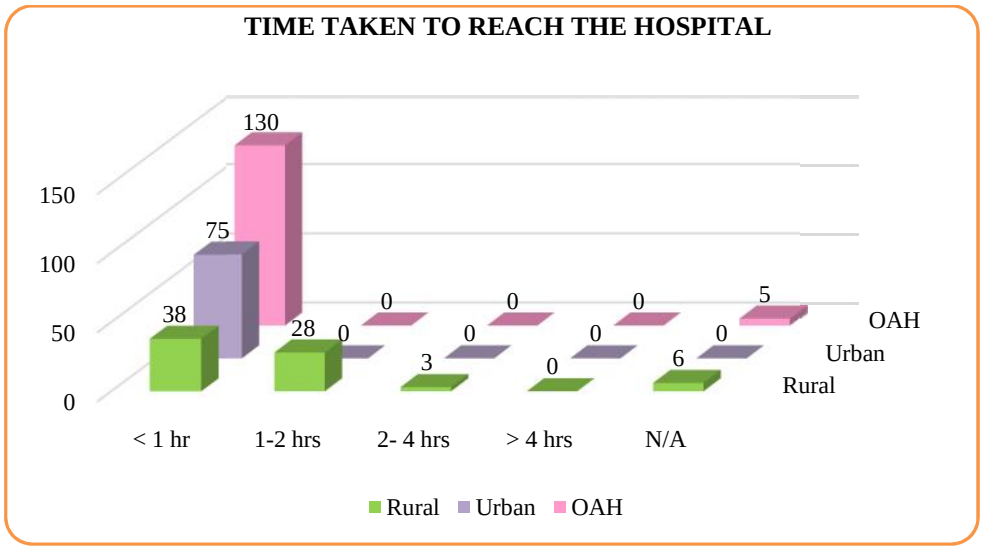


Figure 7.1

The (Figure 7.1) reflects that majority of the elderly sample population have either government run hospitals, health centres or private clinics or hospitals in 2 kilometre to 10 kilometre radius. In urban locations all the respondents have hospitals or clinics nearby; this is understandable since there are clinics and hospitals mushrooming day by day in every corner. The private hospitals which provide specialised services charge anywhere from `200 to `500 for one consultation. But there are also a few clinics which charge below `100 which are mostly preferred by the elderly as they are more affordable.

In rural locations 38 respondents live near to a Primary Health Centre (PHC) which could be accessed either by walk or by shuttling rickshaws. According to 28 respondents living in villages, they do not have a PHC. Hence they have to travel at least one to two hours to get medical help, which is mostly to the nearest town or city. Some of the respondents in villages also opt for alternative medicines like Ayurveda, traditional healers and homeopathy. The PHC in several villages according to the respondents have poor infrastructure, no doctors on a regular basis and are mostly attended by the nurses or attendant. All the respondents of rural areas have to go to

the nearby cities for specialised consultation, complicated illness and emergencies. All except five of the Old-age home respondents have good access to health care. This is because the Old-age homes are usually located in or near to urban locations. 5 respondents each in the Old-age home as well as rural location in the not applicable category are those who have never visited or consulted a doctor.

As age increases morbidity and debility sets in making health care an important factor in their life. The research has tried to examine the relevance and availability of good health care in the Old-age homes sampled for the study.

RESIDENT/ VISITING DOCTOR IN OAH

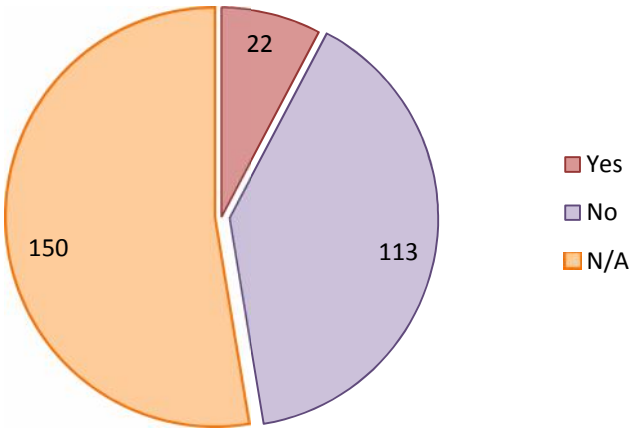


Figure 7.2

The (Figure 7.2) shows that very few respondents in Old-age homes i.e. 22 elderly have been receiving health care in the organisation they are staying in. Only two among the sampled Old-age homes have a visiting doctor who visits the organisation once in a week, and one of them is an alternative health practitioner. The respondents in the organisation admitted that though Ayurveda is very helpful for them in case of pains and other long term diseases they would prefer to have an allopathic doctor as well because most of them take allopathic medicines in case of certain illness as it provides quick relief. It was noticed that elderly staying in these two Old-age homes have better health than other Old-age home respondents. Many of the respondents staying in Old-age homes without a health care facility preferred government run or charities run clinics or hospitals in their locality. But the respondents also admitted

that they would have preferred private clinics if they could afford as the health care provided in most of the government hospitals are poor and did not give much relief to their illness and took longer time to cure.

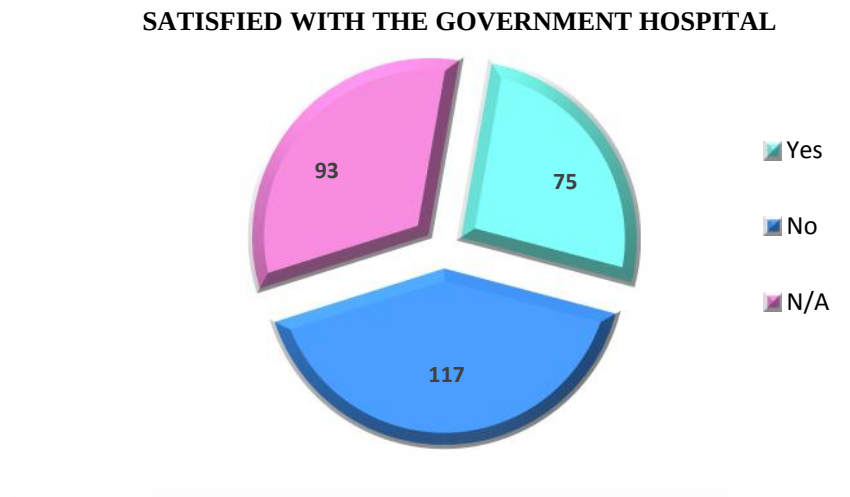


Figure 7.3

The (Figure 7.3) shows that, 192 respondents have visited government hospitals for treatment. Out of this only 75 respondents agreed that they are satisfied with the hospital treatment and facilities. 93 sample populations in the not applicable category are those who have never visited a government hospital for any illness. The government hospitals when visited by the researcher, it was noticed that the wards were crowded more by visitors rather than the patients. Though there is a separate ward for the chronically ill, in case of shortage of beds these patients are accommodated among the patients in general wards. It was also noticed that the isolation ward for chronically ill patients is not actually isolated from other wards. It is connected to the other rooms and people are allowed to move in and out freely. Some of the specialised out-patient departments like orthopaedic was found to be over crowded with patients waiting for hours and desperately trying to get attention. The departments are in shortage of manpower and are not able to meet the needs.

The doctors in the Dental Department of one of the hospitals visited said that most of the patients who visit the hospital are from the lower class and maintained less dental hygiene. It was noticed that only one of the sterilisation equipment was in working condition. The replacement procedures of any medical equipment are time consuming and complicated. This forces the doctors to adopt alternative sterilisation methods

which are not hundred percent safe and they admitted that chances of infections and transfer of communicable diseases like HIV cannot be ruled out. According to one of the General Physician in one of the Government Hospital the geriatric patients are sometimes not operated even if needed because most of them turn out to be anaemic and weak.

7.2 Facilities Available in Hospitals

The study has tried to understand the facilities available in hospitals. For this purpose four prominent hospitals in different study locations were visited and required information was collected with the consent of the concerned authorities. Some of the hospital authorities approached for the study was not very forthcoming. They were apprehensive of giving any information. Therefore the information obtained through these four hospitals cannot be extrapolated.

District	Hospital	Consult. Fee ₹	Concession for 60+	Geriatric Ward	Geriatric Friendly	Enough seats	Well organised	Neat & Clean	Pharmacy	Multi-Speciality
Anand	Sree Krishna Hospital, Karamsad	Reg: 100 (Life time) Consul: Nil	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Banaskantha	Palanpur Civil Hospital	Consul: 5 BPL: Nil	No	No	No	No	No	Yes	Yes	Yes
Surat	Asaktashram Hospital	Consul: 100	No	No	No	No	Yes	Yes	Yes	Yes
Kachchh	Nanavati Hospital	Consul: 200	No	No	Yes	Yes	Yes	Yes	Yes	Yes

Table 7.2

7.2.i Consultation Fees

Four hospitals were sampled for the study in which there is one Government Hospital, two Trust run hospitals and a Private Hospital. The consultation fees in government hospitals range from ₹5 to ₹10 but for BPL card holders the consultation is free. In the two trust run hospitals the Sree Krishna Hospital in Karamsad charges ₹100 for registration which is for life time and the out-patient consultation is free. Whereas, Asaktashram Hospital which is also a trust run hospital charges ₹100 for each consultation. In specialised private hospitals like Nanavati in Bhuj the consultation fees range anything from ₹200 to ₹500. It was noticed that the geriatric patients do not receive any kind of concession in the fees in any of these hospitals.

7.2 ii Geriatric Ward/ Speciality

None of the hospitals visited have a doctor specialised in geriatrics nor do they have a geriatric ward. The morbidity pattern among the elderly are found to be very different from the morbidity patterns in other age groups. Thus geriatric patients have to be dealt with a different approach and care pattern which would help them to lead a good healthy life. Many of the illnesses among the elderly are overlooked or ignored assuming it to be part of old age, but many researchers have argued that these illnesses with timely intervention could be cured.

7.2 iii Pharmacy

All the hospitals visited have their own pharmacy, while the government hospitals provided medicines free of cost, the Trust run hospitals are paid counters. The pharmacy section in the government hospitals complained of shortage of medicinal supply from the central pharmacy under the health department. Therefore the patients have to buy these medicines from the pharmacy outside the hospital which proves to be very costly for them.

7.3 A Global Overview of Health Care Services for the Elderly

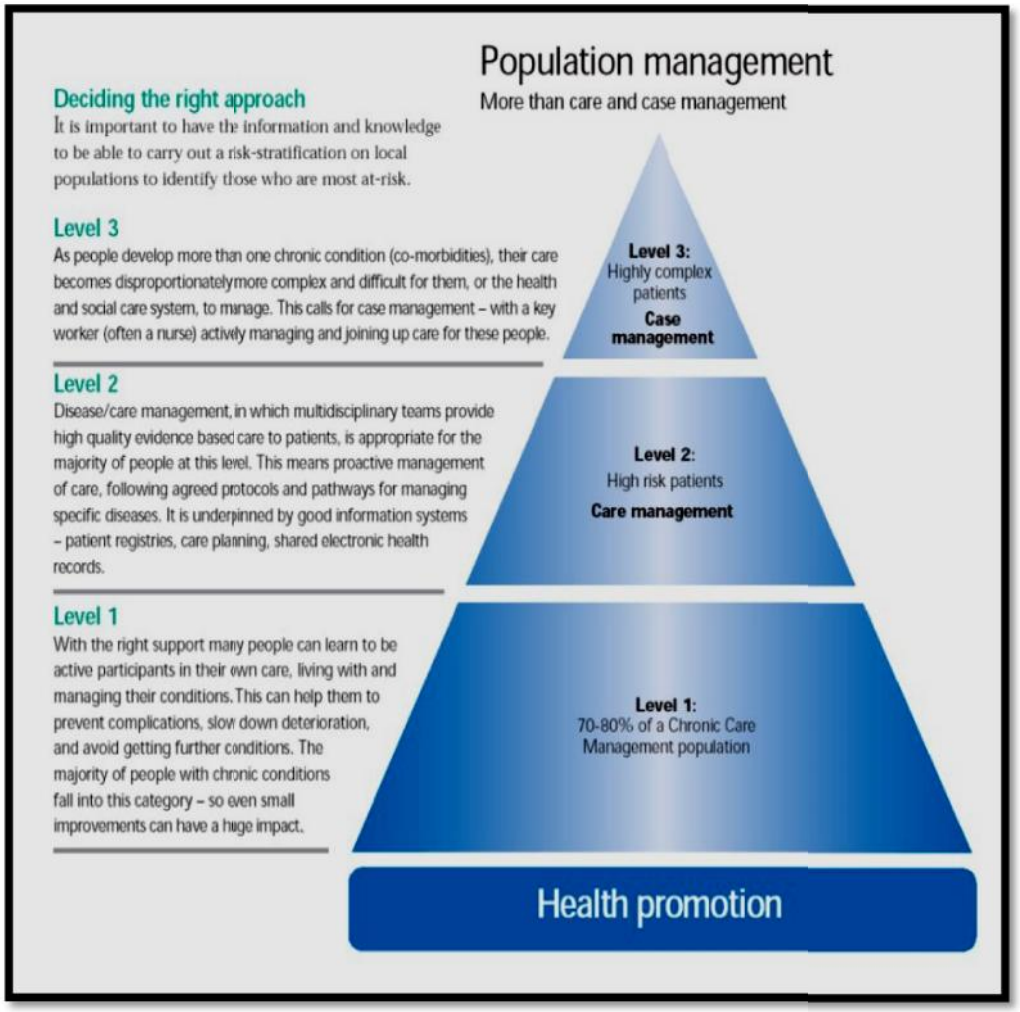
Different countries world over have adopted different approaches to serve the needs of the elderly. The elderly are disproportionate users of healthcare. Delivery of healthcare services to different sections are driven primarily by regulatory and policy initiatives of the government of that country. However, with the rising proportion of elderly and increasing cost of health care with technology advancement has led to

increased consciousness in the health systems worldwide. Therefore, the modern day healthcare delivery systems focus on providing mix of services and allow choices by consumers on where to obtain health care based on the efficiency of services (ASSOCHAM, 2014, p. 19).

Healthcare of the elderly should be multi-sectored, which involves the individual himself, the family, the community, certain non-profit organizations, the commercial sector, and the government. Integrated care with reduced cost has been a hallmark of modern day healthcare delivery models. These models coordinate the work done by various healthcare providers, such as primary care physicians, specialists, hospitals, pharmacies and laboratories. Integrated care helps improve care quality, makes care delivery more convenient for members, and increases communication among various care providers. At the same time, these enable to find efficiencies that reduce costs, improve or maintain quality, and allow for innovation (ASSOCHAM, 2014, p. 19).

One of the most widely used models has been ‘Kaiser Model’ (Figure7.4). The model provides a useful framework to manage the healthcare needs of different sections of elderly population. The bottom of the pyramid consists of (approximately 70-80 per cent) people with long-term conditions who can care for themselves and thus, need minimal input from health and social services. High risk patients, which are in the middle layer, need more active disease and care management from professionals. Patients with highly complex needs, who are represented by the top layer forms a small proportion. This section account for a large number of emergency admissions to hospital and would require trained health care professionals and support system to actively manage their case (ASSOCHAM, 2014, p. 19).

Kaiser model focuses on integrating organizations and disciplines. The model focuses on developing partnerships between clinicians and other actors in health sector, while employing high proportion of doctors in leadership roles. Beneficiaries requiring long-term care are classified according to need, with intensive management targeted at those at highest risk. More emphasis is paid on patient education and integrated and proactive management. Healthcare programs based on Kaiser Model could help reduce hospitalization and improve co-ordination of various agencies providing health care (ASSOCHAM, 2014, p. 20).



Kaiser Model of Health Care [Source: ASSOCHAM India (2014)]

Figure 7.4

The following section provides an overview of the structure of elderly health care in four countries that is Brazil, Indonesia, Singapore and Sweden.

7.3.i Brazil

Brazil has a Unified Health System (SUS) which is publicly funded to give universal free access to healthcare to the whole population. The system is decentralized at three levels i.e. federal government, state government and municipal authorities. The system has a Basic Health Unit (BHU) which caters to the basic health demands of the population referring to other specialized services if needed. The organization and provision of services referred to are based on risk or specific conditions of the affected. The second model of Primary Health Care (PHC) is based on Family Health

Strategy (FHS) which offers participative and comprehensive care in a system which is coordinated centrally. The FHS was first introduced in the poorest localities which was out of the purview of PHC replaced the traditional model of care. The model provides a primary person-centered care; with a priority to prevention and health promotion followed by curative medicine FHS in health care for the elderly also shows that the FHS contributes to higher quality of life (ASSOCHAM, 2014, p. 20).

7.3.ii Indonesia

According to the United Nations, In Indonesia the 60+ population is expected to rise from 8% of the population to 13% in 2025. The Indonesian government plans to introduce one of the biggest health care schemes the National Social Security System (SJSN) from 2014 by setting up an insurance fund to cover all 240 million of its citizens. The aim of the scheme is to provide free health care to all.

The key highlights of the scheme are as follows:

- Five separate social insurance programs would be established for Health, Work Accident, Old Age, Pension and Life.
- The four existing profit oriented limited liability state enterprise would be responsible for administering the five new social insurance funds.
- National Social Security Council which is responsible for running the SJSN system would have five members from government ministries, two from employers, two from workers, and the remaining six appointed experts.

Contribution structure differs between formal and informal sector. Under the SJSN law, the burden of financing the various social insurance programs is allocated among workers, employers, and the government. Both the formal sector workers and their employers have to contribute towards the social insurance programs in which the cost would be shared equally between employers and workers. Contributions in informal sector are nominal for workers while the Government puts in the rest of the amount but those who are not poor in this sector have to pay their own contributions (ASSOCHAM, 2014, pp. 20-21).

7.3.iii Singapore

In Singapore 60+ elderly comprise of 15.8% of the population. The rate of utilization of public sector primary care and hospital services among this section of population is

found to be much higher. This rate is estimated to increase further by 2030. Ministry of Community Development and the Ministry of Health are two government bodies responsible for elderly care. The Ministry of Health provides various schemes and subsidies to support the elderly. The government is also promoting Voluntary Welfare Organizations (VWOs) as the main service providers for elderly care. Government provides full support and assistance to these VWOs by following steps:

- Assistance of up to 90 per cent for capital expenditure and for cyclical maintenance costs for existing building.
- Up to 50 per cent for operating/recurrent expenditure.
- Up to 100 per cent rental subsidy for use of government premises or state land. 100 per cent rebate for input along with manpower (doctors and nurses and permits for foreign medical experts).

The VWOs provide various health services to the elderly population:

- Community hospitals are for patients, especially elderly patients, who require longer inpatient care, but who do not require the high technology and sophisticated care of acute hospitals. The patients admitted should also have rehabilitation potential.
- Chronic sick hospitals admit long stay patients who have no rehabilitation potential but require medical and nursing care.
- Nursing homes provide primary nursing care with little or no medical care.
- Day Care Centres are rehabilitation centres for the elderly suffering from senile dementia, the terminally ill and frail elderly.
- Home medical and home help services are also available to the home-bound elderly (ASSOCHAM, 2014, p. 21).

7.3.iv Sweden

Sweden, have always had a high public expenditure towards care for the elderly. The Scandinavian model is based on community living and allows the elderly to live a normal and an independent life. This is basically construed as living in their own homes with various forms of support, such as safety alarms, meal service, transportation service, medical and social services delivery.

The Swedish Parliament has defined the following objectives for national policy for the elderly:

- Live an active life and have influence over their everyday lives.
- Grow old in security and retain their independence.
- Be treated with respect.
- Have access to good healthcare and social services.

Within this framework, the responsibility of care for the elderly rests at three levels:

Level 1: The central government realizes policy goals through legislations and financial grants.

Level 2: The regional councils are responsible for health and medical care.

Level 3: Local municipalities are responsible for social service and housing needs of the elderly.

These three authorities work towards providing support and facilities for elderly living (ASSOCHAM, 2014, p. 22).

7.4 Role and Presence of NGOs

In 1982 India adopted the United Nation's International Plan of Action on Ageing in the World Assembly Conference in Vienna. In the Eighth Five Year Plan the government sought to encourage Non-Governmental Organisation (NGO) to provide institutional as well as non- institutional services through a limited grants-in-aid program (Sawhney, 2005, p. 180). In 1999 the Indian government declared the National Policy for Older Persons (NPOP), which emphasized the dominant role the NGOs should play in assisting the government in dealing with the medical, psychological and socio-economic problems faced by the elderly (ibid, p. 180).

The first organisation to devote itself to the need of the aged was 'The Friend in Need Society' in Madras established as early as 1840. 'The Little Sisters of the Poor' in Calcutta followed suit in 1882 by opening a home to provide shelter, clothing and medical care to the old. HelpAge India which is affiliated to HelpAge International a global NGO was set up in 1978, the organisation looks for partner agencies to implement its various projects and programs on elderly (Sawhney, 2005, p. 182).

HelpAge is an international NGO working towards the right to an active**,** healthy and dignified life for elderly. Their services consciously try to move from welfare

towards development and long term sustainability. Their work includes bringing awareness about elderly rights, adequate health insurance, right to universal pension etc. They also give services related to health through health camps and mobile units. But according to their website their works are mostly concentrated in and around Ahmedabad.

The study has tried to identify the NGOs working on elderly issues in the study locations to assess the role of NGOs in elderly issues. “Tribhuvandas Foundation” an NGO working in the health sector in Anand district mainly focuses on mother and child health care and awareness throughout the district. But they also have clinics set up in different locations which give health care to all at a very nominal rate that is ₹20 to ₹50 which also includes medicines. The study couldn’t identify any other NGO working on elderly issues in other study locations.

7.5 Major Findings and Interpretations

- As per the data given by National Health Mission (NHM) there is a visible lag in infrastructure and manpower in the health sector throughout the state.
- According to the study majority of the respondents have either government run hospitals, health centres, private clinics or hospitals in 2 kilometres to 10 kilometre radius.
- The respondents who do not have a health care facility nearby have to travel at least one to two hours to get medical help.
- Some of the respondents also take alternative medicines like Ayurveda, traditional healers and homeopathy.
- The PHCs in several villages have poor infrastructure and no doctors on a regular basis and mostly nurses or attendant are the ones who prescribe treatments.
- All the respondents in villages have to go to the towns or cities for specialised medical help and treatment for major illness and emergencies.
- The economically poor respondents in Old-age homes have better access to health care if their organisation is near to government hospitals or if they have a visiting doctor.

- The respondents who visited government hospitals for treatment due to poor economic status would prefer to visit private hospitals if they could, because the treatments provided in government hospitals were not satisfactory.
- The government hospitals were over-crowded; there was shortage of manpower among the doctors as the patients complained that they have to wait for long hours even for preliminary examination.
- The chronically ill patients were also admitted in general wards as there was shortage of beds.
- Replacement and maintenance of equipment involved long procedures and was time taking.
- The doctors in government hospitals admitted that most of the geriatric patients were not operated even if needed to as they were anaemic and weak.
- There was also shortage of manpower in the diagnostic labs and the existent technicians were not able to meet the demands.
- The supply of medicines from the state government health department is much lesser than what is needed.
- There is no concession for geriatric patients, patients are charged from ₹5- ₹10 in government hospitals and free treatment is given only for below Poverty Line (BPL) card holders.
- One of the trust run hospitals which is in Anand district charged nothing for out-patient consultation.
- There was no geriatric ward or geriatric specialised doctors in any of the hospitals.
- Government hospitals provided medicines free to all patients irrespective of age.
- The trust run hospitals had paid pharmacy counters without any concession.
- No NGO working for elderly was identified in any of the study locations.
- One NGO working on health particularly on maternal and child health was identified in Anand district of Gujarat.

Conclusions

The study found that there are great contrast between different types of hospitals in Gujarat in providing health care, and affordability. There needs to be more geriatric

friendly hospitals with specialists and supporting staff trained in needs of geriatric. The state needs more NGOs to work on different issues of elderly especially their health and economic aspect. More private enterprises should include Geriatric supports and causes in their CSR agendas.

HOSPITALS AND HEALTH SERVICES

Photograph 7.1

Palanpur General Hospital (Banaskantha)

Photograph 7.2

The administrative section of Palanpur General Hospital (Banaskantha)

Photograph 7.3

The over-crowded corridors of Palanpur General Hospital (Banaskantha)

Photograph 7.4

The general ward of Palanpur General Hospital (Banaskantha)

Photograph 7.5

An elderly patient on an extra bed in the corridor of Palanpur General Hospital (Banaskantha)

Photograph 7.6

Sree Krishna Hospital (Karamsad Anand)

Photograph 7.7

The Lobby and the pharmacy in Sree Krishna Hospital (Karamsad Anand)

Photograph 7.8

Vaheval Primary Health Centre (Surat)