

Quality Of Life of Elderly in India

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Abstract: *Quality of life is a multidimensional concept in determining the adding of life to years. The quality of life is influenced by social, economic, psychological domains which influence and are significant to older people. These domains vary according to the individual's life characteristics including social and personal circumstances. The aim of this article is to be informative and to provide a view on how health problems of elderly affect the quality of life.*

Keywords: *Quality of Life, Elderly*

I. Introduction

There are approximately 893 million elderly above the age of 60 years and more globally. By the end of 2050, there will be 2.03 billion people aged 60 years and over. Ageing puts major pressure on the socio economic demands on countries financial budget. To cope with the changing demand government need to draw major policy initiatives based on the importance of social, cultural and personal factors contributing to the quality of life.

A lot of research has been conducted on active and successful ageing. The definition of active ageing given by Rowe and Kahn (1997) who also coined successful ageing defines "successful ageing as including three main components include low probability of disease and disease-related disability, high cognitive and physical functional capacity, and active engagement with life" (Rowe & Kahn, 1997, p. 433). Successful ageing refers to those cases where ageing people are free of (acute and chronic) diseases, do not suffer from disability, are intellectually capable, possess high physical fitness and active.

Majority of the people wish to grow older, but would like to be free from presence of chronic illness or disabilities. Major efforts is being directed to increase the life expectancy, hence a substantial amount of elderly and very old people will have to experience the need to be dependent.

Quality of life is a great concern in modern research. The quality of life can be measured both objectively and subjectively.

Objective quality of life can be measured by the extent to which a person has access to and command over relevant resources like income, health, social networks, and competencies serve individuals to pursue their goals and direct their living conditions (Erikson, 1974). Hence, objective quality of life is high among those cases where economic condition is high, health status is good, social networks are large and reliable, and competent. Objective quality of life can be measured by external observers. Subjective quality of life, gives emphasizes on individual's perceptions and ability to interpret things. Every individual tries to compare his living condition with different internal values and thereby aspires the same situation differently.

Subjective quality of life depends on the individual person and lies in the eye of the beholder (Campbell, Converse & Rodgers, 1976). Hence, high subjective quality of life can be defined as subjective well-being (high life satisfaction, strong positive emotions like happiness, and low negative emotions like sadness).

The objective living condition if characterized to be good, the quality of life subjectively perceived may be extremely low. The situation can be Vice versa, not all people living in poor state of living condition are dissonance or dissatisfied with their lives. This consideration has lead to development of theories combining both the high and low values of subjective and objective quality of life.

WHO defines quality of life as:

"An individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment." (<http://www.who.int/msa/mnh/mhp/ql1.htm>)

WHO's focus is a health-related quality of life approach, particularly the one that investigates the individual's own views in relation to their disease or illness. However, unlike the majority of medical quality of life outcome measures, WHO encompasses psychological and social (i.e. relationships and the environmental) factors which may impact well-being.

The main factors impeding quality of life is presence of chronic physical or psychological illness. The chronic illness has a profound influence on the physical and psychological wellbeing of the elderly. It is presumed to be the biggest burden on the individual, care taker and the society to which the person belongs to. Though chronic illness drives the quality of life the influence of social, behavioural, economical and environmental sources can reduce the impact.

The health promoting behaviours can assist with the management of chronic illnesses (Browning, Heine, & Thomas, 2012), and personal control over one's life activities and environment can influence perceptions of wellbeing in the face of illness (Mollenkopf & Walker, 2007). Social integration in old age has precursors in earlier phases of the life span. Loneliness in old age – a subjective indicator of poor social integration is influenced strongly by the social network. Social resources, including social activities and social support, are key influences on QOL particularly in impoverished environments such as low SES neighbourhoods (Mollenkopf & Walker, 2007). Positive self-perceptions of ageing are important influences on wellbeing (Levy, Slade, & Kasl, 2002). Neighbourhood characteristics, including social cohesion within a neighbourhood and safety, are also associated with wellbeing in late life (Pearson, Windsor, Crisp, et al., 2012). Economic resources are important in providing a living standard that allows the older person to live an independent and socially connected life and to access appropriate health care.

The current study explores the dimensions leading to the medical and psychosocial problems which are faced by the elderly and strategies in bringing about improvement in quality of life.

II. Methodology

A cross sectional survey design was adopted in identifying the health problems of the elderly and their quality of life. The study was conducted in selected rural population of Udipi district, Karnataka, INDIA. The study participants comprised of 100 elderly individuals who were randomly selected using simple random sampling technique. Those samples who were below 60 years of age, not willing to participate in the study and unable to comprehend, suffering from chronic debilitating illness including psychological health problems were excluded from participating in the study. The data collection instruments utilized were: socio demographic proforma, observational checklist on presence of physical and psychological morbidity, The WHOQOL-BREF was used to assess the quality of life. It took into consideration four domains of quality of life i.e. physical, psychological, environmental and social relationship. It had 26 questions and the mean score of items within each domain was used to calculate the domain score.

A house to house survey was conducted in the collection of the data and informed consent was obtained from the samples.

The data was analysed using SPSS software and template provided by WHO for scoring WHOQOL. Descriptive statistics including frequency and percentage and inferential statistics was used for analyzing data.

III. Results

A total of 100 samples including 75% females and 25% males participated in the study. Out of the total samples majority 56% of females and 47% of the male's age ranged between 60 -65 years. Majority of the samples (90%) of them were married, only 2% of them were living separately from their spouses. A large number of the samples belonged to Hindu religion (76%), Christians (20%), Muslims (3%), and Jain (1%). Maximum number of the samples were illiterate (58%), only 15% of them had completed their education up to postgraduate level. Agriculture was the primary occupation undertaken by maximum number of the samples (84%), remaining had no job in view of illness. Sons were the major source of family support (64%) followed by daughters, neighbours and relatives. It was crucial to observe that few of the samples were supported by nongovernmental organization. Majority (74%) of them had an independent house of kacha type, reining of them lived in rented houses. A total of 75% belonged to lower socioeconomic status.

Majority (85%) of elderly had a good quality of life, while those having a poor quality of life were 15%. The quality of life was better in males in all the domains ie; physical, psychological, social and environmental (72.55, 78.33, 81.33 and 74.55) respectively as compared to females (68.65, 74.67, 78.9 and 63.67).

Morbidity of the samples was anaemic (45%) and had dental problems (58%), followed by joint pains (76%), cataract (35%), and hypertension (62%) respectively. Further 65% of them were clinically diagnosed to have diabetes, 5% of them were suffering from cardiac problems, 15% were having senile deafness, 31% suffered from acid peptic disease, 23% had chronic obstructive pulmonary disease. Regarding morbidity with respect to age it was observed that in the age group of 65-70yrs 35% of them were hypertensive, 41% were suffering from Diabetes Mellitus. In the age group >75yrs 10% were anaemic, 10% were suffering from cataract, 12% were having dental problems.

IV. Conclusion

The findings of the current study showed that majority of the samples had a good quality of life which could be attributed to the positive life events which had occurred related to the society or individual. It is truly said that increased age gives way to increased morbidity. The presence of increased morbidity among the elderly could be attributed to the elderly being deprived of health care services. As the elderly population is increasing at a rapid growth it is very essential to sensitise the community regarding the needs of the elderly. There is a need to train the community health workers in recognising the health problems of the elderly.

References

- [1]. J. W. Rowe, and R.L. Kahn, Successful aging, *The Gerontologist*, 37(4), 1997, 433-440.
- [2]. R. Erikson, Welfare as a planning goal. *Acta Sociologica*, 17, 1974, 273-278.
- [3]. Campbell, Converse, P. E and W.L.Rodgers, *The quality of American life: Perceptions, evaluations, and satisfactions*, 1976, New York: Russel Sage.
- [4]. Browning, C. Heine, and S. Thomas, Promoting ageing well: Psychological contributions, 2012, In L. Ricciardelli & M. Caltabiano (Eds.), *Applied topics in health psychology*, 57-71. Wiley-Blackwell.
- [5]. H. Mollenkopf, and A. Walker, Quality of life in old age: International and multi-disciplinary perspectives, *Social Indicators Research Series*, Volume 31, 2007, Springer.
- [6]. B.R. Levy, M. Slade, and S. Kasl, Longitudinal benefit of positive self-perceptions of aging on functioning health. *Journal of Gerontology: Psychological Science*, 57, 2002, 409-417.
- [7]. E. Pearson, and T. Windsor, and D. Crisp, *Neighbourhood characteristics and Ageing Well – A survey of older Australian adults*, NSPAC Research Monograph 2, 2012, Canberra: National Seniors Productive Ageing Centre.