International Journal of Community Medicine and Public Health
Zaidi I et al. Int J Community Med Public Health. 2024 Jul;11(7):2765-2770
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20241836

Original Research Article

Barriers to healthcare and health seeking behaviors among elderly people living in rural regions of India: a study based on 9 villages in Eastern Uttar Pradesh

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Received: 05 May 2024
Revised: 11 June 2024
Accepted: 12 June 2024

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ABSTRACT

Background: The elderly population in India is experiencing exponential growth and facing various health and well-being challenges. This demographic shift is especially pronounced in rural areas, affecting social, financial, family, and transportation aspects, subsequently impacting health and well-being. This study aims to comprehensively understand these needs and priorities by exploring the multifaceted challenges faced by the elderly in India.
Methods: An exploratory qualitative research study with a quantitative component was conducted in 9 villages in Uttar Pradesh's Siddhartha Nagar District. Participants included individuals aged 60 years and above (n=29, M:F ratio of 13:16). Data were collected using Focus Group Discussions and Personal Interviews to assess the challenges faced by the geriatric population. The methodology involved multi-directional interactive sessions focusing on health, illness, and coping.
Results: Participants averaged over 5.8 medical conditions. Those with better Socio-Economic Status (SES) reported multiple conditions but fewer troubles, while the majority, being very poor, did not consider health a primary concern. There were no complaints about the lack of public health facilities or transportation. The study highlights the complex interactions between healthcare, family, and financial difficulties that older people in rural India experience, underscoring the need for specialised treatments. The low level of knowledge about government programmes emphasises the need for improved outreach techniques to close existing accessibility gaps.
Conclusions: The study recommends focused interventions and improved policies to meet the unique needs of India's rural elderly population. Policymakers and healthcare providers can enhance the well-being of this vulnerable demographic by understanding the complex nature of their issues.

Keywords: Access to healthcare, Financial constraints, Demographic transitions, Health burden, Healthcare challenges, Vulnerable populations

INTRODUCTION

Vulnerable populations are social groups, who are at risk and have an increased susceptibility to adverse health outcomes, and limited access to healthcare services.[1] Many studies have concluded that the most vulnerable groups are people with low SES, elderly people, people living in rural regions, people living in urban slums, and people from low income countries, among others.[2,3] That draws the attention towards this one particular group, Elderly people living in rural regions of India, which falls in the category of many vulnerable groups. The elderly population is particularly vulnerable due to a decrease in physical capacities and a rise in health-related problems.

Due to the ongoing demographic transition from high fertility, high birth rates, and higher death rates to low fertility, decreased birth rates, and low mortality rates, there is a shift towards a period of rapid population growth.[4] According to the 2021 census, India, is facing an upward surge of increasing elderly population from 76 million in 2011 to 140 million in 2021.[5] This has raised considerable concerns, particularly due to the increased burden of healthcare resources and their accessibility. This situation is more pronounced in rural areas of India, exacerbating the vulnerability of the elderly population.

The increased susceptibility of India's elderly population is a consequence of complex interplay between various factors. These multifactorial reasons includes demographic transition, ageing, geographic disparities, economic constraints, accessibility to healthcare services and basic needs, psychological aspects, housing issues, limited transportation, poor medical resources, and social dynamics.[3,6] Ageing and demographics are two examples of phenomena that are essentially unavoidable and are difficult to influence or control because they are firmly anchored in the basic dynamics of populations and the passage of time but considering that the majority of points can be conditioned. This can significantly improve the health status of elderly people living in rural regions.[7]

Most of them are living in poverty, their life expectancy is less than their urban counterparts, their population and proportion are increasing like never before in history, death of their friends and spouse, medical conditions due to old age, poverty, lack of transport facilities, lack of healthcare facilities in the nearby region, and many others which needs to be explored further.

When compared to male counterparts, elderly women are frequently confronting distinctive challenges including fewer financial constraints and dismissal of their health problems as mere by products of ageing process [8]. While elderly widows are facing heightened vulnerability in rural areas to health issues, access to health care social protection schemes primarily associated to a number of limitations, including difficulties with mobility, restrictions on work prospects, problems relating to real estate, and financial limitations.[9]

The developed countries have established the concept of "active ageing", which includes a multi-directional framework helping elderly people to have a quality life in all terms. It describes the interaction among factors, such as maintenance of health and well-being, involvement in social activities, and overall security or protection, which promote optimal health and well-being during the aging process.[10] While previous research acknowledged the susceptibility of older adults, this study aims to make a valuable contribution by offering a comprehensive understanding of the interrelated dynamics of financial constraints family dynamics, and healthcare accessibility that are unique to this area. By providing a thorough examination of the experiences of the elderly in a setting that has not been well-represented in prior research, the study seeks to close this knowledge gap and improve our comprehension of the complex issues that this population group faces.

The primary objective of this study is to determine the healthcare challenges faced by the elderly people in Uska Bazar Town Area, Siddharth Nagar District of Uttar Pradesh State, India. By tackling the stated objective, this research adds significant knowledge to the current discussion on challenges faced by the ageing populations by highlighting the necessity of customised interventions and improved policies to guarantee the welfare of senior citizens in the Siddharth Nagar District. This study builds upon a comprehensive literature review done on barriers ot access healthcare among elderly people living rural regions of India, under the same funding and project.[11]

This study aimed to determine the healthcare challenges faced by the elderly individuals Uska Bazar Town Area, Siddharth Nagar District of Uttar Pradesh State, India, and to evaluate the accessibility of healthcare services and the impact of socio-economic factors on their health. Also, to understand the role of family support in the healthcare decisions of elderly.

METHODS

Study design

Through a thorough house-to-house survey, we selected participants for an exploratory qualitative study. The inclusion requirements included senior citizens who were 60 years of age or older. The objective was to interview as many participants in-depth as we could within the time limits at hand. Each in-depth interview lasted around an hour on average, which allowed for a full examination of each person's viewpoints and experiences.

Study participants

This study involved participants from nine villages located in the Uska Bazar Town Area, Siddharth Nagar District of Uttar Pradesh State, India. The data collection of the study was conducted in the month of December, 2018. The population of each village ranged between 300

to 500 residents. According to the 2011 census's demographic distribution, which shows that about 8.5% of people are elderly, it was calculated that these communities would consist of about 350 elderly people.

Nine towns were selected for the study using a random sampling technique. Our team, which is strategically positioned in the area and works in over 60 villages in the Siddharth Nagar district under the umbrella of Tata Trusts' project PRAYAAS, was principally responsible for determining the criteria for village selection. Out of the thirty senior people who were approached for the study, 29 of them voluntarily accepted to take part in the data collection process. Nevertheless, one respondent declined to participate, stating that they were too busy for the survey.

Table 1: Distribution of socio economic status with caste and gender.

Socio economic status		Caste		Gender	
BPL	24	OBC	24		
MPL	3	General	4	Male	13
APL	2	SC	1	Female	16

The participants in the study exhibited an age range spanning from 60 to 86 years and the calculated mean age of the participants was 69.41 years.

The team that was working with us had developed strong connections in the community, so they could introduce us to senior citizens in the villages with ease. A pre-tested questionnaire with 17 closed questions (some with multiple choice) and 14 open-ended questions was used for the participant interviews. Notably, everyone who took part quickly answered questions that were closed. But as open-ended questions about barriers to healthcare and the function of family support were examined, a recurrent theme became apparent. A prevalent concern among nearly all attendees was the noteworthy challenges caused by poverty, which emerge as an arduous task of providing necessities like clothing, food, and housing.

We attempted to conduct Focus Group Discussions (FGDs) after we noticed that people can be chronically saturated and unable to completely assess the amount of the issues they confront. The idea was to establish a forum where people could freely communicate and identify common issues, including how difficult it would be to walk 10 kilometres to get to a public health centre. But it soon became clear that even in the group environment, people were reluctant to talk honestly about problems with financial difficulties and family support. After making this discovery, we continued to do individual in-depth interviews, so we performed so for the length of the study. This change made room for a more individualised and private setting, enabling individuals to voice their concerns free from what they saw as limitations.

Open questions: The study's open-ended questions explored several facets of the participants' experiences. These included the financial challenges associated with accessing medical care in a hospital, providing a detailed examination of financial limitations. Additionally, study into family issues and the taking of views into account when making significant choices seek to shed light on the complex web of family dynamics. The participants' job status and knowledge of government programmes for the elderly enhance our comprehension of their socioeconomic background. Discussions concerning everyday work challenges, financial assistance to the household, and unfulfilled support requirements offer a thorough understanding of the participants' circumstances inside their homes. A layer of depth is added to the study by the examination of emotional behaviour, such as feelings regarding respect and instances of spousal expectations. These carefully developed questions are a vital tool for gathering significant qualitative data and assist in providing an in-depth understanding of the difficulties that the elderly in the Siddharth Nagar District's Uska Bazar Town Area experience. The interviews were recorded using a device, transcribed, and translated with Google Voice and Google Translate. The transcriptions were then manually reviewed to ensure accuracy.

Closed questions: In response to closed-ended questions, the socioeconomic standing of every household was assessed by considering variables like the type of profession (past or present), income, expenses, and ownership of 13 items, including luxury and necessary goods, investments (health insurance), and identity documents (PAN, Aadhar, bank account). The participant and their spouse's identification of 19 common illnesses or ailments was necessary for the medical condition evaluation. Furthermore, without adding any variables, the participant's and their children's educational level was enquired about. Caste, land ownership, poverty class, kind of habitation (kaccha/pakka), and other pertinent elements were used to identify social standing. Data were recorded in Google Forms, transferred to Excel, and frequencies were analysed.

RESULTS

With 29 people suffering from 158 conditions/diseases overall, each person had an average of roughly 5.45 afflictions.

Two men and four women made up the six widows that took part in the study. The state government was providing a widow's pension to one female widow.

Just two respondents-the widow mentioned earlier-were genuinely receiving benefits from the government pension plans for the elderly, despite the fact that six respondents were aware of them.

Twenty-three of the 29 participants continued to work in the unorganised economy. Nineteen of them expressed concern that their husbands or children were frequently busy and that they had to temporarily leave their businesses or farms for a day in order to go to the hospital, which would disturb their work.

Two of the participants were still being paid after retiring as government schoolteachers. These people had the highest levels of satisfaction out of the two Affluent Persons (APLs) in the study group. Living in joint families with their children and grandkids, they had good social well-being. Upon being asked how their kids or grandchildren handled their rage and their power to make decisions, one person responded, "How can they not obey me?" with confidence and pride. Why were they not listening to me? I give them pocket money.

An 82-year-old woman who lived in a kaccha house related how her room leaked during a particularly rainy period the year before. She slept on plastic sheets for a duration of 12-13 days and then fixed it on her own.

A male patient, 75 years old, described a medical emergency that occurred two years ago that included TB bone. No one in his family offered to help, even though it was urgent; instead, it was his neighbours who took care of him and took him to the hospital.

On a single instance, a 70-year-old woman claimed that she had to walk five kilometres to the public health centre since neither she nor her family had the time or money to pay for medical care. Similarly, when a 72-year-old woman needed medical attention and neither her family nor the community could help, she had to travel three kilometres by herself.

The 72-year-old woman described an event in which she needed medical attention; from her hamlet, she travelled two kilometres to the National Highway, where she hitched a ride with an unknown vehicle to the hospital. To go to public health facilities, people had to walk three to ten kilometres on average (five kilometres on average).

A few elderly men who participated in the survey indicated discontent with having to walk in order to access healthcare services, both for themselves and for their spouses. They emphasised the difficulty of having to deal with their busy kids, who frequently refuse their requests for company during medical visits. Of the responders, seventy percent said they went to the hospital alone.

Eight participants stated that they choose to consult with Traditional Healers because of their affordable rates and the extra advantage of receiving consultations in their homes. Although there were private practitioners nearby, they were unable to use them due to budgetary limitations. They chose to visit with traditional healers as a result, and they expressed great pleasure with the low-cost, home-based consultations and prescriptions they obtained.

Twenty of the participants discussed the difficulties involved with doing regular or professional work, and 22 (76%) reported having back or knee pain. They acknowledged that they were in agony but also that they had to work hard to meet their fundamental requirements.

Despite living in the same hamlet or block, many bemoaned their children's disrespect, disobedience, occasional visits, and lack of communication.

Case of a diabetic patient

A sixty-year-old woman who has been married for forty years is battling a diabetic foot ulcer. Her family, which consists of three daughters and one son, depends on agriculture for their financial support. The family has a cell phone without internet connection, a PAN card, an Aadhar card, and her husband's bicycle.

She suffers from diabetes, numerous joint ailments, weakness, and dental issues. The family sets aside about 4000 rupees a month for medical costs. Every month, her spouse has to cycle her over 10 kilometres on uneven, kaccha roads to a medical institution, despite her complaints of weakness and pain in her knee joints. Every time they attend the hospital, they have to forfeit a full day's worth of agricultural labour. To make matters worse, their lone unmarried daughter at home has vision impairments that affect household duties.

She knows of the "Elderly Pension Scheme" that the government of Uttar Pradesh offers, but she is unable to take advantage of the advantages because of her personal issues with the village head, Pradhan. She emphasises that her health does not stop her from working in the fields barefoot and that stopping would compromise agriculture and revenue. In response to a question regarding the potential risks involved with her work, considering her diabetes-related foot ulcer, she says, "It's better to die of medical issues than to die of hunger." Her spouse further states, "Diabetic foot will take years to kill; hunger can do that within a month.

DISCUSSION

29 out of 30 people who were contacted agreed to participate, demonstrating the high response rate. The one person who declined was an elderly guy who said he was too busy to participate as he crossed the road to enter the fields. It is imperative to acknowledge that the findings ought not to be generalised to the entire nation or even individual states. The reported caste and socioeconomic class (SES) distributions, however, do represent the usual demographic makeup of Uttar Pradesh villages.

Because of the heavy demands of their daily attempts to meet their fundamental needs, the participants are still

mostly uninformed of the issue at hand. Their concerns about meeting basic requirements take precedence over issues like not having a public health facility close by or having insufficient transportation. They exhibit an incredible amount of forbearance and satisfaction, as they wilfully travel between 5 and 12 kilometres to get to the closest public health centre. This willingness is a result of their contentment with the availability of a public facility, which they expect to receive free treatment from if they are able to access it.

In comparison to previous research, the study's findings offer a nuanced view on the multifaceted issues encountered by the older population in rural India. The mean of around 5.45 health conditions per individual highlights a significant health burden among the elderly, which is consistent with worldwide worries on the heightened susceptibility of ageing populations. Although research conducted in many places have demonstrated that health problems are common among the elderly, the peculiar socio-economic and geographic setting of rural India poses unique obstacles.[12]

The inclusion of widows, especially those who find it difficult to enrol in government pension programmes, is consistent with research looking at older adults' social support networks.[8] Meanwhile, IHDS-II data shows that just 18% of people 60 years of age and older receive any kind of old-age pension, and 15% of widows 60 years of age and older receive a widow's pension.[13]

This highlights a crucial void in focused aid initiatives, particularly for marginalised communities. Simultaneously, the involvement of the unorganised economy participants and worries about how family members' hectic schedules affect their ability to seek medical attention are consistent with a larger body of work regarding the intersection of health and economic interests. But the unique difficulties brought about by the unorganised sector and the rural environment emphasise the necessity of customised actions in this situation.

The relatively affluent subset of retired government schoolteachers reporting higher levels of contentment and well-being is consistent with findings from other studies, which highlight the influence of socioeconomic position on the experiences of the aged. This demonstrates a recurring pattern that shows enhanced well-being is correlated with financial stability, suggesting a larger social tendency.

The instances of personal fortitude the 82-year-old woman fixing her leaky room, the 75-year-old patient depending on neighbours in an emergency highlight the coping strategies and resourcefulness of the elderly in difficult circumstances. But the unique difficulties in getting to medical facilities which frequently involve long walks highlight the pressing need for better rural healthcare infrastructure. This is in line with international requests for older people to have easier access to healthcare services, especially in rural areas.

Studies showing financial constraints in healthcare decision-making align with the desire for traditional healers because of their affordability and ability to provide home-based consultations.[14] This research points to a common problem that older people in low-resource environments experience, highlighting the demand for accessible, culturally appropriate healthcare solutions.

The patient with diabetes serves as an additional example of the complex difficulties that older people and their families encounter, which is consistent with international studies on the structural impediments to high-quality healthcare.[15-17] The elderly's access to social assistance programmes have found that bureaucratic obstacles are made more complex by the incapacity to benefit from government pension systems because of personal issues with the village chief.

This study has few limitations. Compared to the wealthy Western world, the eastern half of Uttar Pradesh, which is considered to be among the least developed areas of a developing nation, is devoid of many amenities. As such, this study's generalizability cannot be extended to all rural environments, the Indian subcontinent, or even the state of Uttar Pradesh as a whole. We acknowledge that our analysis may not have fully included outliers due to the non-probability sampling method used.

CONCLUSION

In conclusion, this study highlights the various vulnerabilities that the senior population in rural India faces, exposing a complicated interaction between changing demographics, financial limitations, and restricted access to healthcare. The old population is expected to expand significantly especially in rural areas and this increase will highlight the urgent issues related to resource shortages and accessibility. Notably, healthcare goals were eclipsed by the struggle for basic necessities, highlighting the stark differences in socioeconomic status. Financial, social, and health protection measures must all be included in a comprehensive approach to handle the many difficulties that the elderly face. Enhancing the general well-being of the elderly in rural areas and encouraging "healthy ageing" need developing accessible public health facilities and improving ambulance services. Although the study offers insightful information, it highlights the need for more investigation into subtle differences across various environments in order to provide tailored interventions for this susceptible population.

Funding: Vikas Anvesh Foundation, an initiative of Tata Trusts
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

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Cite this article as: Zaidi I, Chaudhary S, Sharma T, Vardha J, Khayum A, Anjum S, et al. Barriers to healthcare and health seeking behaviors among elderly people living in rural regions of India: a study based on 9 villages in Eastern Uttar Pradesh. Int J Community Med Public Health 2024;11:2765-70.