

Subjective Well-being, Perceived physical and Mental Health Status of Elderly: A comparative Study in Urban and Rural India

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Abstract

Introduction: Good physical health, mental health and wellbeing are important factors in the lives of the aged. With this thought, this study was aimed to assess and compare subjective wellbeing, perceived physical health problems and mental health status of elderly living with families in urban and rural areas, and to determine the relationship of subjective wellbeing with perceived physical health problems and mental health status. *Methodology:* This descriptive comparative study included 100 elderly from Moradabad, Uttar Pradesh. For measuring subjective well-being, Subjective Well-being Inventory (SUBI) by Sell and Nagpal (1992) was used and structured tool to assess perceived physical health problems and mental health status of elderly was developed. Data were interpreted by descriptive and inferential statistics. *Results:* Results revealed no significant difference between the subjective well-being of elderly living in urban and rural areas. The most common perceived physical health problems among elderly in both urban and rural areas were general health problems, sensory (Eye, ear and nose) problems, cardiovascular problems, musculoskeletal problems. Both urban and rural elderly had fair mental health status and a significant negative correlation was found between subjective well-being and perceived physical health problems in both areas. Also, a significant positive correlation was found between subjective well-being and perceived mental health status of elderly living in urban and rural area.

Keywords: Subjective Wellbeing; Perceived Physical Health Problems; Mental Health Status.

Introduction

Ageing is a universal process which every living organism has to pass through as a biological imperative life [1]. Ageing is an inevitable consequence of life. Every organism that is born must grow old and eventually die. Human beings are no exception. Population ageing is the most significant emerging demographic phenomenon in the world today. Aging is characterized by many changes, particularly in the occupational and financial domain, in physiology, and in health, including psychological and social domains. Such changes influence the well-being of elderly persons and tend to lessen the physical and mental capacity of elderly individuals to cope with the rigors of daily living [2].

Many older people enjoy life, but a significant proportion struggle with loneliness, isolation, low-level mental health problems like depression or even more serious problems that lead to suicide. Certain groups of older people are at more risk of poor wellbeing than others: these are typically the poorest, the very elderly, some minority ethnic groups, the most isolated, those with worse physical health, and, the most significant though often neglected, those without an active social or community life [3]. At present, the elderly population in many countries is facing several problems of which deteriorating health is the most important. It is true among elderly population of India also. Health and wellbeing are a major concern in later life because, it is the most important factor in predicting life satisfaction and wellbeing of the aged. Moreover, advanced age is always associated with poor health, illness and disability [4].

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With 1.21 billion inhabitants counted in its 2011 census [5], India has become the second most populous country in the world. The census also informs that the 60+ population accounts for 7.5% of India's population, translating into roughly 93 million people. It is anticipated that by 2050, the share of the 60+ population is projected to climb to 19%, or approximately 323 million people. The elderly dependency ratio (the number of people aged 60 and older per person aged 15 to 59) will rise dramatically from 0.12 to 0.31 [6]. While the Southern states (Andhra Pradesh, Karnataka, Kerala, and Tamil Nadu) may be considered the biggest drivers of aging in India, other Indian states (notably Haryana, Himachal Pradesh, Maharashtra, Orissa, and Punjab) are also experiencing an elderly population boom, largely in rural areas [7]. 7th April is celebrated as World Health Day. In 2012, WHO highlighted the importance of elderly health and the theme for the year 2012 was: 'Ageing and Health'; to which each and every one of us can relate. Using the slogan "Good health adds life to years", campaign activities and materials focus on how good health throughout life can help older men and women lead full and productive lives and be a resource for their families and communities [8].

Need of the Study

As interest in the study of aging is age-old, every culture had made its own agenda and ways of handling the problem of aging. However, interest in the scientific approach to gerontological issues among researchers is of recent origin. In comparison with the long and continuous history of research in the general area of adjustment to various stages in the human life cycle, the concern of adjustment of older people is relatively a new area of research. In the West, the research on adjustment to aging has gained recognition as one of the major areas of research, in theory building and intervention. In India, the study of aging is now getting considerable scientific attention not only from medical practitioners and demographers but also from nursing, social scientists and psychologists [9].

So, the present researcher was also interested in the few aspects of the old age problem. Though many studies have been done on subjective well-being, physical and mental health problems, quality of life and level of satisfaction, there are very few nursing research studies done to identify elderly person's perceived physical health problems, mental health status and concept of well-being in the rural and

urban population. The investigator especially wants to explore how the perceived physical health problems and mental health status affect the well-being status of elderly living in rural and urban areas so that need based health care services can be organized and provided in rural and urban areas.

Therefore, the investigator feels the need to conduct a comparative study to determine the well-being status and its relation to the perceived physical health problems and mental health status of elderly living with families in rural and urban area of district Moradabad, Uttar Pradesh.

Methods

The research approach in this study was quantitative approach with non experimental comparative descriptive research design to determine the subjective well-being and its relation to the perceived physical health problems and mental health status of elderly living with families in selected rural and urban areas of district Moradabad, Uttar Pradesh. Total Sample consisted of 100 elderly above 65 years of age living with families, 50 from selected rural area and 50 from selected urban areas of district Moradabad, Uttar Pradesh and the sampling technique used was convenient sampling technique. Structured interview schedule was used to collect the data. Content validation of interview schedule was done by seven Nursing and Psychiatric experts. The interview schedule was divided into four sections: Section one comprised of items pertaining to socio-demographic data of the subjects. Section two was Subjective Well being inventory (Standardized tool) developed by Sell and Nagpal (1992) contained 40 items. Section three comprised of 87 items to assess the perceived physical health problems of elderly. Section four contained 40 items to assess perceived mental health status of elderly. Administrative approval was taken from the concerned authorities and informed consent was taken from the subjects. The data obtained was subjected to analysis using descriptive and inferential statistics.

Results

Section 1:

The data presented in the Table 2 depict mean, median and standard deviation of subjective well-being of the elderly living with families in rural and

Table 1: Description of Demographic Characteristics of the Study Subjects Living in Urban and Rural Areas

Sample Characteristics	Urban Area (n ₁ =50)		Rural Area (n ₂ =50)	
	Frequency	Percentage (%)	Frequency	Percentage (%)
Age				
65-70 yrs.	24	48	17	34
71-80 yrs.	16	32	20	40
Above 80 yrs	10	20	13	26
Gender				
Male	36	72	24	48
Female	14	28	26	52
Educational Status				
Illiterate	22	44	39	78
Primary	12	24	8	16
Secondary	7	14	2	4
Higher secondary	5	10	0	0
Graduation	4	8	1	2
Post graduation and Above	0	0	0	0
Marital Status				
Married	37	74	23	<46
Unmarried	2	4	0	0
Divorced	0	0	0	0
Death of spouse	11	22	27	54
Religion				
Hindu	20	40	27	54
Muslim	25	50	21	42
Sikh	5	10	2	4
Christian	0	0	0	0
Any other	0	0	0	0
Source of Income				
Pension	9	18	3	6
Re-employed	2	4	0	0
Dependent on spouse/ children/relative	27	54	35	70
Investment in property/ bank etc	6	12	0	0
Business	5	10	3	6
Agriculture	1	2	9	18
Activity status				
Socially active	30	60	35	70
Home bound	20	40	15	30
No. of Children				
Nil	4	8	0	0
1	0	0	2	4
2	5	10	2	4
3 or more	41	82	46	92
Type of family				
Joint family	30	60	33	66
Nuclear family	17	34	17	34
Extended family	3	6	0	0

Section 2: Findings Related to Subjective Well-being of Elderly living in Urban and Rural Areas.

Table 2: Mean, Median, Standard Deviation, Mean difference, Standard Error of Mean Difference and 't' value for Significance of Mean difference between Subjective Well-being Scores of Elderly Living with Families in Urban and Rural Areas

Group	Mean	Median	Well-Being Score		SE _{MD}	't'
			Standard Deviation	Mean D		
Elderly living in urban area (n ₁ =50)	83	81	14.16	6	3.18	1.88
Elderly living in rural area (n ₂ =50)	77	78	17.55			

n₁+n₂=100

't' (98) =1.98, p ≥ 0.05, not significant at 0.05 level of significance

Section 3: Findings Related to Perceived Physical Health Problems of Elderly Living in Urban and Rural Areas

Table 3: Mean, Modified Mean and Rank Order of Perceived Physical Health Problems of Elderly Living with Families in Urban and Rural Areas

Category	Elderly Living in Urban Area (n ₁ =50)			Elderly Living in Rural Area (n ₂ =50)		
	Mean	Modified mean	Rank	Mean	Modified mean	Rank
General health problems	0.58	0.44	I	6.66	0.56	I
Sensory (Eyes, Ears and Nose) problems	5.46	0.36	II	4.62	0.30	III
Mouth , Throat' and 'Gastrointestinal' Problems	4.02	0.21	IX	3.98	0.21	VIII
Cardiovascular Problems	2.36	0.24	VII	2.5	0.35	II
Respiratory problems	1.1	0.18	X	1.22	0.20	IX
Urinary Problems	2.28	0.32	IV	1.77	0.25	VI
Musculoskeletal Problems	2.94	0.35	III	2.34	0.26	V
Endocrine problems	0.94	0.23	VIII	0.54	0.14	X
Central Nervous System	1.52	0.25	VI	1.34	0.22	VII
Reproductive system problems	0.58	0.29	V	0.54	0.27	IV

n₁+n₂ =100

urban area. The findings showed that mean subjective well-being of the elderly living in the urban area (83) was higher than the mean subjective well-being of the elderly living in rural area (77). The total mean scores of elderly living in urban as well as in rural area was found to be 83 and 77 respectively. These scores were lower than the normal mean score on normal adult Indian samples of 90.8 given in the manual of Subjective Well-being Inventory (SUBI), which indicated that the sample under study had slightly lower subjective wellbeing than the adult Indian sample, as given in the standardized SUBI. The median subjective well-being of the elderly living in urban area (81) was higher than the median subjective well-being of the elderly living in rural area (78), which means that the subjective well-being scores of elderly in urban area were more homogenous than subjective well-being scores of elderly living in rural area.

The obtained mean difference of 6 was found statistically not significant as evident from calculated

't' value of 1.88, which was less than the table value of 1.98, df (98) at 0.05 level of significance. Thus it can be inferred that the obtained mean difference was by chance. This shows that there was no significant difference between the subjective well-being of elderly living in urban and rural areas.

The data in the Table 3 and Figure 13 reveals that in urban area the common physical health problems perceived by elderly were general health system (0.44) followed by sensory (eyes, ears and nose) (0.36), musculoskeletal system (0.35) and urinary system (0.32) of the elderly. Whereas in rural area, the most common perceived physical health problems among elderly were related to general health, cardiovascular system, and sensory system with modified means of (0.56), (0.35) and (0.30) respectively.

Data presented in the Table 4 depicts mean, median and standard deviation of mental health status scores of elderly living with families in rural and urban area. The findings show that mean score of mental health status of the elderly living in the urban area (65) was

Section 4: Findings Related to Perceived Mental Health Status of Elderly Living in Urban and Rural Areas

Group	Perceived Mental Health Status Scores				SE _{MD}	't'
	Mean	Median	Standard Deviation	Mean D		
Elderly living in urban area (n ₁ =50)	65	69.5	16.85	5	3.31	1.51
Elderly living in rural area (n ₂ =50)	60	62.0	16.32			

't' (98) =1.98, p ≥ 0.05 , not significant at 0.05 level of significance

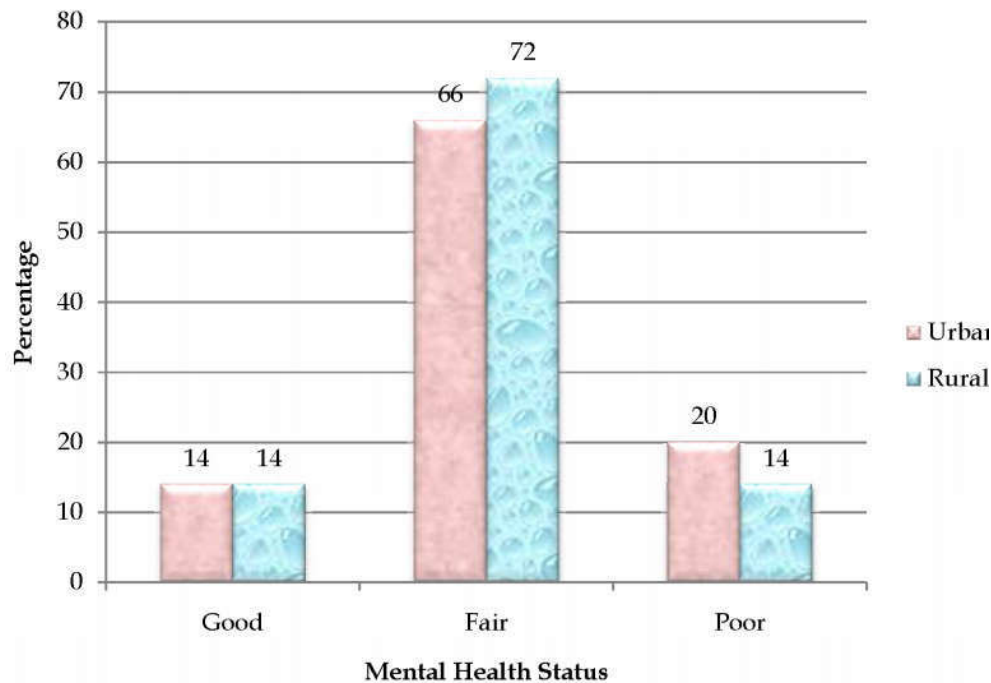


Fig. 1: Bar Diagram showing frequency and percentage of elderly living in urban and rural areas by their mental health status.

higher than the mean score of mental health status of the elderly living in rural area (60). The median of mental health status of the elderly living in urban area (69.5) was higher than the median of mental health status of the elderly living in rural area (62.0). The standard deviation mental health status of the elderly living in urban area (16.85) was a little higher than the standard deviation mental health status of the elderly living in rural area (16.32), indicating that the scores of elderly living in rural area were slightly more homogenous.

The mean difference of 5 was found statistically not significant at 0.05 level of significance as evident from the 't' value of 1.51, which was less than the table value of 1.98, df (98) at 0.05 level of significance.

Hence, there was no significant difference between mental health status of elderly living in urban and those living in rural area.

Section 5: Findings Related to Relationship between Subjective Well-being, Perceived Physical Health Problems and Mental Health Status of Elderly Living in Urban and Rural Areas.

The findings in table 5 show that there was a statistically significant negative (Inverse) correlation between subjective well-being and perceived physical health problems of elderly living in urban area as evident from the 'r' value of 0.38 (absolute 'r' value), which was more than the table value of 0.354, df (48)

Table 5: Correlation between Subjective Well-being and Perceived Physical Health Problems of Elderly Living in Urban and Rural Areas $n_1, n_2=100$

Group	Factor	Mean score	Standard Deviation	'r' value
Elderly living in urban area	Subjective well-being	83	14.16	-0.38**
	Perceived physical health problems	27	11.73	
Elderly living in rural area	Subjective well-being	77	17.55	-0.51**
	Perceived physical health problems	26	11.75	

** 'r' (48) =0.354, ≤ 0.01 level, significant at 0.01 level of significance

** 'r' (48) =0.354, ≤ 0.01 level, significant at 0.01 level of significance

Table 6: Correlation between Subjective Well-being and Perceived Mental Health Status of Elderly Living in Urban and Rural Areas $n_1+n_2=100$

Group	Factor	Mean score	Standard Deviation	'r' value
Elderly living in urban area	Subjective well-being	83	14.16	0.47**
	Perceived mental health status	65	16.85	
Elderly living in rural area	Subjective well-being	83	14.16	0.53**
	Perceived mental health status	60	16.32	

** 'r' (48) =0.354, $p \leq 0.01$ level, significant at 0.01 level of significance

** 'r' (48) =0.354, $p \leq 0.01$ level, significant at 0.01 level of significance

at 0.01 level of significance, indicating the lesser subjective well-being when the perceived physical health problems are more.

While in rural area also it was found that there was a statistically significant negative (Inverse) correlation between subjective well-being and perceived physical health problems of elderly as evident from the 'r' value of 0.51 (absolute 'r' value), which is more than the table value of 0.354, df (48) at 0.01 level of significance, indicating the lesser well-being when the perceived physical health problems are more.

The findings in Table 6 show that there was a statistically significant positive correlation between subjective well-being and perceived mental health status of elderly living in urban area as evident from the 'r' value of 0.47, which is more than the table value of 0.354, df (48) at 0.01 level of significance, indicating, the higher well-being is associated with the good mental health status.

While in the rural area also, it was found that there was a statistically significant positive correlation between subjective well-being and perceived mental health status of elderly living in urban area as evident from the 'r' value of 0.53, which was more than the table value of 0.354, df (48) at 0.01 level of significance, indicating, the higher well-being is associated with

the good mental health status.

Discussion

The findings of the study revealed that there was no significant difference between the subjective well-being of elderly living in urban and rural areas. This finding was in agreement of with those of Larson [10] that no difference in well-being was reported between urban and rural residence.

A study by Alam [11] indicates that a very large majority of the elderly suffer from curtailed functional abilities in physical (eating, bathing, dressing, walking, climbing stairs etc.) as well as in sensory (hearing and vision) health domains. Other studies by Kaur et al. [12]. Kaul K. An exploratory study of health problems encountered by elderly subjects and the health facilities provided to them in a selected urban area in Delhi. Unpublished Master of Nursing dissertation. University of Delhi; 1991 and Thakur, Banergee, Nikumb [13] also revealed that a majority of elderly persons reported vision impairment, hearing problem, general weakness, urinary problems etc. In the present study, problem in seeing, blurred vision, photophobia, generalized weakness, fatigue, increased

frequency of urination and lack of control over passing of urine were common problems among elderly.

The present study indicates that elderly living in urban area had a better mental health status as compared to the elderly living in rural area. These findings are in conformity to the findings of the UN report [14] on status of elderly in selected states of India, which reported that urban elderly had better mental health than the rural elderly.

In the present study correlational analysis revealed that there was a statistically significant negative correlation between subjective well-being and physical health problems. The findings of this study are in conformity with the findings reported by and Nagpal [15] and by Kashyap and Sidhu [16], who in their study found significant negative correlation between subjective well-being and physical health problems.

Data from the UN report [17] on status of elderly in selected states of India indicated that nearly half of the elderly have good mental health status. The report was found contrary to the present study that revealed that majority of the elderly from urban (66%) and rural (72%) had fair mental health status.

Conclusion

It can be concluded that condition of the elderly is poor in both urban as well as rural areas, in terms of poor health, poor accessibility to health care services and poverty. In order to sustain they have to earn their livelihood themselves even in the old age because either their progeny is economically poor themselves or because they have migrated to cities for earning their livelihoods. Hence, the elderly are left to fend for themselves in the villages. Major concern for the elderly is their physical problems and they are ignorant about the effects of these problems on their mental health status. So, there is a need to explore the concept of mental health status further. Because physical health problems and mental health status influence the well-being of an elderly. Therefore, it becomes necessary to identify the strategies that ensure better quality of life among the elderly.

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