Quality of life of senior citizens: A Rural-Urban comparison

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***Abstract*: Background: The experience of aging is unique to every individual because of the individual differences in personalities, varying social support network, and differing cultures to which one belongs. Quality of life (QUALITY OF LIFE) of senior citizens is greatly influenced by their previous lifestyle, culture, education, health care beliefs, family strengths, and integration into the communities. Aims: To assess the sociodemographic profile, QUALITY OF LIFE, and to compare the QUALITY OF LIFE of senior citizens in rural and urban areas. Methodology: Data were collected from 830 rural senior citizens and 120 urban senior citizens through multistage random sampling technique. The tools used in this study were sociodemographic data sheet and WHO QUALITY OF LIFE-BREF-26. Results: Majority of senior citizens belonged to the age group 65–75 years in rural (65.3%) and urban (65%) areas and majority were females (rural 61.4% and urban 66.7%). A major percentage (44.7%) of senior citizens in rural areas lived with their spouses and children, whereas 40% of them in urban areas lived with their children and 40% with their spouse and children. Majority of study subjects in rural (90.6%) and urban areas (97.5%) were not involved in any social activities. The senior citizens in urban areas showed better QUALITY OF LIFE than the senior citizens in rural areas. This was statistically significant in the overall perception of QUALITY OF LIFE, the overall perception of health, physical health, psychological health, and environment ($P < 0.05$). Conclusion: This study showed that QUALITY OF LIFE was poorer among senior citizens in rural areas. In India, the population of senior citizens is greater in rural areas where the health care facilities are minimal. Hence, policies and programs related to senior citizens should be launched in rural areas without neglecting the needs of urban senior citizens. Training of voluntary workers, health care professionals, and family members on the care of senior citizens should be implemented. QUALITY OF LIFE of senior citizens could be enhanced only with the support of family members.**

***Keywords*: Quality of life, rural areas, senior citizens, urban areas**

Introduction

Aging is a universal phenomenon, which is experienced by every human being across various cultures. The experience of aging is unique to every individual because of the individual differences in personalities, varying social support network, and differing cultures to which one belongs. The response of the society to the aged also differs across cultures because of the abilities or inabilities of the society due to various economic, social, and political factors.

In India, 90% of older persons are from the unorganized sector, with no social security at the age of 60. Thirty percentage of older persons live below the poverty line and another 33% just marginally over it. Moreover, 80% live in rural areas, 73% are illiterate, and can only be engaged in physical labour, 55% of women over 60 are widows, and there are nearly 200,000 centenarians in India. In Andrapradesh, out of a population of 3.1 crores, 10.1% are elderly citizens. According to the 1961 census, the number of elderly was just 1.0 million; by the time of 2001 census, the number increased to 3.4 million. According to the projections, the number of elderly is expected to exceed 6.6 million by 2021. In Chittoor District, out of 1953,646 population, 251,835 (12.8%) are elderly.

Quality of life (QUALITY OF LIFE) is a multidimensional concept including physical, psychological, social, and economic components. Life satisfaction is an individualized, subjective assessment of a person's QUALITY OF LIFE according to his or her chosen criteria. Combining perception with performance or capacity is an important aspect of QUALITY OF LIFE of persons with chronic illness or disability. Research has found that the effect of physical disability or chronic illness cannot be appreciated without taking into consideration both the specific areas of functioning affected by the person's condition and those aspects of QUALITY OF LIFE (social, psychological, and functional) that are of particular importance to the individual.

QUALITY OF LIFE of senior citizens is greatly influenced by their previous lifestyle, culture, education, health care beliefs, family strengths, and integration into the community. QUALITY OF LIFE for older adults is greatly enhanced by their involvement in planning, sponsoring, and evaluating programs and services in institutional, outpatient, and community settings.

The QUALITY OF LIFE of the elderly depends on various factors such as physical health, psychological health, the living arrangement and level of independence, personal and social relationships, working capacity, access to health and social care, home environment, transportation facilities, and the ability to acquire new skills. There is a dearth of literature related to QUALITY OF LIFE of senior citizens in rural and urban areas living with their own family members, and this study attempted to bridge the gap.

Methodology

This study was intended to compare the QUALITY OF LIFE of senior citizens in rural and urban areas of Chittoor District and hence a nonexperimental descriptive survey design was used. The study was conducted in selected wards of Chittoor District under Panchayat and Municipal administration. The sampling technique used in this study was multistage random sampling.

Senior citizens from urban areas were selected by the following method. The Chittoor District was divided into urban and rural zones according to the administration as the first stage. There are two municipal corporations namely Chittoor and Tirupathi, six

municipalities in Chittoor District, namely, Kalahasti, Nagiri, Palamaneru, Pungunooru, Puttoor and Madanapalle. From these, Chittoor municipality was selected randomly by lottery method as the second stage. There are Fifty wards for the Chittoor municipality. From the list, four wards namely, Murakambattu, Muthirevula Doddipalle, and Kattamanchi (approximately 10%) were selected randomly as the third stage. The fourth stage includes a selection of senior citizens. Systematic random sampling was used to select thirty subjects from each ward. A sampling frame of senior citizens was prepared for each ward based on voter's list. The sampling interval width (k) was established by dividing the size of the population (N) by the required sample size (n). The number of senior citizens in each ward varies from 70 to 90, and the required sample size was 30 per ward. The first subject was selected randomly from the list, and every k^{th} senior citizen was selected accordingly. The same procedure was repeated in other three wards, and thus 120 subjects formed the sample from an urban area.

The same method was followed for the selection of senior citizens from the rural area. There are 1372 Grama Panchayats in Chittoor District. Out of that, eight (approximately 10%) Grama Panchayats were randomly selected by lottery method as the second stage. The selected Grama Panchayats were Gudupalle, Grurram konda, K.V palli, Kalakada, Yerravari Palem, Pallepattu, Pulicherla, and Pakala. Each Grama Panchayat has got 12–30 wards and altogether there are 162 wards. As the third stage, 13 wards (10%) were again selected randomly by lottery method. The fourth stage included selection of subjects by systematic random sampling method. A sampling frame of senior citizens was prepared for 13 wards based on voter's list. The sampling interval width (k) for each ward sample was established by dividing the size of the population (N) of that ward by the required sample size (n). The number of senior citizens in each ward varies from 120 to 150, and the required sample size from each ward was 64. Then, the first subject was selected randomly from the list, and every k^{th} senior citizen was selected. The same procedure was repeated in other 12 wards to comprise 830 senior citizens from the rural area.

The data were collected by the investigator first from the urban areas and then from the rural areas. The sociodemographic data sheet was prepared to collect information regarding personal, health, social, and spiritual aspects of the senior citizens.

The QUALITY OF LIFE of senior citizen was assessed by WHO QUALITY OF LIFE-BREF-26. This tool focuses on client's life during past 2 weeks. The WHO QUALITY OF LIFE-BREF contains a total of 26 questions. The first two questions deal with the overall perception of QUALITY OF LIFE and overall perception of health. The remaining 24 questions are included under four domains. The domains of the tool are physical health, psychological health, social relationships, and environment. All items were rated on a 5-point scale with a higher score indicating a higher QUALITY OF LIFE. It is a standardized tool and the Cronbach's alpha coefficients ranged from 0.73 to 0.81 indicating good internal consistency among the items within a domain. The investigator obtained approval from Institutional Review Committee, Medical College, Chittoor and received written informed consent from all participants of the study.

Results

Table 1: Frequency distribution and percentage of senior citizens based on exercises performed, preference on diet, immunizations received, and system of treatment followed (*n*=950)

Health data	Frequency (%)	
	Rural (*n*=830)	Urban (*n*=120)
Place of seeking medical help		
Government hospital	276 (33.3)	50 (41.7)
Private hospital	554 (66.7)	70 (58.3)
Frequency of medical consultation		
Monthly	114 (13.7)	20 (16.7)
Quarterly	107 (12.9)	9 (7.5)
Half yearly	78 (9.4)	5 (4.2)
Annually	18 (2.2)	1 (0.8)
Whenever illness occurs	509 (61.3)	85 (70.8)
Never	4 (0.5)	0 (0.0)
Distance to medical care facility (km)		
<1	156 (18.8)	23 (19.2)
2-3	516 (62.2)	92 (76.7)
4-5	125 (15.1)	5 (4.2)
>6	33 (3.9)	0 (0.0)
Geriatric welfare clinic		
Available	0 (0.0)	0 (0.0)
Not available	830 (100.0)	120 (0.0)

Table 2: Frequency distribution and percentage of senior citizens based on age, gender, marital status, education, employment status, monthly income and cohabitation (n=950)

Personal data	Frequency (%)	
	Rural (*n*=830)	Urban (*n*=120)
Age (years)		
65-75	542 (65.3)	78 (65.0)
76-85	247 (29.8)	35 (29.2)
86-95	41 (4.9)	7 (5.8)
Gender		
Male	320 (38.6)	40 (33.3)
Female	510 (61.4)	80 (66.7)
Marital status		
Unmarried	9 (1.1)	2 (1.7)
Married	514 (61.9)	66 (55.0)
Widowed	300 (36.1)	51 (42.5)
Divorced	2 (0.2)	1 (0.8)
Separated	5 (0.6)	0 (0)
Education		
No formal education	41 (4.9)	7 (5.8)
Primary	470 (56.6)	48 (40.0)
Secondary	240 (28.9)	54 (45.0)
Pre-degree	22 (2.7)	6 (5.0)
Graduation and above	57 (6.9)	5 (4.2)
Employment status		
Employed	215 (25.9)	57 (47.5)
Unemployed	615 (74.1)	63 (52.5)
Monthly income (rupees)		
Below 1000	172 (20.7)	38 (31.7)
1001-3000	273 (32.9)	13 (10.8)
No income	385 (46.4)	69 (57.5)
Cohabitation		
With spouse	120 (14.5)	15 (12.5)
With children	285 (34.3)	48 (40.0)
With spouse and children	371 (44.7)	48 (40.0)
With sibling/friend/servant	34 (4.1)	5 (4.2)
Alone	20 (2.4)	4 (3.3)

Table 3: Frequency distribution and percentage of senior citizens according to place of seeking medical help, frequency of medical consultation, distance to medical care facility, availability of geriatric welfare clinic (n=950)

Health data	Frequency (%)	
	Rural (*n*=830)	Urban (*n*=120)
Place of seeking medical help		
Government hospital	276 (33.3)	50 (41.7)
Private hospital	554 (66.7)	70 (58.3)
Frequency of medical consultation		
Monthly	114 (13.7)	20 (16.7)
Quarterly	107 (12.9)	9 (7.5)
Half yearly	78 (9.4)	5 (4.2)
Annually	18 (2.2)	1 (0.8)
Whenever illness occurs	509 (61.3)	85 (70.8)
Never	4 (0.5)	0 (0.0)
Distance to medical care facility (km)		
<1	156 (18.8)	23 (19.2)
2-3	516 (62.2)	92 (76.7)
4-5	125 (15.1)	5 (4.2)
>6	33 (3.9)	0 (0.0)
Geriatric welfare clinic		
Available	0 (0.0)	0 (0.0)
Not available	830 (100.0)	120 (0.0)

Table 4: Frequency and percentage of senior citizens in rural and urban areas based on overall perception of quality of life (n=950)

Overall perception of QOL	Frequency (%)	
	Rural (*n*=830)	Urban (*n*=120)
Very poor	7 (0.8)	0 (0.0)
Poor	74 (9.0)	9 (7.5)
Neither poor nor good	295 (35.5)	36 (30.0)
Good	424 (51.1)	64 (53.3)
Very good	30 (3.6)	11 (9.2)
Total	830 (100.0)	120 (100.0)

QOL: Quality of life

Table 5: Frequency and percentage of senior citizens in rural and urban areas based on overall perception of health (n=950)

Overall perception of health	Frequency (%)	
	Rural (*n*=830)	Urban (*n*=120)
Very poor	25 (3.0)	1 (0.8)
Poor	276 (33.3)	35 (29.2)
Neither poor nor good	171 (20.6)	21 (17.5)
Good	349 (42.0)	55 (45.8)
Very good	9 (1.1)	8 (6.7)
Total	830 (100.0)	120 (100.0)

The majority of senior citizens in rural (51.1%) and urban areas (53.3%) rated their overall perception of QUALITY OF LIFE as good.

The majority of the senior citizens in rural (42%) and urban areas (45.8%) also rated their overall perception of health as good. The findings in [Table 8] show that the urban senior citizens expressed a better QUALITY OF LIFE than rural senior citizens in all the four domains. Both rural and urban senior citizens scored high in environment domain (13.82 and 14.88) and low in physical health domain (12.21 and 13.09).

There was a statistically significant difference in the overall perception of QUALITY OF LIFE and health between the rural and urban senior citizens ($P < 0.05$ for both). There was a statistically significant difference between the senior citizens in rural and urban areas in all the domains of QUALITY OF LIFE ($P < 0.05$) except the social relationship domain ($P > 0.05$).

Discussion

This study revealed that majority of senior citizens belonged to the age group 65–75 years both in rural (65.3%) and urban (65%) areas. A study on senior citizens in rural areas showed that 66% of study subjects belonged to the age group of 65–75 years. Similar finding was also shown in a study conducted in a geropsychiatric clinic., Females formed the major group (rural 61.4% and urban 66.7%) compared to males. Similar finding was observed in studies conducted in Andrapradesh., Moreover, the greater life expectancy of females compared to males also might be a reason for this finding. Majority of study subjects in rural (61.9%) and urban (55%) areas were married and living with their spouses. This is the true reflection of Indian culture where spouses live together until their last breath. Similar observations were made by the investigators in their study on senior citizens in rural areas. Majority (56.6%) of senior citizens in rural areas had primary education, whereas 45% of them in urban areas had a secondary level of education. This finding is in consistent with previous studies. Majority of senior citizens (rural 74.1% and urban 52.5%) were unemployed during the time of data collection. Similar finding was observed in studies, where the majority of senior citizens were unemployed. Furthermore, old age may be considered as a period of rest and relaxation. Majority of senior citizens in urban areas (57.5%) had no regular income, whereas 53.6% of study subjects in rural areas had monthly income between Rs. 1001–3000. This finding was supported by the previous studies. A major percentage of senior citizens in rural (44.7%) and urban areas (40%) lived with their spouse and children's family. This finding was in tune with a previous study where 51.1% senior citizens lived in extended families, 35.5% in nuclear families, and only 13.3% in joint families. Majority of senior citizens in rural (47.1%) and urban (43.3%) areas were engaged in household activities. This might be due to the fact that, in Andrapradesh, both men and women go for work and thus senior citizens at home were engaged in rearing of grandchildren and other household activities. Awareness about the primary prevention of illness among senior citizens and the need for a regular health check-up were less, and they followed allopathic system of treatment considering its quick relief and convenience. A major percentage of senior citizens in rural (66.7%) and urban (58.3%) areas sought medical help from private hospitals, and they consulted the physician only when illness arise. Similar finding was observed in a previous study. The concept of geriatric care facility has yet to come in the country as in developed country.

Majority of study subjects in rural (90.6%) and urban areas (97.5%) were not involved in any social activities and not having membership in social clubs (89.5% and 100%). During old age, people might have preferred to sit idly at home. Majority of senior citizens in rural and urban areas (71.1% and 75%) engaged in watching television and listening to music during their leisure time. It was observed in Andrapradesh that almost every house has a television irrespective of their economic status, and entertainment programs are available from various channels for 24 h. Most of these programs are good sources of entertainment for the senior citizens and hence they spent quite a lot of time in watching television and listening to music. Elderly in a rural population have been observed to enjoy their leisure time at home. A study on psychosocial problems and utilization of leisure hours of aged persons revealed that the group of elderly persons who were engaged in meaningful leisure time activities felt less psychosocial problem than those without meaningful leisure time activities. Majority of senior citizens (rural 66.3% and urban 65%) did not feel social isolation because most of them either lived with their spouse or children or grandchildren. This finding was supported by a previous study. Both the groups (99.1% rural and 99.2% urban senior citizens) believed in God. In a study to assess the needs of elderly, 80% of them perceived the spiritual need as the most important need.

In this study, majority (51.1%) of senior citizens in rural and urban areas (53.3%) rated their overall perception of QUALITY OF LIFE as good. This study also elicited that majority of senior citizens in rural (42%) and urban areas (45.8%) rated their overall perception of health as good. The urban senior citizens expressed a better QUALITY OF LIFE than rural senior citizens in all the four domains. Both rural and urban senior citizens scored high in environment domain (13.82 and 14.88) and low in physical health domain (12.21 and 13.09). Furthermore, the urban senior citizens expressed better health than the rural senior citizens. Although there are no studies to substantiate, it could be assumed that the health status of an individual might have an influence over QUALITY OF LIFE.

This study indicated that there was a statistically significant difference between the senior citizens in rural and urban areas in all the domains of QUALITY OF LIFE ($P < 0.05$) except the social relationship domain ($P > 0.05$). The urban samples expressed a better QUALITY OF LIFE. In a study to find out the health-related QUALITY OF LIFE among elderly in urban, rural, and island community in Taiwan showed that the urban elderly population had the greatest health-related QUALITY OF LIFE, particularly on the physical health. The remote island elderly population had the highest scores on the vitality and mental health, whereas the rural elderly population had the poorest health-related QUALITY OF LIFE, particularly rural women. An Indian study showed that senior citizens in various age groups differed significantly in the domains of physical, psychological, and social relations, whereas single and married subjects differed significantly in the domains of environmental and social relations.

Since the terminally ill and bedridden senior citizens and senior citizens with severe hearing impairment were excluded from the study, their QUALITY OF LIFE could not be assessed. The study was limited to one district of Andrapradesh alone and hence the findings could not be generalized.

Conclusion

This study depicted that senior citizens in urban areas were having better QUALITY OF LIFE than the senior citizens in rural areas. In India, the population of senior citizens is high in rural areas where the health care facilities are very minimum. Hence, policies and programs related to senior citizens should be launched in rural areas without neglecting the needs of urban senior citizens. Training of voluntary workers, health care professionals, and family members on the care of senior citizens should be implemented. To enhance the QUALITY OF LIFE of senior citizens, several things can be done including formulating self-help groups in the local area with the help of voluntary organizations or village level workers, setting up multidisciplinary geriatric clinics all over the country in all health care settings both in public and private sector so as to manage specific age-related problems, conducting regular health check-up camps, and immunization programs for the senior citizens at village level, financially supporting all needy senior citizens through pension schemes and arranging counselling programs for the senior citizens and family members.

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