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Quality of Life Among Elderly In Non-Institutional Care

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Abstract: ***The aim of the study is to find out quality of life of elderly people above 60 years in the non-institutional elderly care with reference to day care centre by ARUWE, Ayanavaram at Chennai. The study was conducted on a purposive random sample of 30 elderly attending Day care services. WHO-QoL-BRIEF version was used to measure the QoL. The interview schedule was administered; data was collected and was subjected to statistical analysis using Karl Pearson Correlation, Anova and Students-t-test. The results envisages that 63.3% of them have low quality of life where as 36.7% have high of quality of life, 46.7% have low health satisfaction where as 53.3% has high health satisfaction, 66.7% have low physical score where as 33.3% has high in physical score,76.7% has low psychological score where as 23.3% high psychological scores. 63.3% has low social relationships scores where as 36.7% has high social relationship. 60% has low score in environmental domain where as 40% has high score in environmental domain.***

Keywords: Care**,** Day Care, Quality of life, elderly, non-institutional care.

1. Introduction

Elderly are vulnerable section of society. According to Lakshmi et al (2013) India is a country which is densely populated and positioned as largest population of elderly in India [1]. According to Hussain (1997) Ageing is characterised as reduction in functional capacities and structural changes in the body [2]. Spouses and children take care of the elderly partner or parents in the families but as the days passes joint family system has almost slowly faded, brought out challenges in caregiving of old age dependents in the present days. In the perspective of care towards care recipients are not static but going through paradigm shifts. Day care provides non-professional care and professional care involving in care as multi-disciplinary fashion in their locality. In India the care was prevailing only in families. Family care was hidden in Indian families due to urbanisation and globalization. Now community care concept has sprung through community based rehabilitation, community participation and social capital. The care recipients who are residing in their fascinates are more dependent and their QoL is diminishing gradually, so alternative forms of care need system emerged in the community. According to Chandramouli (census 2011) Kerala ranges 12.6% and Tamilnadu 10.4 % are the states which has highest old age population rates [3]. As the population is increasing the quality of life of the elderly has to be ensured which is the positive indicator of healthy and active ageing. According to Elizabeth Hurlock [1953] Old age is the second childhood stage [4]. The foundations of active ageing are laid in the early phases of life. Early life experience of individuals will be reflected in the later stages of life. So investment for later stages of life must be made like gaining health, social participation and networking, dignity etc in the former days. From this we predict that maintaining quality of life must be significant and given first priority in our lives. Initiatives for improving quality of life should be made through adoptive methods and assistive devices. Family and community are key venues where care can be begotten According to WHO (1996)"Quality of life defined as individual's perception of their position in the context of culture and value system in which they live and in relation to their goals, expectation, standards and concern"[4]. There is high need for Older adults in day care with specific special needs. According to steven H .Zarit [2011] in his study on Effects of Adult day care on daily stress of caregiver's: A within-person approach highlights that ADS use lowered caregivers exposure to stressors [5]. Noelle L Fields [2014] portrays in his study on The effectiveness of adult day services for older adults- A review of the literature from 2000-200l that ADS has got more attention due to shifts in policy towards home and community based services for elderly population and 61 articles review predict that the need to implement and test more specific interventions targeting the wants of the adult day care population[6] (Secondo fassino et al.,(2002) states in his study on Quality of life of independent older adults at home by highlighting that Quality of life doesn't confines with only health states but also psychological, functional and existential domains. He has found that in his study that cultural prejudice has made the definition of dependence worsen. Secondly psychopathological factors contribute negative effect on attitudes of life. Thirdly most of the respondents of the study were influenced by degree of depression. He finally recommends QOL-oriented therapy strategy must be articulated and psychosocial intervention in this population has to be provided and strengthened [7]. Syed shujaquadri et al.,(2013) portrays in his community based cross-section study that in rural India males had good quality of life in all domain who are graduates recently married, belong to non-scheduled cast and living in extended families yet study insist that the elderly are subjects for medical and psychosocial problems for other section of society. So there is a need for strategies to improve the quality of life [8].

2. Methodology

The main aim of the study is to carefully investigate the quality of life of neglected elderly in the day care homes. The Objectives are to know the socio-demographic details, overall quality of life, overall health satisfaction, physical health domain, psychological domain, social relationship domain, environmental domain and to suggest welfare measures for elderly women in the light of gerentological social work perspective. The researcher used Descriptive research design to explain the facts about the quality of life Theuniverse was 30 respondents [WDS] collected from a social welfare organisation, ARUWE. The sample size for the study was 30 respondents. The tool used by researcher was interview schedule to collect the data from the respondents through Purposive random sampling.

The WHO-QOL-BRIEF (1996) was administered to find out the quality of life in widows, divorced and neglected elderly in institution. The scale comprises of physical, psychological, social and environmental domains. The scale is 5 point scale. The reliability and reliability has follows 0.721, 0.763, 0.801 and 0.754[7]. Limitations of the study are, study had been conducted with a small sample, in a day care and the time was also constrain. An ethical implication of this study is to administer informed concern to the respondents. Scope of the study is to serve as an indigenous study in the light of social work, to serves as document source for policy makers, to promote welfare measures like Day care facility for elderly in each panchayat, to inspire social workers to plan effective intervention and rehabilitation programmes.

3. Analysis and Interpretation

From the demographic details it has found that in terms of age groups the respondents belong to age categories as 43.3% of respondents belong to 60-65 years, 40% of the respondents belong to 66-70 years, 13.3% of the respondents belong to 71-75 years and 3.3% of the respondents belong to 76-80 years and above. In terms of caste based classification among the respondents are 36.7% belong to backward class, 13.3% belong to other backward class, 50% of the respondents were belonging to scheduled caste. In terms of educational status of the respondents are 63.3% were illiterates, 26.7 had primary education and 10.0% had secondary education. In terms of perceptions of living condition of the respondents 40% are dependent are dependent and 60% are independent. In terms availing pension scheme 50% are availing pension where are other 50% of respondents does not receive it.

It reveals from the study that 63.3% of them have low quality of life and 36.7% have high of quality, 46.7% have low health satisfaction and 53.3 has high health satisfaction, 66.7% have low physical score and 33.3% has high in physical score,76.7% has low psychological score and 23.3% high psychological scores. 63.3% has low social relationships scores and 36.7% has high social relationship. 60% has low score in environmental domain and 40% has high score in environmental domain.

Hypothesis – 1
There is significance relation between the age of the respondents and quality of life of elderly in community based care.

Karl Pearson Coefficient Of Correlation Between Age of the Respondents With Various Dimension of Quality of Life of Elderly in Community Care

Dimensions	*Correlation value*	*Level of co-relation*	*Statistical inference*
Quality of life	0.023	Very low positive relationship	P<0.05 Not significant
Health satisfaction	0.020	Very low positive relationship	P<0.05 Not significant
Physical	0.177	Low positive relationship	P<0.05 Not significant
Psychological	0.368	Positive relationship	P>0.05 Significant
Social relationship	-0.167	Low negative relationship	P<0.05 Not significant
Environment	0-525	Negative relationship	P>0.01 Significant

The above table highlights that relation between age and overall quality of life, overall health satisfaction and Physical domains have very low positive relationship and it is found that statistically not significant because the age doesn't determines quality of life. It may occur due to intrinsic motivation and development not the age factor plays in enhancing quality of life of individuals. Hence age hypothesis is accepted. With reference to psychological domain has positive relationship and statistically significant. Hence the age determines psychological domain it may be because of psychosomatic manifestations of the age influences psychological domain and has relationship. Since it significant because age determines the quality of life. Hence the null hypothesis is rejected. It is found to be statistically significant because age determines the quality of life. Hence the null hypothesis is rejected is rejected. It may be reason that environment in which they are residing and accustomed may not culturally motivating them in the past days they have spent and social relationships are not healthy because of social backwardness and social relationships are not healthy because of social backwardness and lack social skills in the elderly in the community.

Hypothesis: -2
There is significant variance among the respondents caste with various dimension of life in community care.

One Way Anova Among Respondents Caste With Various Dimension Of Quality Of Quality Of Life.

Dimensions	*Quality of Life*	*Sum of Squares*	*Df*	*Mean*	*Mean Square*	*Statistical Inference*
Quality of Life	Between Groups	.968	2	G 1 = 3.27	.489	F = 1.401
	Within Groups	9.332	27	G 2 = 3.75	.346	P < 0.05 Significant
				G 3 = 3.20		

health satisfaction	Between Groups	.839	2	G 1 = 3.55	.420	F = .703 P < 0.05 Significant
	Within Groups	16.127	27	G 2 = 3.50	.597	
				G 3 = 3.20		
Physical	Between Groups	.535	2	G 1 = 21.75	.267	F = .094 P > 0.05 Not Significant
	Within Groups	76.932	27	G 2 = 21.75	2.849	
				G 3 = 22.00		
Psychological	Between Groups	20.988	2	G 1 = 17.64	10.494	F = 4.138 P < 0.05 Significant
	Within Groups	68.479	27	G 2 = 19.50	2.536	
				G 3 = 16.93		
Social Relationship	Between Groups	.717	2	G 1 = 8.00	.358	F = .777 P > 0.05 Not Significant
	Within Groups	38.083	27	G 2 = 8.25	1.410	
				G 3 = 8.33		
Environment	Between Groups	9.335	2	G 1 = 22.73	4.667	F = .306 P < 0.05 Significant
	Within Groups	101.865	27	G 2 = 23.25	3.773	
				G 3 = 23.93		

G 1 = Backward Class G 2 = Other Backward Class G 3 = Schedule Class

With regard to overall quality of life and the mean score of BC, OBC and SC were compared and found that schedule caste has low score, backward caste has moderate score and other backward class shows high quality of life score. With regard to health satisfaction, physical and psychological the mean score of BC, OBC and SC were compared and found that backward caste has low score, Schedule caste has moderate score and other backward class has high health satisfaction. With regard to social relationship the mean score of BC, OBC and SC were compared and found that other backward caste has low score, backward caste has moderate score and schedule caste had high social relationships score. With regard to environment the mean score of BC, OBC and SC were compared and found that schedule caste has low score, other backward caste has moderate score and backward caste has high social relationships score. The results are alarming through varied culmination of mean score. It is evident that not through pre-conceptual notion of social stratification standards of life will determine the quality of life domains but through adoption of life style to present scenario standards of life are determinants of quality of life. Caste doesn't determine quality of life.Thus when tested using anova was found to be not significant in all dimensions. Hence null hypothesis is accepted and research hypothesis is rejected.

Hypothesis: 3

There is significance difference between respondent's educational Qualifications with various dimensions of quality of life.

Student **t** - Test Between The Respondent's Education And With Various Dimension Of Quality Of Life In Non-Institutional Care

Dimensions	*Education*	*N*	*Mean*	*Std. Deviation*	*Std. Error Mean*	*Statistical Inference*
Quality of Life	Illiterate	19	3.21	.787	.181	t = -.855 df = 28 P > 0.05 Not Significant
	Primary	11	3.45	.688	.207	
health satisfaction	Illiterate	19	2.84	1.167	.268	t = -1.230 df = 28 P > 0.05 Not
	Primary	11	3.36	1.027	.310	
						Significant
Physical	Illiterate	19	21.84	2.774	.636	t = -2.218 df = 28 P < 0.05 Significant
	Primary	11	23.91	1.758	.530	
Psychol-ogical	Illiterate	19	18.26	1.558	.357	t = -.298 df = 28 P > 0.05 Not Significant
	Primary	11	18.45	1.916	.578	
Social Relationship	Illiterate	19	7.79	1.960	.450	t = -.284 df = 28 P > 0.05 Not Significant
	Primary	11	8.00	1.949	.588	
Environmen	Illiterate	19	25.32	3.637	.834	t = -.529 df = 28 P > 0.05 Not Significant
	Primary	11	26.09	4.253	1.282	

With regard to the respondents' education with reference to being illiterate and primary educated mean scores were compared with quality of life, health satisfaction physical, psychological, social relationships and environment found difference in mean score of respondents who illiterates are lower than respondents who have primary education. This may be due to the fact that education brings intrinsic transformation during the course of time. Education does not determine quality of life, health satisfaction and social relationships domains. When difference was tested using t-test the difference were not found to be significant. But in terms physical domain determines the quality of life. It may be because of informal education about the intake of food they consumed in their young age was good and natural without chemicals which helps them to maintain in later days of their life. When tested difference was tested using t-test the difference was found to be significant. Thus null hypothesis is accepted and research hypothesis is rejected.

Hypothesis 4

There is significant difference between the respondent perceptions about living conduction with various dimensions of quality of life.

Student **t** - Test Between The Respondents Perceptions About Living Conditions And With Various Dimension Of Quality Of Life In Non- Institutionalised Care.

Dimensions	*living condition perceptions*	*N*	*Mean*	*Std. Deviation*	*Statistical Inference*
Quality of Life	Dependent	12	3.50	.522	t = .749 df = 28 P > 0.05 Not Significant
	Independent	18	3.17	.618	
health satisfaction	Dependent	12	3.50	.798	t = .860 df = 28 P > 0.05 Not Significant
	Independent	18	3.28	.752	
Physical	Dependent	12	21.83	1.403	t = -.389 df = 28 P < 0.05 Significant
	Independent	18	21.89	1.779	
Psychological	Dependent	12	18.17	1.586	t = -.510 df = 28 P < 0.05 Significant
	Independent	18	17.11	1.779	
Social Relationship	Dependent	12	8.83	1.030	t = .932 df = 28 P > 0.05 Not Significant
	Independent	18	7.78	1.060	
Environment	Dependent	12	23.92	2.314	t = .128 df = 28 P < 0.05 Significant
	Independent	18	23.06	1.662	

With regard to the respondents perceptions of living condition about being dependent and independence mean scores were compared with quality of life, health satisfaction and social relationships found that mean score of respondents who perceived dependency are greater than respondence who have perceptions of independent. This may be due to the intrinsic perception of dependence itself act as a push force to maintain standard of life.Perceptions about dependency do not determine quality of life, health satisfaction and social relationships domains. When difference was tested using t-test the difference were not found to be significant. With regard to the respondents perceptions of living condition about being dependent and independence mean scores were compared with physical, psychological and environment domains found that mean score of respondents who perceived as independent are lower mean score than who have perceptions of dependent perceptions. This may be due to psychosomatic neglect in terms dependent response in terms of physical and psychological domains and it terms of environment independent perceptions makes individual move forward in any environment. Perceptions of dependence do not determine better physical and psychological domains. Perceptions of independence determines better environment. When difference was tested using t-test the difference were not found to be significant but in environment domain the difference was found significant. Hence the null hypothesis is accepted and research hypothesis is rejected

Hypothesis: 5

There is significance difference between respondents availing pension scheme with various dimensions of quality of life.

STUDENT **t** - Test Between The Respondents Availing Pension Scheme And With Various Dimension Of Quality Of Life.

Dimensions	**Pension**	**N**	**Mean**	**Std. Deviation**	**Statistical Inference**
Quality of Life	Yes	15	3.20	.561	t = -.096 df = 28 P > 0.05 Not Significant
	No	15	3.40	.632	
health satisfaction	Yes	15	2.33	.816	t = -.794 df = 28 P > 0.05 Not Significant
	No	15	3.40	.737	
Physical Health	Yes	15	22.33	1.496	t = -.055 df = 28 P > 0.05 Not Significant
	No	15	21.40	1.682	
Psychological Health	Yes	15	17.47	2.200	t = .288 df = 28 P > 0.05 Not Significant
	No	15	17.60	1.242	
Social relationship	Yes	15	8.20	1.265	t = 1.322 df = 28 P > 0.05 Not Significant
	No	15	8.20	1.082	
environment	Yes	15	23.47	2.167	t = .530 df = 28 P > 0.05 Not Significant
	No	15	23.33	1.799	

With regard to the respondents availing pension scheme and not availing respondents mean scores were compared with quality of life, health satisfaction psychological aspects and found that mean score of not availing pension scheme and having quality of life, health satisfaction, psychological were greater than the respondents availing pension scheme and having quality of life, health satisfaction and psychological aspects. This may be due to some kind of inner confidence, positive perception and inner competence about maintaining quality of life, health satisfaction and psychological domains. Availing or not availing pension scheme does not determine quality of life, health satisfaction and psychological domains. When difference was tested using t-test the difference were not found to be significant.

With regard to the respondents availing pension scheme and not availing respondents mean scores were compared with physical, social relationship and environment domains found that mean score of not availing pension scheme had lower physical, social relationship and environment domains were as mean score of respondents availing pension scheme had higher mean scores in physical, social relationship and environment mean scores. This may due to the partial financial support encourage their physical aspects to be promoted, enhance social relationship and favourable environment in a partial manner. Availing or not availing pension scheme does not determine physical, social relationship and environment domains. When difference was tested using t-test the difference were not found to be significant. Hence null hypothesis is accepted and research hypothesis is rejected.

4. Major Findings

- 63.3% of elderly people in a day care centre have low quality of life
- 53.3% of elderly people in a day care centre have high health satisfaction
- 66.7% of elderly people in a day care centre have low physical score
- 76.7% of elderly people in a day care centre have low psychological score.
- 63.3% of elderly people in a day care centre have low social relationships scores
- 60% of elderly people in a day care centre have low score in environmental domain.

5. Suggestions From Geriatric Social Workers Perspective

- Systematic person-centered interventions must be planned and administered to all care centres.
- Pre and post retirement counselling for elderly must to be done in the institutions from elderly are retiring.
- Making safe living arrangements for widowed, divorced and separated.
- Retirement homes in India must exist for holistic healthy development in the community.
- Promotion of health seeking behaviour among elderly through barefoot counselling.
- Promote and motivate regular follow up to adhere pharmacotherapy.
- Promote and motivate regular follow up to adhere counselling and psychotherapy
- Social support groups must be promoted in the community
- Facilitate social network among the elderly to heal
- Promote community participation of elderly in the communities for decision making.
- Mobile clinics accessible to all remotes in urban and rural communities.
- Psychosocial clinics for prevention of community's common mental illness in the community.
- Educate and prevent the various forms of abuses and Social security measures must be ensured for people in the community.
- Homeless elderly must be assured basic need and rehabilitated in the community.
- Strengthen respite care in home and community to break long time caregiving.
- Palliative care elderly with chronic disease like dementia in the communities for the welfare of elderly in the end of life care
- Foster care homes must establish for elderly in the community to foster social networking and care.
- Speciality course on geriatric social work is obligatory in India to meet the holistic needs of the elderly in non-institutional care settings.
- Capacity building programms for medical and para medical professionals. Psychiatry much be branch medicine, must not be separated.
- Crash course for barefoot health workers on grass root level in elderly fascinates. .
- Educate on rights of the elderly to tap and avail the needs through rights perspective..

6. Conclusion

As the longevity of ageing population increasing the magnitude of the neuropsychiatric problem, general health problems, decline in functionality leads to disabilities and deviations in Bio-psychosocial, economic and environmental problems. These problems manifest as crisis and trauma makes them vulnerable and susceptible to decline in quality of life. It the responsibility of geriatric social workers to extend non-institutionalised care effectively and promote active ageing and prevent ageing crisis

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