# Poverty and Access to Health Care among Elderly

**Shahida Akhtar[1] and Dr. Wakar Amin[2]**

*[1]Research Scholar, University of Kashmir*
*[2]Assistant Professor, Deptt. of Social Work, University of Kashmir*
*E-mail: [1]akhtarshahida40@gmail.com, [2]wakaramin78@gmail.com*

**Abstract—***In developing countries like India, poor health and inability to access health care are an important part of the experience of ageing, particularly among people living in poverty. The onset of old age for poor elderly is characterized by problems caused by poverty throughout their lives, overlaid with health problems, changing family structures which creates challenges for them and also results in the decline of their already meager resources. However, many of the health conditions associated with elderly people can be prevented or delayed if people have access to suitable health care throughout their lives .So, while the rapidly increasing number of elderly people throughout the world represent a biological success for humanity, the living conditions of the poor elderly have by and large lagged behind those enjoyed by the economically active population. This paper documents disparities in access to health care services among poor elderly using a framework incorporating quality, accessibility, availability, affordability and acceptability of health services from the perspectives of older people's health and well-being.*

**Keywords***: Elderly, Poverty, health services, access to health care*

## 1. INTRODUCTION

In developing countries like India, old age heralds a period of deprivations for those who lack access to social and economic resources including access to education, nutrition and health care. Health for the elderly may be conceptualized as the ability to live and function effectively in society and to exercise maximum self-reliance and autonomy; it is not necessarily total absence of disease. [1] Healthy elderly people are a valuable social and economic resource to their families and communities. Lack of financial resources or information can create barriers in accessing health services. Access to Health care by the elderly can be defined as the ability of the aged to get the required medical care from the health service providers when they need it. [2]. It's a comprehensive measurement of access to health care that requires a systematic assessment of physical, financial and socio-psychological access to services. Utilization of health care is used as an operational proxy for access to health care. Access has four dimensions: availability, geographic accessibility, affordability and acceptability [3]. However, when health care is needed but is delayed or not obtained, people's health worsens, which in turn leads to lost income and higher health care costs, both of which contribute to poverty [4].

Based on the study of urban life in nineteenth century York, Benjamin Seebohm Rowntree (1901) argued that poverty is linked to age and family formation in a cyclical fashion. According to his study, children tended to live in poverty as they grew up in households with many other children but

typically only one breadwinner (the father). Poverty often eased for these children when they reached the 'youth' stage of their lives and started earning an income of their own. However, by the time these young people had established their own families, they tended to be affected by poverty again as they were raising (often large numbers of) children of their own. Poverty eased again as these children gradually left home, only to increase at the onset of old age that was associated with inability to continue earning an income and the absence, at that time, of significant pension incomes. [5]. Poverty can be defined in absolute or relative terms. Most international comparative poverty research has adopted a relative definition of poverty. Poverty can be understood as the lack of freedom to lead the life people have reason to value, with people and communities empowered to lead healthy lives seen both as a means to overcoming poverty and an end in itself. [6]. The relationship between poverty and access to health care can be seen as part of a larger cycle, where poverty leads to ill health and ill health maintains poverty. [7]. Poverty, with its deleterious effects on health, education, self-esteem, quality of life and lifestyle is one of the major concerns of elderly people. [8]. Poverty prevents the poor elderly from accessing health care services which in turn takes a heavy toll on their health. Elderly people living in poverty find themselves socially excluded and isolated from decision-making processes. Since, efforts to understand poverty have dominated much of the debate on development in recent years, but the poverty experienced by the majority of older people, particularly in developing countries, has been largely ignored. Here, those factors are reviewed that affect access to health services among poor elderly, focusing on the role of poverty. The relationship between poverty and health care is a common subject of research and policy. Here, a conceptual framework is used that builds on longstanding descriptions of access to health services. In this framework, four main dimensions of access are described and a common thread is that the poor elderly are at a disadvantage in nearly all dimensions of accessing health care and these dimensions include the following:

## 2. ACCESSIBILITY AND ELDERLY:-

Accessibility concerns the built environment, and dimensions such as distance to facilities, availability of transport, and the walk ability of neighborhoods, which can either support or constrain older people's access. It is a key enabler for people to have more opportunities, be it with regard to social, cultural or economic participation. An accessible environment allows elderly people to maintain essential links to friends, family and the wider community. It facilitates them in maintaining their independence. In the context of health, accessibility has four sub dimensions: nondiscrimination, physical accessibility, economic accessibility (or affordability), and information accessibility Discrimination can be direct or indirect. Direct discrimination occurs where older people are deliberately excluded from accessing services due to their age (UN, 2012). For example, a Help Age International publication highlights examples of older people being "told by health staff that they had lived their time and should not finish the medicine that the young can use" or "not sending an ambulance for anyone who they think is too old" [9]. Indirect discrimination occurs where older people are inadvertently excluded. For example, WHO (2012) advocates for a life-course approach to ageing, recognizing that illness and disability during old age are not inevitable, but rather the result of living conditions and choices made across the life course. Physical accessibility meant that the physical environment has to be conducive to the wellbeing of elders and should enable them to participate in activities as an integral part of the community just like any

other person. Besides this, accessibility also includes the right to seek, receive, and impart health-related information in an accessible format. Not all elderly people use the services for which they are eligible. Information is an important and underlying determinant of health at all ages [10]. The lack of information can constrain access to appropriate and timely care, especially to the poor elderly who are not well aware about the various health care facilities available for them. Notably, older people might have specific needs with regard to health information. For example, literacy rates among the older population aged 60 years and older are distinctly lower than those for the adult population aged 15 years and older as a whole. Literacy enables a person to access health information and care, interact with a health professional, and understand the treatment or medication. So, in order to make the health care services accessible to the poor elderly more public clinics and hospitals need to be build with the advantages of having more convenient opening hours and being more responsive to the health care needs of elderly.

## 3. AVAILABILITY:-

Availability refers to a sufficient quantity of functioning public health and health care facilities, goods, and services, as well as programs. In the context of ageing, this implies considering the extent of availability of health services, facilities, and tools that meet the health needs of older people [11].It means having the right of care available to those who need it, such as hours of operation and waiting times that meet demands of those who would use care, as well as having the appropriate type of service providers and materials. Availability can be measured in terms of the opportunity to access the health care as and when needed. The common problem of limited hours, long waiting times, absentee health workers, and lack of drug stocks at public clinics are some of the reasons why poor elderly, so readily use informally trained health providers and shopkeepers or bypass nearby clinics. [12].As, poor elderly people are more prone to chronic illnesses, the un-availability of medicines and other medical equipments at govt. run hospitals made them more vulnerable as these people cannot afford to buy medicines from market or to get treated at private hospitals. Health care facilities should be responsive to the health care needs of poor elderly people. There is a need to make health services age-friendly and assure availability of health care services in a time bound manner.

## 4. FINANCIAL ACCESSIBILITY OR AFFORDABILITY:-

Financial access, or affordability, is considered as one of the most important determinants of access and is most directly associated with dimensions of poverty. Besides the direct cost of treatment and informal payments, there are also indirect costs that deter the poor elderly from seeking treatment. These indirect costs include the opportunity cost of time of both the patient and those accompanying him or her, transportation costs, and expenses on food and lodging. It is important to note that out-of-pocket payments for health care create substantial barriers in access to care, especially for older people living in poverty. [13]. Besides, health financing schemes are typically designed and funded to meet high-cost but relatively rare or catastrophic events, while the health expenditures of older people may predominantly comprise low-cost but recurrent expenditures, such as for medicines to manage chronic health conditions. So, health services need to be financed in order to make them affordable for the poor elderly.

## 5. ACCEPTABILITY:-

Acceptability includes a consideration, for example, of whether services are age friendly or responsive to older people's needs, taking into account the diversity of older people, as they are not a homogeneous group but face varying health risks and circumstances [14].It also includes gender-responsive approaches that recognize the differences between older men and older women in terms of their exposure to risk, health-seeking behaviors, access to care, and impact of ill-health [15]. Response should be tailored to the specific needs and circumstances of older people as rights holders, not passive recipients of benefits. The Madrid International Plan for Action on Ageing (2002) as well as CESCR highlight the importance of enabling people to "age in place," empowering them to participate in and contribute to their community as they grow older, supported by health care, long-term care, and other social services and an age-friendly environment. Besides, there is a need to expand the coverage of health interventions in order to bring poor elderly within the ambit of these interventions.

In addition to these four dimensions of access, quality of health care is an important component of each dimension and is ultimately related to the technical ability of health services to affect people's health. Adequately skilled, competent and empathetic health workers are an important component of assuring good-quality health services. For example, 40% of older people in a Help Age analysis described the tone of health workers as "mocking," whereas others spoke about feeling unwelcome and disrespected [16].However, general consensus is emerging in the field of health care quality assurance (QA) that the concern for the quality of health services should not be limited to clinical effectiveness or economic efficiency but rather should include social acceptability as an important quality objective. Indeed, Donabedian had suggested that patient satisfaction is a major quality outcome in itself. [17].

## 6. CONCLUSION

Meeting the health needs of poor elderly people is a large and complex agenda. The poor elderly suffer from a disproportionate burden of disease yet usually have less access to health care, whether measured by geographic accessibility, availability, financial accessibility, acceptability, or quality of care. Success depends in part on gaining a local understanding of the dimensions and determinants of access to health services, along with concerted efforts to improve services for the poor elderly. There are many innovations in financing, service delivery, and regulation of care that holds promise for improving access for the poor elderly. The same can be said of older strategies. In either case, the challenge remains to find ways to ensure that vulnerable populations have a say in how strategies are developed, implemented, and accounted for and to ensure that information and incentives are aligned in ways that can demonstrate improvements in access by the poor elderly people.

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