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Original Research Article

Geriatric health care in degenerative disorders – a public health initiative

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ABSTRACT

Background: A project under public health initiative (PHI) scheme for geriatric health care in degenerative disorder of elderly in urban and rural area of Tehsil Huzur, Bhopal, Madhya Pradesh was conducted. The study explored geriatric problems with comorbidity among individuals. The survey form covers 33 items which were further sub-divided that capture the clinical variables, physical and cognitive status, medical diagnoses, major health problems and symptoms, current service use, medication use and overall health status. During the survey 50084 patient's data were collected and after cleaning of data whose data is incomplete, this left a sample of 19740 patients.
Methods: The retrospective cohort study was conducted.
Result: The main characteristics of study sample, according to enrolment. The 10 most common chronic diseases observed in the study population in a decreasing frequency were knee joint pain (58.55%), cardiovascular diseases (51.26%), eye or vision related conditions or problems (46.59%), hypertension (38.16%), constipation (34.20%), back pain (33.33%), refractive error (33.31%), diabetes (27.60), sleep related problem (20.75%) and abdominal discomfort (18.56%). The knee joint pain (58.55%) was more prevalent in males (29.45%) than females (29.10).
Conclusions: The age-related physiological deterioration of normal physical functioning is the source of many chronic health issues, such as poor mobility, vision, hearing, memory loss, difficulty eating and digesting food, and an inability to manage specific physiological systems. Integrating AYUSH treatments into conventional healthcare could enhance holistic approaches to addressing chronic illnesses in geriatric age group.

Keywords: Cohort study, Degenerative disorders, Geriatric, PHI

INTRODUCTION

Epidemiology has identified age as a separate risk factor for chronic non-communicable diseases.[1] Population aging is a clear consequence of the "demographic transition" which is the change from high mortality/high fertility to low mortality/low fertility. The number of elderly persons in the overall population has increased as a result of a decline in the proportion of young people and an increase in life expectancy brought on by lower fertility and death rates.[2] In India, the life expectancy at birth has increased from "42 years in 1951-1960" to "58 years in 1986-1990," to "67 years by 2011-2016" and it is currently reached "72 years by 2023 for males and 74 years for females".[3,4]

According to the United Nations (UN), a nation is considered to be "aging" or "greying" if its percentage of citizens over 60 is greater than 7%. With a proportion of 7.47% in 2001, 8.3% in 2008, and predicted to reach 12.6% by 2025, India has so earned the moniker of "an aging

nation". Additionally, according to UN projections, 21% of Indians, or roughly 324 million people, will be over 60 by 2050, up from 6.8% in 1991.[5]

Age-related physiological decrease of normal bodily functioning leads to a number of chronic health issues, including poor mobility, vision, hearing, memory loss, difficulty eating and digesting food, and an inability to manage specific physiological systems. However, a number of factors have a significant impact on an individual's longevity, including heredity, leading a healthy lifestyle, abstaining from smoking, maintaining a healthy weight and diet, and engaging in proper exercise. Chronic exposure to environmental contaminants can even shorten the lifespan of people with the strongest genetic composition. However, because age and disease incidence are positively correlated, an extended lifespan may inevitably result in a greater requirement for health care services during the additional years of life.[6]

However, the elderly age group has two medical conditions: a higher burden of chronic noncommunicable diseases and other communicable diseases due to age-related physiological changes and weakened immunity. The ability to maintain one's independence and avoid expensive caregiving services by shopping for oneself, cooking one's own food, bathing, dressing, walking, and climbing stairs without help is known as quality of life (QOL), and chronic diseases can further limit daily activities and QOL by causing medical, social, and psychological disorders.[7]

The objective of the study was to explore geriatric problems with comorbidity among individuals.

METHODS

Data source

Data were obtained from urban and rural area of Tehsil Huzur, Bhopal, Madhya Pradesh during the survey of a project under public health initiative (PHI) scheme for geriatric health care in degenerative disorder of elderly.

Data collections

Data were collected using a survey form for a project under PHI scheme for geriatric health care in degenerative disorder of elderly. The survey form covers 33 items which were further sub-divided that capture the clinical variables, physical and cognitive status, medical diagnoses, major health problems and symptoms, current service use, medication use and overall health status. Data collection was standardized and usually done by Internee's and PGT's of GHMC and H, Bhopal who were specially trained to verify all information with sources including family members, and review of physician reports or medical records. All assessors followed a standardized training procedure.

Time frame

The study was conducted from April 2018 to December 2019.

Sample

The retrospective cohort study explored geriatric problems with comorbidity among individuals. During the survey 50084 patient's data were collected and after removing patients who didn't have any geriatric symptoms and comorbidity, this left a sample of 19740 patients.

Selection criteria

The subjects were screened from the study population as per the mentioned inclusion and exclusion criteria.

Inclusion criteria

All the 50 and above 50 years population of all age, sex and races were included in the study.

Exclusion criteria

Individuals below the age of 50 years were not included in the study.

Statistical techniques and data analysis

Data were analysed from the descriptive and inferential point of view. Baseline descriptive data (categorical and continuous) were collected. Microsoft Office Excel Sheet 365 for Windows was used for the analysis of data.

Ethical issues

No invasive methodology was involved and there was no therapeutic experimentation. No investigations were advised to the patient. The proposed plan of work had been placed before the concerned Ethical committee and the permission was obtained for the same.

RESULTS

Among the 19740 participants entering the study, from 50-70 years patients were 16566 (83.92%), 71-90 years patients were 3083 (15.62%), 91 years and above patients were 91 (0.46%) and mean age was 63.8 years. Male and Females were respectively 10671(54.06%) and 9069 (54.06%). As per localities 15914 (80.62%) patients were from urban and 3826 (19.38%) were from rural area. Married patients were 18132 (91.85%), 146 (0.74%) patients were unmarried and 1462 (7.41%) were widow. The main characteristics of study sample, according to enrolment is that the 10 most common chronic diseases observed in the study population in a decreasing frequency were knee joint pain (58.55%), cardiovascular diseases (51.26%), eye or vision related conditions or problems (46.59%), hypertension (38.16%), constipation (34.20%),

back pain (33.33%), refractive error (33.31%), diabetes (27.60), Sleep related problem (20.75%) and abdominal discomfort (18.56%). The knee joint pain (58.55%) was more prevalent in males (29.45%) than females (29.10%).

Similarly, a higher frequency of cardiovascular diseases (25.84%) in males but the prevalence of Shoulder joint pain, back pain and other joint pain respectively 5.30%, 17.41% and 7.69% were more in female than male patients.

Among the 19740 participants entering the study, 16566 patients were in the age group of 50-70 years, 3083 patients were in the age group of 71-90 years and 91 patients were in the age group of 91 years and above (Figure 1 and Table 1).

Table 1: Data of the study.

S. no.	Individual-level key indicators	Age (years)			Sex		Residence		Total
		50-70	71-90	91	Male	Female	Urban	Rural	
Marital status									
1	Married	78.06	13.4549	0.3394	52.29	39.56	74.08	17.77	91.85
2	Unmarried	0.53	0.1976	0.0152	0.55	0.19	0.60	0.14	0.74
3	Widow	5.33	1.9656	0.1064	1.21	6.20	5.93	1.47	7.41
Health risk behaviour									
4	Currently smoking/chewing tobacco[1]	21.39	3.0902	0.0811	16.88	7.67	18.93	5.63	24.56
5	Prevalence of heavy episodic drinking[2]	5.99	0.9017	0.0253	6.21	0.71	5.19	1.73	6.92
Physical activity									
6	Exercise[3]	5.78	1.2310	0.0152	3.54	3.49	5.54	1.48	7.02
7	Yoga, meditation, Asana and Pranayama[4]	5.93	1.3171	0.0152	3.66	3.60	5.72	1.54	7.26
Self-reported prevalence of diagnosed other cardiovascular diseases									
8	Cardiovascular diseases[5]	43.10	7.9229	0.2330	25.84	25.42	39.93	11.32	51.26
9	Stroke	0.12	0.0304	0.0051	0.11	0.05	0.01	0.15	0.16
10	Hypertension	31.91	6.0740	0.1722	19.63	18.53	31.87	6.28	38.16
Self-reported prevalence of diagnosed other chronic risk conditions									
11	Diabetes	22.75	4.7112	0.1418	15.14	12.46	23.02	4.58	27.60
12	Thyroid disorders	0.54	0.0709	0.0000	0.16	0.45	0.57	0.05	0.61
13	Cancer	0.28	0.0557	0.0000	0.15	0.19	0.28	0.06	0.34
Self-reported prevalence of diagnosed chronic lung diseases									
14	Chronic obstructive pulmonary disease	2.18	0.0405	0.0101	1.33	0.90	1.88	0.35	2.23
15	Asthma	6.51	1.1905	0.0152	3.43	4.28	6.15	1.57	7.72
16	Exertional dyspnoea	8.69	1.5755	0.0557	5.04	5.28	7.90	2.42	10.32
17	During rest dyspnoea	3.64	0.8359	0.0304	2.40	2.11	3.77	0.73	4.50
Self-reported prevalence of diagnosed bone/joint diseases									
18	Shoulder and neck joint	8.57	1.5957	0.0608	4.93	5.30	7.06	3.17	10.23
19	Back	28.67	4.5390	0.1266	15.93	17.41	24.84	8.50	33.33
20	Knee joint	49.50	8.7893	0.2634	29.45	29.10	45.04	13.52	58.55
21	Other	12.42	2.6241	0.1165	7.47	7.69	11.88	3.28	15.16
Self-reported prevalence of diagnosed neurological or psychiatric problem									
22	Memory loss	7.51	1.9504	0.0811	5.06	4.48	8.12	1.42	9.54
23	Alzheimer's disease	0.26	0.0912	0.0051	0.22	0.14	0.30	0.06	0.36
24	Parkinson	0.13	0.0507	0.0051	0.13	0.06	0.14	0.05	0.19
25	Dementia	0.07	0.0051	0.0051	0.05	0.03	0.08	0.00	0.08
Self-reported prevalence of diseases or conditions related to urogenital systems									
26	Difficulty in controlling urine	2.43	0.7345	0.0152	1.79	1.38	2.75	0.43	3.18
27	Difficulty in passing urine	6.44	1.7882	0.0811	5.26	3.05	6.75	1.56	8.31
28	Incontinence of urine	0.77	0.1874	0.0203	0.57	0.41	0.77	0.21	0.98
29	Prostate enlargement	0.71	0.3901	0.0253	1.13	0.00	1.07	0.06	1.13

Continued.

S. no.	Individual-level key indicators	Age (years)			Sex		Residence		Total
		50-70	71-90	91	Male	Female	Urban	Rural	
Self-reported prevalence of diagnosed eye or vision and ear related conditions									
30	Eye or vision related conditions or problems	38.80	7.5735	0.2178	24.14	22.45	37.02	9.57	46.59
31	Cataract	7.16	2.4367	0.0811	4.85	4.82	7.84	1.84	9.68
32	Glaucoma	2.84	0.7447	0.0253	1.86	1.74	2.87	0.74	3.61
33	Refractive error	28.80	4.3921	0.1114	17.43	15.88	26.31	7.00	33.31
34	Hearing or ear-related problems	8.89	3.1155	0.1114	6.27	5.85	9.30	2.82	12.12
Self-reported prevalence of symptoms-based sleep problems									
35	Sleep disturbed	17.02	3.6170	0.1165	10.57	10.19	16.47	4.28	20.75
Self-reported prevalence of diseases or conditions related to gastrointestinal systems									
36	Appetite less	8.49	1.5502	0.0557	5.03	5.06	7.32	2.77	10.09
37	Chewing problem	2.47	0.6332	0.0101	1.83	1.28	2.73	0.39	3.11
38	Constipation	29.00	5.0507	0.1520	18.37	15.83	26.01	8.19	34.20
39	Diarrhoea	2.67	0.4762	0.0253	1.68	1.49	2.63	0.54	3.17
40	Abdominal discomfort	15.57	2.8926	0.0963	9.50	9.06	14.14	4.42	18.56
41	Haemorrhoids	1.03	0.1672	0.0000	0.61	0.59	0.97	0.23	1.20
42	Pain during stool	4.74	0.9068	0.0051	3.08	2.57	4.63	1.02	5.65
43	Swallowing problem	0.93	0.2330	0.0101	0.66	0.51	1.01	0.16	1.17
Family medical history: prevalence of chronic health conditions among family members									
44	Cancer	0.76	0.1469	0.0000	0.54	0.37	0.73	0.18	0.91
45	Diabetes	16.08	3.1054	0.1216	10.26	9.05	15.67	3.64	19.31
46	Heart disease	1.83	0.4357	0.0101	1.30	0.97	1.84	0.43	2.27
47	Hypertension	22.59	4.0780	0.1621	14.29	12.54	21.80	5.03	26.83
48	Obesity	6.10	1.0436	0.0253	4.16	3.00	5.93	1.24	7.17
49	Breathing distress	2.94	0.4458	0.0101	1.94	1.46	2.73	0.66	3.39
50	Stroke	4.25	0.8663	0.0152	3.04	2.09	4.03	1.10	5.13

[1]Currently smoking/chewing tobacco refer to smoking and chewing any tobacco product such as cigarette, bidi, cigar, hookah, cheroot, gutka or pan masala, [2]heavy episodic drinking refers to those who reported consumption of at least 60 grams or more (10 grams= 1 standard drink) of pure alcohol on at least one occasion in the past 30 days, [3]those who are either engaged in moderate physical activity (at least 150 minutes throughout the week) or vigorous physical activity (at least 75 minutes throughout the week) or an equivalent combination of moderate- and vigorous-intensity activity, [4]refers to yoga/meditation/asanas/pranayama practicing daily or more than once a week, 5 cardiovascular diseases include hypertension, heart disease and stroke (any one or more)

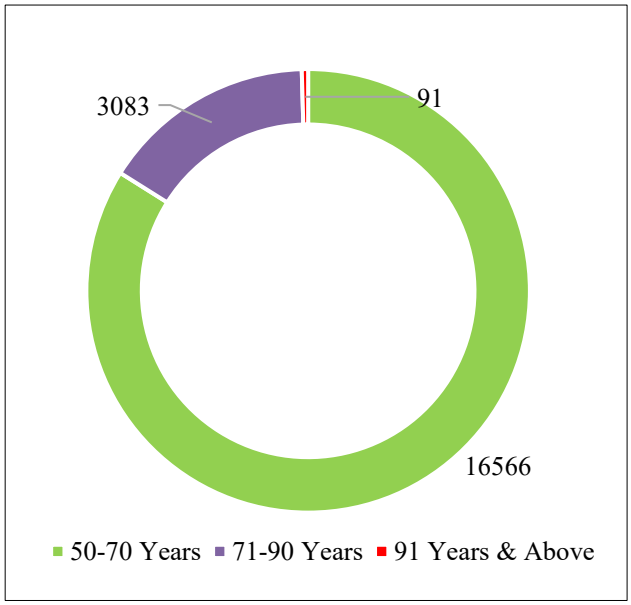

Figure 1: Age demographics.

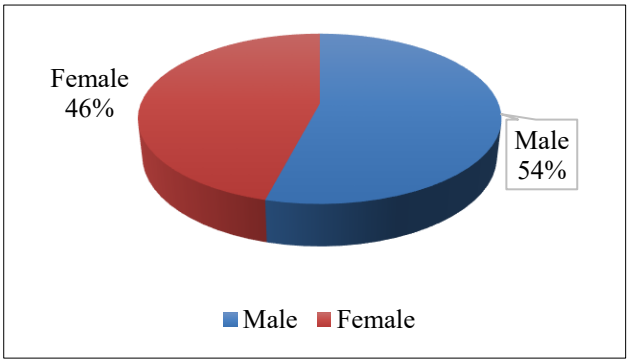

Figure 2: Sex demographics.

Among the 19740 participants entering the study, 10671 patients were Males and 9069 patients were females (Figure 2).

Among the 19740 participants entering the study, 3826 patients were belonging to rural area and 15914 patients were belonged to urban area (Figure 3).

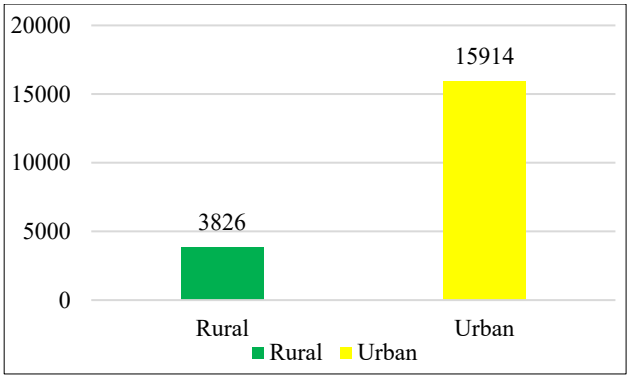

Figure 3: Residence of participants.

Among the 19740 participants entering the study, 18132 patients were married, 146 patients were unmarried and 1462 patients were widow (Figure 4).

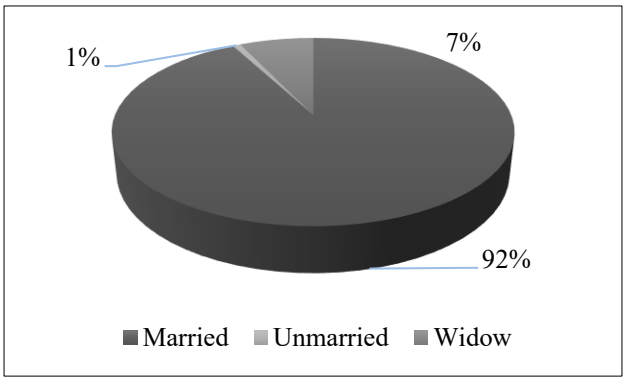

Figure 4: Marital status of the participants.

DISCUSSION

Old age is an unpreventable physiological state which suffers both from communicable and non-communicable diseases. Thus, various dimensions that affect the lives of the elderly are elaborated in the present study which includes demographic, lifestyle habits, health and psychological conditions.

Knee joint pain (58.55%) was most common significant non-communicable diseases with the predominance in men (29.45%) than women (29.10%). Similarly, Tsou and Ching observed that musculoskeletal disorders lead to incorrect biomechanics, impaired mobility, skeletal and muscular de-conditioning which further results in the decreased functional reserves and ability to adapt to physiological, physical and psychosocial challenges.[8] cardiovascular diseases which include hypertension, heart disease and stroke (51.26%) was the 2nd most common significant cause of chronic non-communicable diseases morbidity in the studied population. Apart from the age-related cardiovascular changes, aging can lead to an increased sedentary living, overweight and obesity, excessive food intake and reduced food metabolism which can further predisposed the elderly population to CVDs.

Eye or vision related conditions (46.59%) was the third most common significant cause of chronic non-communicable diseases morbidity with higher prevalence in men (24.14%) than women (22.45%). Khalaj, Barikani and Ghasemi study observed that, refractory errors, amblyopia, cataract and diabetic retinopathy was prevalent eye problems in old people.[9]

Diabetes (27.60%) was reported at a significant higher trend among men (15.14%) than women (12.46%) in the study population. As study of Chentli and other showed that, the prevalence of diabetes among older adults will rise as life expectancy rises along with the rates of obesity and sedentary lifestyle.[11] Due to its silent or nonspecific symptoms, diabetes mellitus is often overlooked in elderly adults. Therefore, the best method to obtain an early diagnosis and avoid complications from diabetes is to test for postprandial GMD systematically. Additionally, the high incidence of related co-morbidities and the likelihood of frailty are characteristics of aging. For this reason, it's critical to give elderly diabetic patients specialized, high-quality treatment. To prevent iatrogenic consequences, particularly dehydration and hypoglycaemias, any treatment should be based on the classification and individualization of the aged.

A significant urogenital problem (13.6%) which include difficulty in controlling urine and passing urine, urine incontinence and prostate enlargement was reported more frequently in men (8.75%) than women (4.84%) in the present study. UI is a syndrome that is very common among older persons. Many older individuals suffer needlessly from symptoms that impair their quality of life in general and certain activities in particular, and the condition is frequently underreported. In order to debunk the misconception that UI is a typical and unavoidable aspect of aging, continuity promotion initiatives must keep up their efforts. Treatment may be able to cure UI in many situations, or at the very least, make it easier for patients and caregivers to manage.[12] Even though a sizable portion of the males in these older demographic experienced symptoms related to the lower urinary tract and an enlarged prostate, only one-third of them planned to go to their doctor about them.[13]

The prevalence of chronic lung diseases (24.77%) presenting in the form of asthma, allergic bronchitis and/or chronic obstructive pulmonary disease was more prevalent in women (12.57%) than men (12.20%), which might be attributed to chronic exposure to the fumes and smoke released by chullas used for cooking purposes by women in the study area. Similarly, according to Arif et al, there is a correlation between current or likely asthma and female gender, low socioeconomic level, hay fever, obesity, and smoking status.[14]

Neurological or psychiatric problem (10.17%) was reported with a significant higher trend in men (5.46%) than women (4.71%) in the present study. A substantial percentage of senior people suffer from age-associated

memory impairment, an age-dependent condition; some of these patients may be in the early stages of Alzheimer's disease, indicating that the ailment may be more common than previously thought.[15]

The low cancer prevalence (00.34%) in the current study may be due to cultural restrictions on disclosing the diagnosis, the fact that most cancer patients first try to treat their symptoms with traditional medicine from an unlicensed practitioner, and that they only seek medical attention when their illness is advanced. Additionally, an increased pathogenic load from the gut and age-associated declines in growth hormones and protective enzymes put the elderly liver at higher risk for hepatic disorders, which may be connected to the chronic liver disease seen in our study.[10]

A study of Teut and others showed that, homeopathic medical therapy may play a beneficial role in the long-term care of older adults with chronic diseases.[16] According to Kundu and his team's study, homeopathic medicines are effective in improving memory.[17] Nigwekar and Jani's study concludes how homoeopathy is ideal for treating people with musculoskeletal system disorders who require ongoing geriatric care.[18] Many older people reported subjective relief from their MSS concerns. The elderly people embraced and used homeopathic remedies with ease.

On more study shows that, in spite of government initiatives to integrate AYUSH into India's official healthcare system, the report emphasizes that allopathic medication continues to be the most common treatment for senior citizens. For chronic illnesses like COPD, stroke, arthritis, and neurological disorders, older persons choose to employ AYUSH services. Holistic approaches to managing chronic diseases may be improved by incorporating AYUSH services into traditional healthcare. The AYUSH, which is well-liked by Children, senior citizen, women and people living in rural areas, might contribute to better coverage of basic care for the poor. Since non-organized AYUSH is so common, it needs to be regulated. In order to obtain a thorough grasp of the consumption of distinct ISM&H services, future waves of LASI surveys should take into account gathering data for each medical system, as AYUSH is a combination of four ISM&H.[19]

Since aging is predicted to continue, finding efficient preventive or therapeutic strategies is essential to lowering burden and associated expenses. Our goal is to persuade governments, civil society organizations, and interdisciplinary scholars to acknowledge geriatric suffering as a growing global health concern, particularly in developing nations. In social care and public health, we hope that our research will help raise awareness of geriatric sufferings.

Homoeopathy is a therapy that has three primary agents and many components: the patient, with their condition and personal traits; the medicine, with its composition and production process; and the doctor, with their treatment philosophy and health beliefs. In order to enhance practices and clarify the possible role of homoeopathy in connection to other therapies, both conventional and unconventional, employed in Western health systems, it would be helpful to build research and evaluation frameworks as well as provide critical education in the field.

The limits of secondary data, biases like recall biases in self-reported health data, and the intrinsic limitations of observational research for determining causal correlations must all be acknowledged, though. Our comprehension of the use of particular ISM services may be limited if we take into account AYUSH, which comprises four distinct ISM categories with varying customer profiles.

Utilizing nationally representative data from the LASI, the study provides insights into the trends in older individuals' use of AYUSH services over time. The study contributes to the scant data on referrals to or use of AYUSH service.

CONCLUSION

Numerous chronic health problems, including as impaired mobility, vision, hearing, memory loss, difficulties eating and digesting food, and an inability to manage particular physiological systems, are caused by the age-related physiological decline of normal physical functioning. In order to control disease-related morbidity and mortality, screening programs should be implemented at the community level for early diagnosis, treatment, and ongoing, routine monitoring of treatment compliance. Integrating AYUSH treatments into conventional healthcare could enhance holistic approaches to addressing chronic illnesses. According to the report, allopathic medication continues to be the most common treatment for senior citizens in India, even in spite of government initiatives to mainstream AYUSH into the country's official healthcare system. When it comes to chronic illnesses like COPD, stroke, arthritis, and neurological disorders, older persons prefer to employ AYUSH services. By using holistic methods, AYUSH treatments can improve the management of chronic diseases when included into traditional healthcare. Popular with rural and female residents, the AYUSH may contribute to better coverage of basic healthcare for the poor. Since non-organized AYUSH is so common, it needs to be regulated. In order to obtain a thorough grasp of the consumption of distinct ISM services, future waves of LASI surveys should think about gathering data for each medical system, as AYUSH is a combination of four ISM.

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