Utilization of health services by the elderly and their health status in a health division in Sri Lanka

A. Balasuriya[1], S. A. P. Gnanissara[2]

Abstract

Objectives: To assess the health status and the extent of utilization of health services by the elderly in the Divisional Director of Health Services area Beruwala in the district of Kalutara in Sri Lanka

Methodology: A community based descriptive study of 426 non-institutionalized elderly aged 60 years and above was done. A pre-tested interviewer-administered questionnaire was used to assess health care utilization of a stratified sample.

Results: Only 17.8% were old-old while the majority (59.9%) were females. Mean number of years of schooling for males was one year more than that for females. More widows than widowers were present. Thirteen percent of the elders did not have a caregiver. Five percent of the elderly had a severe mental illness. Considerable dependence on Physical and Instrumental Activities of Daily Living was seen. There was a high level of utilization of health services.

Eighty-five percent of the chronically ill elderly preferred government or private allopathic medical treatment while for acute illnesses preference was 71.8%. The place of self-care for acute illnesses was evident while the preference for Ayurveda treatment for both chronic and acute illnesses was about 13%.

Conclusion and recommendations: There is notable morbidity among the elderly. Though the majority preferred allopathic medical treatment for chronic and acute illnesses, some preferred Ayurveda treatment. Self-care was also evident.

Key words: elderly, health services, utilization, health status, Sri Lanka

Introduction

Sri Lanka has the fastest growing elderly population in the world (1). The elderly population above 60 years of age enumerated from the population census in 1981 was 981,808 or 6.6% (2). It is estimated that by the year 2041, about a quarter of the population would be 60 years and older (3). Life expectancy at birth for males in 1991 was 69.5 years and for females it was 74.2 years (1). The average life expectancy at age 60 years was 20 years in 1991 (4).

Recent trends show that cardiovascular diseases, cancer, rheumatological and neurological conditions are on the rise (5). Apart from this epidemiological transition, the demographic transition has posed many questions. They are the increasing old age dependency, decline in the number of kith and kin to look after the elderly, increasing participation of females in the labour force, decreasing numbers of elderly in the work force, higher number of females in old-old age groups and other health related matters like increased utilization of health and social services by the elderly.

Data on utilization of health services by the elderly in Sri Lanka and in other countries show that the elderly are affected more by factors like availability, affordability and accessibility of services (6). However data available on utilization of on utilization health services by the elderly in Sri Lanka is limited. This research was done to assess the health status and the extent of utilization of health services by the elderly in the Divisional Director of Health Services (DDHS) area Beruwala in the district of Kalutara in Sri Lanka.

Methodology

Study area was Beruwala DDHS area in the Kalutara district.

Study population was non-institutionalized elderly aged 60 years and over living permanently in the study area.

A two-stage sampling method was used. Sampling frames for each of the 43 Public Health Midwife (PHM) areas in the DDHS area were constructed using the voters' lists that were compiled within the previous four months. Ten respondents were selected randomly from each PHM area using random number tables. The sample size was 430 or 5 % of the target population.

Date collection was done by the PHM of the area, using an interviewer-administered, structured pre-coded and pre-tested questionnaire. The questionnaire consisted of three sections: basic characteristics, health status and service use of the elderly respondent. The questionnaire was developed using several standard questionnaires,

1. Medical Officer, National Institute of Health Sciences, Kalutar, Sri Lanka.
2. Former Deputy Director General of Education, Research and Training, Ministry of Health, Sri Lanka.

namely; Comprehensive Assessment and Referred Evaluation (CARE), Multiple Assessment Instruction (MAI) and Older American Resources and Services (OARS) questionnaires (7).

Anonymity of respondents and confidentially of information were assured and informed consent was obtained from the respondents and their caregivers. Internal validity was ensured by clear instructions for and thorough training of data collectors, by testing and re-testing method and by cross-checking of questions.

Results

The response rate was 99.1% or 426 respondents. Basic characteristics of the respondents are given in Tables 1 and 2.

Table 1. Distribution of respondents by gender

Gender	No.	%
Male	171	40.1
Female	255	59.9
Total	426	100.0

Table 2. Distribution of respondents by sex according to some basic characteristics

Variable	Male		Female		Both sexes	
	No	%	No	%	No	%
Age group						
60-64	51	29.8	88	34.5	139	32.6
65-69	44	25.7	77	30.2	121	28.4
70-74	34	19.9	56	22.0	90	21.1
75-79	23	13.5	23	9.9	46	10.8
80+	19	11.1	11	4.3	30	7.0
Educational level						
No schooling	6	3.5	31	12.2	37	8.7
Grade 1-5	101	62.4	159	45.0	260	61.0
Grade 6-10	63	37.1	63	24.7	126	29.6
Grade 11 & above	1	0.6	2	0.8	3	0.7
Marital status						
Currently married	140	81.9	80	31.4	220	51.6
Widowed	17	9.9	164	64.3	181	42.5
Divorced/ separated	1	0.6	2	0.8	3	0.7
Never married	13	7.6	9	3.5	22	5.2
Availability of a caregiver						
Not Available	26	15.2	29	11.4	55	12.9
Available	145	84.8	226	88.6	371	87.1
Helping at home						
Often	64	37.4	155	60.8	219	51.4
Occasionally	35	20.5	44	17.3	79	18.6
Seldom	72	42.1	56	43.8	128	30.0

There were 59.9% females. Of the males in the sample, 29.8% were below 65 years of age while 24.6% were above 75 years (old-old). There were 34.5% of females below the age of 65 years and 13.3% were old-old. More females (12.2%) than males (3.5%) had no formal education. Mean number of years of schooling was 4.8 and 3.9 respectively for males and females. Widowhood was more among females (64.3%) than males (9.9%). Nearly 13% of the elders did not have a primary caregiver, who helps the elder when needed. The help given at home by way of looking after the house, taking care of grand children and doing household work like sweeping and housekeeping was assessed. More females (60.8%) than males (37.4%) helped at home often. Over 42% of males seldom helped in these chores while 37.4% helped often. In contrast, 22% of females seldom helped while 60.8% helped often.

Independence in Physical Activities of Daily Living (PADL) was lowest for bathing (78.9%) and highest for highest for transference from bed to chair (94.6%). Three-fourth (74%) were independent in all six activities assessed while 16 respondents (3.8%) were dependent in all of them. The six PADL assessed were eating, dressing, toileting, bathing, transference between bed and chair and grooming. When the elderly needed assistance or had difficulty in doing any activity, it was considered as being partially dependent.

Travelling outside the house using public transport and transacting correctly at a boutique were the two Instrumental Activities of Daily Living (IADL) considered. There were 62.4% elderly who were independent in IADL (table3).

Table 3. Distribution of respondents by sex according to IADL score

	Male		Female		Both sexes	
	No.	%	No.	%	No.	%
Totally dependent	31	18.1	47	18.4	78	18.3
Partially dependent	30	42.1	52	57.9	82	19.2
Independent	110	41.4	156	58.6	266	62.4
Total	171	40.1	255	59.9	426	100.0

Dementia and depression were taken into consideration in the assessment of mental health.

Only 69.8% were in good mental health while 4.9% had severe mental illness (table 4).

Table 4. Distribution of respondents according to mental health status

Mental health status	No.	%
Poor	20	4.9
Satisfactory	108	25.3
Good	298	69.8
Total	426	100.0

Occasional or frequent accidents of controlling bladder and bowel were seen in 6.1% and 1.9% elderly respectively (table 5).

Table 5. Distribution of respondents according to the ability to control bladder and bowel

Ability to control	Bladder		Bowel	
	No.	%	No.	%
Poor	26	6.1	8	1.9
Satisfactory	15	3.5	12	2.8
Good	385	90.4	406	95.3
Total	426	100.0	426	100.0

There were 229 (53.8%) elderly who answered in the affirmative to the question "at present, are you on treatment for any illness for more than three months?" Those elderly were defined as having a chronic illness and were asked regarding their preference in getting medicine. Of these chronically ill elderly, there were 44.1% who preferred government allopathic treatment and 40.6%, private allopathic treatment. Only six elders (2.6%) took treatment directly from a pharmacy while 12.7% preferred ayurveda treatment.

There were 110 elderly (25.8%) who were ill at any time during the previous four weeks. Twenty-two elders (38.2%) had taken private allopathic treatment for that illness while 33.6% had gone to a government allopathic medical institution. Fifteen (13.6%) elders had resorted to self-care in the form of home remedies and 12.7% had taken ayurveda treatment. Only two elders (1.8%) had obtained medicine directly from a pharmacy.

Table 6 – Preference for treatment of chronic and acute illnesses

Type of Illness	No. in the group	% preferring the service					
		Government allopathic	Private allopathic	Over the counter	Ayurveda		Self care
Chronic illness	229	44.1	40.6	2.6	12.7		0.0
Acute illness	110	33.6	38.2	1.8	12.7		13.6

Discussion

When compared with developed countries, this study gives a lesser number of females in older age groups (8). There was a clear difference between the two sexes regarding educational attainment. More than half (64.3%) of the females were widowed but less than one-tenth (9.9%) of the males were widowers. Therefore, naturally the primary caregivers for females were their children or spouses of children in the majority (69.0%) while for male elders, 40.4% were looked after by their wives.

Help given at home markedly differed between the two sexes. This fitted well with the roles assigned for the genders in Asian cultures. But the effect of current employment on this could not be assessed, as the employment status was not looked into. An important factor that has to be considered by policy planners and service providers is that nearly 38% had at least partially impaired IADL and 26% had impaired PADL. Notable distressing health problems were poor mental health and poor control of bladder and bowel.

This study indicated a high level of use of health care services. It was found that 53.8% were chronically ill and were on treatment. The percentage of elderly ill in the preceding month was 25.8%. In a study of 1200 persons of age 60 years and over, conducted in the Western province in Sri Lanka, 44% had used the services of a doctor during the month preceding the survey (6). This high rate of illness among the elderly has to be considered when planning services for them. The ability of self-care by them was shown in taking home remedies for acute illnesses (13.6%). This is encouraging, as the emphasis is on self-care for the elderly (9). This has to be further analyzed to see for what illnesses they took home-remedies and what kind of remedies they took. Taking home-remedies seems to have a positive effect. We need to look into it further to see whether this is due to problem of inaccessibility. Inaccessibility was the second most important reason (14%) for needing more health aids after inability to afford (86%) in the other study (6).

Self-care includes not only self-treatment but also preventive action and related behaviours of a general nature which individuals do for their health. In an economic context, self-care leads to reduced service utilization. It can prolong fitness and good health, and reinforce personnel autonomy, but

should not be a forced-choice due to difficulties in accessibility of other forms of services.

Conclusions and recommendations

There is notable morbidity among the elderly. Widowhood was higher among the females than in the males. Females were less educated. Preference in taking treatment for chronic illness was at government rather than private allopathic medical institutions. This was reversed in the case of acute illnesses. Nearly one-eighth preferred Ayurveda treatment for chronic and acute illness. Self-care was evident for acute illnesses.

Acknowledements

Financial assistance by the National Health System Research programme funded by IDRC, Ottawa, Canada.

References

1. Siddhisena KAP. Mortality trends, determinations and implication in Sri Lanka: Retrospect and prospect. In: Demography of Sri Lanka: issues and challenges. Department of Demography, University of Colombo, Sri Lanka. 2000: 119–139.

2. Department of Census and Statistics. Sri Lanka: Census of population and housing, Preliminary release No. 2. Colombo. 1982

3. Population Division. Emerging population issues in Shri Lanka., Ministry of Health, Colombo: 1993.

4. World Health Organisation. Bridging the gaps. The World Health Report – 1995. Report of the Director General, Geneva: 1995; 37-39.

5. Department of Health Services, Sri Lanka. Annual Health Bulletin – 1999. 2001.

6. Fillenbaum GG. The wellbeing of the elderly – approaches to multidimensional assessment. Offset Publications No. 84. Geneva: World Health Organisation. 1984.

7. Hicky T, Dean K, Holstein E. Emerging trends in gerontology and geriatrics: implications for the self-care of the elderly. Social Science and Medicine 1986; 23(12): 1363-1369.