

**PERCEPTIONS AND ATTITUDES OF GERIATRIC HEALTH CARE SEEKERS TO THE BUILT ENVIRONMENTS OF HEALTH CARE PROVIDERS IN THE RURAL AND URBAN SECTORS OF TRIPURA**Aghore Debbarma<sup>1</sup>, Taranga Reang<sup>2</sup>, Nabagata Roy<sup>3</sup>**HOW TO CITE THIS ARTICLE:**

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**ABSTRACT:** The aged patients seem to be confronted with barriers when using health services. Yet, care providers are often oblivious to these barriers, although they may share to some extent the burden of responsibility for them. **OBJECTIVES:** To study the perceptions and attitudes of geriatric health care seekers towards the health care system. To assess the potential barriers that may restrict the geriatric people from using health services. **METHODOLOGY:** A cross sectional study was conducted among 200 participants'  $\geq 65$  years who were attending health institutions in both rural and urban setting using pre-tested, semi- structured interview schedule. Statistical analyses were performed using Microsoft Excel 2007 and Epi-info version 6.0 software. **RESULT:** Positive impact was found on regard to the family doctor, essential works being carried out, knowledge about the institute ( $P=0.000$ ,  $0.014$ ,  $0.001$  respectively). Exercise played significant role among the males and females ( $P=0.017$ ). Literacy had some positive impact on health status ( $P=0.025$ ), essential works being carried out for themselves ( $P=0.033$ ) and helpful attitude of family members ( $P=0.019$ ). **CONCLUSION:** The significance were being observed in regards to the personal and family level both of which could be related to ignorance towards the health care for themselves or for a geriatric member of any given ignorant family in both urban and rural setting.

**KEYWORDS:** Geriatric health, perception and attitude towards health care system, compliance of geriatric peoples towards treatment, rural-urban difference.

**INTRODUCTION:** Medical professionalism includes both the relationship between a health care provider and a health seeker and a social contact between them and society.<sup>1</sup> This includes acting respectfully toward patients and their families, friends and visitors, even under stressful situations; promoting the safe and efficient delivery of health care to all and to uphold the standards of the professionalism. Healthcare workers are considered to be at particular risk of developing ageist attitudes because they are exposed to a disproportionate percentage of ill or dependent older people.<sup>2</sup>

Research demonstrates that many factors have influence on health care workers' attitudes towards older people, including age, gender, education, exposure to well older people, area of practice, and professional socialization. Ageism has been defined as "a systematic stereotyping of discrimination against people because they are old".

In addition, budget constraints are likely to further reinforce the portrayal of older people as a burden on society. The aged patients seem to be confronted with barriers when using health services. Potential barrier is defined<sup>3</sup> if patients' expectations or health beliefs are not in line with what is proposed by the care provider, they may experience barriers to the use of health services.

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A barrier, as it is used in this paper, restricts the use of health services. It is a wall or limit that prevents people from going into an area or doing what they want to do.

In this study, the health care seekers, i.e., the aged patients were interviewed to perceive whether the built environment of the health institutes as a supportive environment and whether the hospital provides a welcoming homely space for themselves and their visitors that promotes health and wellbeing.

**METHODOLOGY:** A hospital based cross sectional study was conducted among geriatric population of both sexes in both urban and rural area of Tripura. A total of 200 Geriatric patients; 100 from rural and 100 from urban areas were surveyed. For rural area, Geriatric cases attending at Ananda Nagar primary health center and Kumarghat rural hospital located at the remote of west and north Tripura district respectively were considered, while for urban area, patients of similar age group attending at Agartala Government Medical College and Govinda Ballabh Pant Hospital, Agartala and Tripura Medical College and Dr. B.R. Ambedkar Memorial Teaching Hospital, Hapania were interviewed in accordance with the study design.

Geriatric cases of both sexes  $\geq 65$  years were included in the study and persons without emergency health conditions. Patients aged  $\geq 65$  years attending outpatient departments or admitted indoors were interviewed using pre-designed, pre-tested, semi-structured interview schedule from the selected health institutions. A written consent was taken from each individual before conducting study and strict confidentiality was maintained. Statistical test such as frequencies, chi-square test, etc. were performed using MS-Excel 2007 and Epi-info version 6.0. Probabilities of  $p < 0.05$  were taken as statistically significant.

**RESULTS:** This hospital based cross sectional study was carried out among 200 geriatric patients attending Outdoor clinics of selected Government health institutions during July – August 2012 from both urban and rural areas of Tripura. It was conducted to study the perceptions and attitudes of geriatric health care seekers towards the health care providers and the health care system; and assess the potential barriers and the factors, that may restrict the geriatric people from using health care services.

Majority of the participants were between the age group 74-78 years, (73%) male and (83%) Hindu joint family (72.0%) with no formal education (50%), taken care by family members (68.5%), dependent (68.5%), family members were helpful(90.0%), perceived as doctor's good behavior (87.5%), ill (66.5%), no family doctor (78.5%), attend public hospitals when fall sick (59.5%), compliant with the advised given to them (72.5%), received good care from the hospital (78.5%), suffering from arthritis, breathlessness, diabetes, cataract, etc.

One hundred nineteen (59.5%) went to the respective medical institute/hospitals of the concerned area for free services(public), 35% were found to receive medications under emergency situations where they had no other alternative choice; and 5.5% were being referred to the referral institute. One hundred seventy five (87.5%) individuals received good behavior from the treating physician whereas 12.5% individuals experienced satisfactory behavior from the physician. One hundred forty four (72%) individuals have bought the medicines that were prescribed to them or have undergone the tests that were advised and 28% individuals could not afford. One hundred fifty six (78%) individuals have received good service in the hospital centers.

Forty four (22%) individuals, though received good service in the hospitals, they preferred to get treatment from outside the state for better services.

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There were significant association observed between location of family and consultation and requirement of family doctors ( $p=0.000$ ), knowledge of health institute/hospitals regarding geriatric care ( $p=0.001$ ) and beneficial services provided by hospital/health institution ( $p=0.017$ ) (Table 1).

**DISCUSSION:** The present study was set out to explore the attitudes held by groups of elderly health care seekers towards the health care providers. It also presented the potential barriers that exist in the use of health services among the elderly participants. A larger number of potential barriers were identified which were summarized below. Potential barriers may occur at three levels viz. patient, provider and health system delivery. As seen from the participants, most of the respondents belong to the aged group of 74-78years.

This elderly age had itself acted as a barrier, because most of the basic health problems appeared at this extreme age only. It had been seen that about 3/4<sup>th</sup> individuals interviewed were males (73%). Being an aged person and having some kind of low social support had acted as a potential barrier to the notion of entering a medical institute. Religion did not play any significant role in acting as a barrier, though our study had shown that maximum respondents were Hindu. Chinnakali P et al (2012) reported that majority of the participants were females (76%) with mean age of 66 years ( $SD\pm 6.9$ ) and illiterate (65%).<sup>4</sup>

It was in concordance with the present study. Gender difference could act as a barrier although that might be less of a barrier than a predictor of need. Males and females had many similar life experiences and opportunities, but as they occupy different positions in the home and in the labor market, they were exposed to different health risks as well.<sup>3</sup> Breathing problems, joint pains, and sleeplessness were the other complaints among the study population.<sup>4</sup>

About 82.7% of the elderly were satisfied with their treatment. Almost similar problems were also reported by Chinnakali P et al (2012).<sup>4</sup> Kehusmaa S et al (2012)<sup>5</sup> reported that the mean age of the subjects was 78 years (range 65–96 years). It was in concordance with the present study. In the older age group (over 75-year-old subjects), the number of people living alone was higher and impaired cognitive capacity was found more often. Informal care and hospital admissions were also more common in the over 75-year-olds.<sup>5</sup>

Due to these differences in need-specific factors, the over 75-year-olds were the largest client group for home care services.<sup>5</sup> Ladha A et al (2009)<sup>6</sup> reported that mean age for the population was  $71.44 \pm 7.74$ . A total of 238(54.3%) elderly were found to be economically active. More than half ( $n=269$ , 61.4%) of the elderly were found to be illiterate. Only 72(16.4%) of the elderly population were diabetic and 132(30.1%) were hypertensive. Common symptoms that prompted elderly of Azam Basti to seek health care were fever (61.2%), generalized body aches (43.4%) and cough (40.4%).

Over half of the ( $n=269$ , 61.4%) responders reported factors which deterred them from seeking health care, out of which 62% reported financial constraint as the commonest factor. Deterrence from seeking health care was associated with illiteracy ( $p=0.001$ ) and living alone ( $p=0.06$ ). Low education level could also act as a barrier. It was shown in the above results that about 50% aged people had no formal education.

It could be exposed to the elderly people as the most vulnerable and less knowledgeable ones, thus leading to low access to health care and use of preventive care. Hence, being educated was one of the most influential determinants of health care access among the geriatric patients. Our study did not show any negative perception as maximum geriatric respondents (72%) resided with their

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families and together constitutes a joint family. But lack of family and lack of social and mental support giving rise to insecure living conditions could act as a barrier in those nuclear families (28%).

Clearly family support was advantageous in providing emotional support to the aged patient, as their needs might be differently expressed. Lower socioeconomic status could act as a barrier and had a disadvantageous effect on the patient's perceptions towards the use of services provided. As a major group of the participants (68.5%) had no earning methods, there could be a communication breakdown between different members of patient's family, the patient and care provider.

Chinnakali P et al (2012)<sup>4</sup> reported that nearly half (49.5%) of the elderly were not engaged in any occupation during the study period while one-third (33%) were engaged in agriculture and agriculture-related works. Ahmed SM et al (2005)<sup>7</sup> reported that poverty as a major determinant for health seeking behavior (OR 0.6, CI-0.40 – 0.78), seeking treatment from allopathic doctors were low (OR=0.7, CI – 0.60 –0.95). In our study, majority of the elderly individuals (66.5%) were found to be ill. Few believed that they were getting closer to the end of their lives and as a result of which they make little attempt to keep them healthy and active.

Therefore they had no desire to try new things or exercise properly. A study from the US Preventative Services Task Force<sup>8</sup> revealed that regular exercise could reduce life-threatening falls in the elderly by 58%. Another study showed that regular exercise reduced pain and increased function in joints of older Americans suffering from osteoarthritis.<sup>9</sup> Unawareness of service availability or a lack of knowledge about the services at one's disposal could act as a barrier to the use of health services. About 59.5% elderly people, according to our study, preferred free services due to their poor socioeconomic status.

From this it could be well understood that demand in health services was influenced greatly by tastes and preferences. Disapproving perceptions and attitudes with regard to health services could act as a barrier, especially when the aged were dubious about the benefits of health services or simply did not see the benefits of it. Some geriatrics saw providers as a distant group of people and fosters too much respect for medical personnel which restrained them from asking important questions about medical instructions. Some of our respondents failed to give complete knowledge about their illness.

Different understanding of the workings of the body in the case of the food exchange system and the limited ability of some to interpret food labels could also act as a barrier for not receiving optimal medical care. When interviewed, the aged patients mainly reported that they were unable to take the health services because it was beyond their affordability. As stated above, maximum preferred free services and it was also seen that 28% individuals experienced difficulty in the paying of medical bills to certain therapies; for example medicines and investigations of high cost, with recommended dietary products, etc.

Hence high medical costs or lack of financial resources or abstract poverty could become a barrier to health care. Ineffective communication was one of the major factors that prohibited the use of health services because it jeopardizes effective expression of words between the aged patients and health care personnel. Our study reported this as a common scenario, especially in the rural centers. People may feel embarrassed or uncomfortable to seek out services, to express their inner feelings, to ask questions or to represent themselves or their families. Intrusive medical procedures and standard practices applied with insensitivity to patients' needs could act as a barrier to the use of health services.<sup>3</sup>

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On interviewing the female participants, they shared that they felt embarrassment with a physical examination done by male physicians. Incorrect medical practices and management could act as a barrier. There might be a tendency of the primary care physician to refer the patient more quickly to a specialist if it becomes difficult to diagnose the concerns of the older people. As per the opinion of the respondents, discourteous care and stereotypical attitudes failed to meet their expectations, which had acted as a barrier and caused discomfort to the elderly patient.

The rural versus urban conflict meant that living in the most remote and most sparsely populated regions, where there were no, or at least very few, medical providers around, inevitably had a detrimental effect on the health care seekers. In our case about 5.5% elderly patients were being referred to the referral institute. This referral system could act as a barrier, as few of them felt uncomfortable with monitoring procedures. Being at such an extreme age, the cumbersome process of making, obtaining appointments and the prolonged waiting times acted as a barrier and hindered them from using the services that they were entitled to.

Consultations and treatments that were too abrupt could act as a barrier as distrust could arise. There was a fear on the part of the patient that they were not being taken seriously enough. Ironically however, in some of our cases, the short-term treatment possibilities have made health care more accessible to the aged. Stoller, E. P et al (1992) reported that only one third of the respondents contacted any formal provider about any of their symptoms. The most frequent response to a symptom was doing nothing. The next two most commonly reported interventions were over-the-counter medications and activity limitation.<sup>10</sup>

**CONCLUSION:** It was anticipated that the research would help to identify the link between attitude and predicted behavior. In present study the significance were being observed mostly in regards to the personal and family level both of which could be related to ignorance towards the health care for themselves or for a geriatric member of any given ignorant family in both urban and rural scenario.

**RECOMMENDATIONS:** Geriatricians/geriatric clinics in the area, an attempt should also be made to find those doctors who specialize in elderly care. Families or others involved with an elderly persons care must recognize the common problems of elderly loved ones and take corrective action.

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Variables	Response	Location of family		Total (%)	P value
		Urban (%)	Rural (%)		
Health status	Good	44(65.67)	23(34.33)	67(100.0)	0.125
	ill	56(42.10)	77(57.89)	133(100.0)	
Family doctor	No	66(42.04)	91(57.96)	157(100.0)	0.000
	Yes-needed	26(76.47)	8(23.53)	34(100.0)	
	Occasionally	8(88.89)	1(11.11)(100.0)	9(100.0)	
Earning	Shop	14(45.16)	17(54.84)	31(100.0)	0.480
	Tenants	15((62.5)	9(37.5)	24(100.0)	
	Nothing	66(48.18)	71(51.82)	137(100.0)	
	Pension	5(62.5)	3(37.5)	8(100.0)	
Attitude of family members	Helpful	92(51.11)	88(41.89)	180(100.0)	0.601
	Not helpful	4(36.36)	7(63.64)	11(100.0)	
	No answer	4(44.44)	5(55.56)	9(100.0)	
Knowledge of the institute/hospitals	Public	119(62.98)	67(36.02)	186(100.0)	0.001
	No alternative choice	70(67.96)	33(32.04)	103(100.0)	
	Referred	11(100.0)	0(0.0)	11(100.0)	
Compliance	Yes	77(53.47)	67(46.53)	144(100.0)	0.115
	No-costly	23(41.07)	33(58.93)	56(100.0)	
Did the institute provided Beneficial service	Yes	71(45.51)	85(54.49)	156(100.0)	0.017
	Outside better	29( 65.91)	15(34.09)	44(100.0)	

**Table 1: Association of location of family of the respondents with selected variables**

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