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Perceiving Social and Economic Gerontology issues in Elder Healthcare

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Abstract

Population ageing, which implicate an increasing share of elderly persons in a population, represents an unprecedented global demographic transformation and expected to intensify as the twenty first century progresses. The biomedical view, ageing related to physical and mental deterioration of people. Morbidities endured by understanding the sustainability and curable factors. The imbalance occurred due to the very fact that what problems previously endured due to the medical advancement and often cured today. However, somewhere there is blurred line existing between these two important aspects of elderly health i.e. between curing and enduring the issues. In the existing scientific literature, the two commonest concepts discussed and reported are medicalization and bio-medicalization. However, the opposite concept contradicting to the abovementioned concepts operationalized and defined as demedicalization. The paper discussed the present issues of gerontology and knowledge on elder healthcare through available literature review.

Keywords: Eaging; Social; Economic; Healthcare.

Introduction

Population ageing, which implicate an increasing share of elderly persons in a population, represents an unprecedented global demographic transformation and is expected to intensify as the twenty first century progresses. Worldwide, the number of elderly (age 60 and above) are projected to surpass the number of children under the age of 14. (UN World Population Ageing, 2013 & 2017). This dominant demographic trend represents a historic achievement in terms of increased longevity but at the same time offers unpredictable challenges with profound implications on society, health, and the economy.

With roughly 1.36 billion inhabitants in 2019, India is projected to become the world's most populous country within the next six years. According to the 2011 census, people aged 60 and above accounted for 8.6% of the total Indian population, numbering 103 million elderly persons. The share of the elderly population is projected to further rise to 19.5% (319 million) by 2050 (UN Population Division, 2019).

The demographic and epidemiological transition in India has moved a major share of the country's burden of disease to the older population. The change from high rates to low rates in mortality and fertility that complemented socioeconomic development also meant a shift in the leading causes of diseases and deaths,

known as 'epidemiologic transition'. This is considered by the waning of infectious and acute diseases and the developing occurrence of chronic and degenerative diseases. However, infectious/parasitic diseases still pose significant trials to the public health system, causing India to bear a double burden of disease and consequently a significant share of the global burden of disease (Arokiasamy, 2018).

In older age, health needs, and demand for health services usage increase and the burden of chronic conditions and the elderly population are increasing, implying greater health care needs and appropriate provision of geriatric health services for the years to come (Xiaolong Z, et al., 2014).

India is in a phase of demographic transition. According to 2001 census, the population of the elderly in India was 57 million as compared with 20 million in 1951. There has been a shrill increase in the number of elderly persons between 1991 and 2001 and it has been projected that by the year 2050, the number of elderly people would rise to about 324 million.[1] India has thus developed the label of "an ageing nation" with 7.7% of its population being more than 60 years old. The demographic transition is endorsed to the decreasing fertility and mortality rates due to the availability of better health care services. It has been witnessed that the reduction in mortality is higher as compared with fertility. There has been a decline in the crude death rate from 28.5 during 1951–1961 to 8.4 in 1996; while the crude birth rate for the same time period fell from 47.3 to 22.8 in 1996.[2]Over the past decades, India's health program and policies have been focusing on issues like population stabilization, maternal and child health, and disease control. However, current statistics for the elderly in India gives a prelude to a new set of medical, social, and economic problems that could arise if a timely initiative in this direction is not taken by the program managers and policy makers. There is a need to highlight the medical and socio-economic problems that are being faced by the elderly people in India, and strategies for bringing about an improvement in their quality of life also need to be explored.

Gerontology Issues Facing Elder Health Care

The growing 65andolder population doesn't just mean more patients for advanced practice registered nurses (APRN) to treat. As people grow old, they run a greater risk of developing multiple chronic issues. Having one chronic illness to treat is almost expected; 8 in 10 people have a minimum of one chronic disease by 65, consistent with the National Council on Aging. However, treating multiple chronic issues that affect a patient's physical or psychological state could make creating a customized health strategy more complex.

The projected increase in elderly patients also means a greater need for care strategies geared toward the demographic, like assisted living or long-term care. These strategies must consider socioeconomic factors, as patients could also be reluctant to offer up independence or have financial limitations that impact the extent of care they will receive.

Geography also can pose a challenge to providing quality care to elderly patients. A disproportionate number of older individuals sleep in the country's rural areas, where access to geriatric specific care could also be scarcer compared with major metropolitan areas. This might make it difficult for these individuals to receive specific treatments for chronic conditions or maybe locate nearby assisted living facilities. Nurse leaders can mitigate this issue by providing care during areas where seeing a physician in a timely manner can pose a challenge.

Mostly, the development round the ageing assumes that there are an inevitable bodily and mental declines and a consequent need of health and healthcare and thus an ageing process is taken into account as a posh social problem, which claimed to be resolve mostly through (bio) medical management. The critical aspects of geriatrics necessarily should accommodate both the structural inequalities that are existing within the society and therefore the personal experience of the ageing, because both are essential fundamentals for the articulation of the problems and concerns surrounded by the ageing experiences.

The biomedical view related to ageing population related physical and mental deterioration and morbidities with lack of understanding which are curable ones and to what extent and which are those should be endured. And this imbalance occurred due to the very fact that what problems previously can only be endured, due to the medical advancement, today an equivalent are often cured. But somewhere there's blurred line existing between these two important aspects of elderly health i.e. between curing and enduring the issues.

The conceptualization of ageing has progressed over the intervening years and embrace a multidisciplinary approach (Settersten and Angel 2011). Different domains like Psychologists, sociologists, anthropologists, biologists, also as medics and social workers still theorize about ageing and propose an evidence in reference to the key concerns of an ageing globally. Ageing and being aged, both viewed as a negative condition to be managed by multi-disciplinary approach of gerontology. Gerontology embraces a sociological, psychological also as a biological basis; though is usually dominated by the latter i.e. biological one.

According to WHO (2012), despite increasing involves "healthy ageing" and a life course approach; ageing experience continues to be dominated by a "deficit", dysfunctional or biomedical approach.

Understanding towards an equivalent has progressed and gain relevance over the years. This rapid climb within the domain of
ageing research has made various important theories and are important to continue our go after more exploration and understanding to the uncovered facts and unaddressed associated components that intrudes on the growing up process (Powell, 2009). The dynamic aged related to continuous changes that varies and don't occur uniformly among the individuals. These changes rather influenced by genetic, environmental and socio-cultural factors which adds to the complexity of mentioning a universal theory. There are different school of thoughts who works round the theorization of ageing and theoretical understanding that has shaped up by critical analyzing and reviewing different perspective that exists around ageing.

Contextualizing Elderly health and healthcare:

The World Health Organization (WHO) defined health as a state of complete physical, mental and social well-being. This definition presents the holistic view and therefore the focus shifted from a strict medical orientation on health to the subjective well-being of the population, drawing on physical, mental and social perspectives. WHO's definition contradicted the biomedical, categorical model of health, which looks at health and ill-health as static opposites where the absence of illhealth equals the presence of health (for example Boorse, 1977). In 1987 a fourth health dimension of spiritual well-being was introduced (Mahler, 1987).

In line with the multidimensional view of health status, consistent with the salutogenetic model that defined health which describes the wide continuum between health and ill-health (Antonovsky, 1979, 1987). Within this attitude, the health status is dynamic and influenced by both dimensions on the continuum. The key concepts of this model are people's health resources and their capacity to both comprehend their situation and use the health resources available so as to deal with ill-health and other stressors in life (Antonovsky, 1979, 1985, 1987; Lindström & Eriksson, 2005).

In line with the salutogenetic model and its contribution to the theoretical frameworks of the health concept, Keyes (2003; 2005) outlines the positive, multidimensional perspective by introducing the two-continuum model of psychological state. Keyes emphasises that individuals can suffer from symptoms of mental illhealth and simultaneously experience mental wellbeing. He uses the term flourishing, which is defined as a state of complete psychological state during which people feel positive emotions towards life and are emotionally, socially and psychologically functioning well. Consistent with this attitude, the other of flourishing is languishing, which may be a state of experienced dysfunction despite absence of mental disorders a state between complete psychological state and mental disorders at the opposite end of the psychological state continuum (Keyes, 2002).

Elderly individuals tend to conceptualize health as mainly functional capability instead of the 'physical fitness' (Blaxter 1990) and have a tendency to possess lower expectations of health compare to those in time of life (Blaxter and Paterson 1982). In one among the recent studies, it had been found that the elderly population won't to adjust their expectations of what constituted healthiness because they aged is that the understanding health as the cordial interaction between themselves and their surrounding environment (Ebrahimi et al. 2012).

While exploring the elderly view about their own health, their expectation and responses that changes as they age, has been found that there are few key belief pathways that gives the idea for elderly to attribute certain problems to their ageing process than to disease or illness ones. When exploring these belief pathways, very first found that the health problems and deterioration are seemed to constitute a 'normal' a part of ageing; for instance, with reference to symptoms concerning certain body systems, like the eyes, ears and urogenital system (Group et al. 1987). Second, symptoms not considered significant enough to stop activities of lifestyle aren't usually attributed to 'illness' (Group et al 1987); and lastly symptoms perceived as vague are often not attributed to 'illnesses. For instance, forgetfulness, tiredness, and low mood (Morgan et al 1997). These three beliefs are reinforced when health problems are increasingly observed in contemporaries (Sanders et al. 2002, Horrocks et al 2004) and should also explain why older adults with chronic illnesses give positive statements of their own level of health in contrast to more objective measures of morbidity (Blaxter 1990), and minimise the impact of illness on their lives in contrast to younger adults (Pound et al 1998, Sanders et al 2002).

Thus, it's evident that ideas, beliefs, and communication of health and illness could also be modified at older ages, but how it affects the next illness behaviours? The responses of the older towards health problems, it's been suggested that their experience and knowledge accumulated with age provides a particular perspective (Stoller et al 2011).

Regarding the assistance seeking among the elderly, there's a dichotomy that exists within existing literature. It's observed that the help-seeking among the adults aged 60 and above is either reduced or delayed in response towards particular problems (Group et al 1987, Sanders et al 2002, Horrocks et al. 2004, Corner et al 2006). This thought raised from the three key beliefs described above; 'normal', inevitable ageing processes aren't considered amenable to medical treatment (Group et al. 1987, Morgan et al 1997); and a symbol that's vague or doesn't prevent the conduct of necessary functional activities doesn't warrant for medical attention.

Furthermore, the explanations for delayed helpseeking include attributing the symptom to a different pre-existing condition, and not eager to waste a doctor's consultation and time (Corner et al.2006). However, in others studies, it's argued that help-seeking occurs more readily after perceiving a symbol than for younger adults (Leventhal et al 1995) as a part of a strategic adoption of 'resource conservation' and avoidance of uncertainty with increasing age.

Whether, when and where individual seek help it's a phenomenon that has been attributed to shape beliefs and subsequent use of health care or non-healthcare among the elderly cohort may be a moral approach for managing health and illness (Blaxter and Paterson 1982, Cornwell 1984).

In this older segment of the population, problems might be perceived as 'normal' illnesses for e.g. common infections, like cold cough, 'real' illnesses those considered to be potentially life threatening and severe like cancer, diabetes, and heart conditions and therefore the health problems which aren't illnesses and thought of to be occurred as a results of 'natural to during processes. Each problem type was believed to possess a morally appropriate behavioural response and accordingly, health service to be search for.

Discourse of Medicalization and Demedicalization of elderly health and healthcare:

In the existing scientific literature, the 2 commonest concepts discussed or mention are medicalization and bio-medicalization. However, the opposite concept or process contradicting to the above-mentioned concepts is operationalized and defined as de-medicalization.

Broadly, the definition of medicalization given as follow: "to view a traditional physiological process or a event or behaviour as a medical concern, problem or disorder". On the opposite hand, de-medicalization are often considered because the obverse of the medicalization; an alternate point of view, where the individual experiences and perception shifts far away from the thought of illness and towards the thought of health as natural and obvious fact. De-medicalization defines on treat a medical concern, problem or disorder that's amenable to treatment (both cure or relief) as a physiological process or behaviour event. Within the purview of elderly health and healthcare; both medicalization and de-medicalization has significant influence on their health and pathways of seeking healthcare.

The concepts of medicalisation also as its corollary as de-medicalisation are much discussed in details within the existing literature in recent years. Among these studies, the prominent exemplars were Clarke et al., 2003; Conrad, 2005, 2007; Davis, 2009; Foucault, 1991; Freidson, 1970; Illich, 1977; Rose, 2006; Zola, 1972. Among the very initial attempt of defining the concept of the medicalization, Cornal, 1975 was the one who emphasized and argued that the method required both the medical definition of a social problem and medical dominion over that problem: medicalization means defining behaviour as a medical problem or illness and mandating the medical community to supply some kind of medical intervention appropriate for it. In one among another review articles by Conrad in 1992, where he de-emphasized the jurisdictional context of medicalization and given the subsequent definition of medicalization as: Medicalization consists of defining a drag in medical terms, using medical language to explain a drag, adopting a medical framework to know a drag, or employing a medical intervention to 'treat' it. The sociocultural process which will or might not involve the medical community, cause medical group action or treatment, or be the results of intentional expansion by the medical control over any event or behaviour. During this new formulation, medical treatment was one possible mechanism of medicalization but wasn't required for medicalization to occur. This definition soon became the foremost prominent one within the medicalization literature (Davis, 2006).

On the opposite side, de-medicalization defined because the obverse of medicalization (Conard, 1992). The recent research far overweighs on medicalization as compared to demedicalization also as on the restrictions of medicalization (Conard, 2007; Lee, 2003). After intense review of existing literature, the disparity within the research activity makes it obvious that there's probably more medicalization happening within the society than its corollary termed as demedicalization, but a number of the inattention to demedicalization is that the outcome thanks to the conceptual lacking within the medicalization literature.

Conard (1995) proposed a useful definition but under-used typology of medicalization. On elaborating an equivalent definition, Conard and Schneider (1980) presented the extent of medicalization. They postulate that medicalization cab occur at multiple level the conceptual level, the institutional level or organizational level and therefore the interaction level (Doctor patient interaction).

The first research examined medicalization of deviance: alcoholism, drug abuse, mental disability, etc. However, scientists identified that more and more humans' conditions which are considered as normal or natural became medicalized, and adulthood is one example of such alteration. The medicalization of adulthood manifests in various ways. First of all, adulthood itself and ageing process are defined as medical condition which should be treated (Estes and Binney, 1987; Weitz, 2010, Kaufman et al., 2004).

All these concepts raise the question that which of those concepts and the way and when it should be used

when it involves the elderly or aged population is analyzed? Also, it's worth exploring how these different concepts works around accessing healthcare also as in organization of service delivery.

Economic, Social and Cultural Capital: Interaction and its impacts on Elderly Health

The elderly health, healthcare needs and responses are influenced to great extent by the varied sort of capital like social, cultural and economic. The growing power and intersection between these capitals are significant to define and construct perceptions of the body, health, and illness happen during a multitude of process in one's own lifestyle. The cultural and social construction of ageing are closed entwined with the medical and non-medical construction round the ageing and every one are constitutive to at least one another.

There are enough studies done that indicated that both material and non-material resources are found with the health and risk of diseases (Marmot, 2000). These are the resources that are particularly and typically related to the individual's social position that has financial means and interpersonal support, often draw on theories of capital. Relevance of social and economic capital are considerably explored under health research (Szreter, 2004).

Social capital which is additionally measured for the instance through membership in support providing networks indicated relevant association with health outcomes (Kim, Subramanian and Kawachi, 2006). Social capital remains a crucial determinant of health. Probably the foremost enduring and incontrovertible for the category is that the differential in health status (Bennett et al. 2009) and thus, we'd like to conduct more research which is extremely necessary to completely understand the dynamic of the social capital in health (Mackenbach 2012). The relevance of theory of capital in understanding the varied dimensions and aspect of health. Individual with different social position with reference to their possession of various three sorts of capital term as social, cultural and economic capital, contribute because the resource in acquiring or maintaining health status.

People from different social positions differ from each other with reference to their possession of three sorts of capital: social, cultural and economic capital. Each of those sorts of capital are often considered as a resource which may be useful for acquiring or maintaining healthiness (Bourdieu, 1984). The resources needed to pick or adopt specific health-relevant lifestyles emerge from the interplay between economic, social and cultural capital. During this dynamic form social inequalities affect through collective behavioural variations people's health status and risks. (Abel, 2008).

Recently, there are studying seemed to be found Linking health inequality and cultural capital, where the arguments were mostly supported the culturally based activities, knowledge and perception that present a singular sort of health relevant capital. The term ''capital'' refers to resources generated by labour. Cultural capital often broadly defined as people's symbolic and informational resources for action (Bourdieu, 1992). Those resources (eg values, behavioural norms and knowledge) are mostly acquired through social learning, where learning conditions varying across the social classes, status groups or milieus (Swartz, 1997).

The concept of cultural capital is emerging and gaining attention in its application in health research. Linking cultural, social and economic capital variables enables to spot distinct social spaces within which different health indicators might be situated (Veenstra, 2007). Cultural capital refers to the operational skills, linguistic styles, values and norms that one accrues through education and lifelong socialization.

The interplay between the various sorts of capital also can be understood together of the operating principles within the processes resulting in social distinction, inequality and therefore the reproduction of class (Bourdieu, 1970). Economic, social and cultural resources are correlated and play and interact around one another. These different sorts of capital are often converted and take each other's form. For instance, when income (economic capital) is employed for advanced education (cultural capital). Interactions of those sorts of capital also can happen as intergenerational transmission of capitals. as an example, investment by the oldsters within the children's education. Further, children's higher educational status may later not only lead them to raised paid jobs, but even be instrumental in acquiring social capital, for instance by increasing their chances for membership in powerful networks and thus are often articulated as cultural sort of capital.

Cultural Capital: Its effect on Social and Economic Capital for Elderly Health

Social capital enables with an access to interpersonal support systems which will, among other benefits, be resourceful and relevant in matters of private health and community health action (Edmondson, 2003). For acquiring social capital and to sustain and use it, other resources are required. Beyond monetary resources, certain behaviour and value orientations expected to be a part of social capital- providing networks. Exchanging similar values, knowing the way to approach other members or person properly, the power to use appropriate language and communication styles are samples of non-material conditions and cultural techniques required to possess such social networks and use an equivalent within the direction of health and health seeking.

Cultural capital, once acquire such networks, also facilitates the utilization of social capital towards health gains. Within the sort of shared values and operational skills, cultural capital provides the means to actively participate in and enjoy social capital networks that provide interpersonal support in health matters. What this means is that specific cultural resources are mandatory within the acquisition and instrumental within the use of health-effective social capital.

Economic capital empowers individual with an option, which are mostly relevant to their health: paying for medical services or insurance plans, having the ability to afford to measure during a health promoting, supportive and safe neighbourhood etc. However, for people when operating within a given economic frame of options, cultural resources inherit play. This is often the case, for instance when health related values and norms, perceptions and knowledge guide people's health lifestyle choices. The available range of options for the health-relevant commodity depends on financial means, where cultural capital plays a key role for using those financial resources for specific healthy choices.

Economic capital approaches often come short of elucidating the social differences observed in those health behaviours that can't be explained by financial determination: unhealthy patterns of consumption like smoking, excessive eating or drinking or sedentary lifestyles are in large parts more determined by people's norms and values than by insufficient financial means. Income explanations alone provide no convincing answers to questions on how unhealthy lifestyles became normative in several groups, milieus and social classes.

Referring to the above examples, it appears reasonable to argue that cultural capital within the sort of values, perceptions, knowledge and behavioural norms is instrumental within the use of economic resources for health gains.

Effect of Economic and social resources on cultural capital for health

People's chances to acquire health effective cultural capital significantly increased in the presence of other types of capital. Whereas in isolation, social capital increase to accumulate health relevant cultural capital, for instance through informal access to health information, expert knowledge and advice. Memberships in networks or social groups have been found to improve health knowledge. Thus the acquisition of health relevant cultural capital is in major parts directly dependent on the availability of other types of resources, namely economic and social capital. Moreover, it draws attention to the fact that the resources needed to select or adopt specific health relevant lifestyles emerge from the interplay between economic, social and cultural capital.

Health and healthcare Inequalities among elderly

Aged and its related problems are perceived and understood during a multitude of various ways, often with important cultural variations, socioeconomic variation. These may include to physical appearance, key life events, for instance retirement or another sort of disengagement, or social roles grandparenthood, or ceremonial duties (Midwinter, 1991). As we mentioned and described, the aged are a really heterogeneous group, and consequently it's dangerous to generalize about their specific health needs Also, it's debatable whether longevity means a healthy active year or prolongation of the lives inconsiderately of health or just an extension of more years to measure with morbidity. Like younger age groups, elderly populations usually display complex patterns of disparity. No matter the connection between longevity and morbidity, and of health inequalities between the aged, it's clear that several diseases are strongly related to later life. (Fried & Wallace, 1992).

The share of deaths thanks to non communicable diseases is increasing within the Asia Pacific region. Cardiovascular diseases and cancers were the foremost common causes of death in 2012 (OECD and WHO, 2016). In India, about 42 per cent of all older persons suffered from a chronic condition thanks to non-communicable diseases in 2007, and therefore the rate was higher for ladies than for men.

Ageing doesn't only ask an individual's chronological or physiological age, but also the attitudes, viewpoints and belief towards ageing. The prevailing body of literature recognized the good heterogeneity among individual at every and different of life (Dannefer, 1988; Maddox, 1987) and there are of the factor that determine individual; behaviour, including consumption of care are beyond the control of the individual (Riley, Kahn, & Foner, 1994).

The heterogeneity and variety not only exist at individual level, but also it reflects within the social and cultural setting of the individual. The concept of who is an elderly comes as a results of interactions among individuals within the society. As far as assumptions and expectations on ageing cares, each culture holds its own perspectives or view-points on ageing, which altogether, is a component of socialization When reflecting on the cultural differences, one should considerate about the gratification it brings also because the opposite side of the coin. (Laroche 2003, p.6-8). Cultural difference has got to do with the differences of both visible and invisible aspects of two cultures or different cultures. As a results of culture being different in relative to a different culture, an equivalent culture could be perceived differently by people from diverse cultural backgrounds. These differences could also be as a results of different norms, believes and practices not being identical or same. People think, feel, act and react

differently, and it's these differences that distinguish one people or one society from the opposite. How people behave or interact might be shaped by their interaction with members of own culture as compared thereto of other cultures, education, longevity of stay during a country, class, and other personality traits.

In line with this, Bourdieu (1986) defines and uses the term cultural capital, which may be a concept that encompasses knowledge, skills, educational level and other similar advantages which raise an individual's status in society (Bourdieu, 1986). These also are important factors that influence how ageing people are perceived in their social context. Within the developed world the age and milestones usually mark life stages, while in many developing countries adulthood is taken into account to start when active contribution to society is not any longer possible and replaced with other social roles and assignments (Freund & Smith, 1997; Gorman, 1999).

Conclusion

The elderly health, healthcare needs and responses influenced to great extent by social, cultural and economic capitals. People from different social positions differ from each other with reference to their possession of three sorts of capital: social, cultural and economic capital. People's chances to acquire health-effective cultural capital significantly increased in the presence of other types of capital. Whereas in isolation, social capital increase to accumulate health relevant cultural capital, for instance through informal access to health information.

Aged and its related problems perceived and understood during a multitude of various ways, often with important cultural variation and socioeconomic variation. Ageing does not only ask an individual's chronological or physiological age, but also the attitudes, viewpoints and belief towards ageing.

The prevailing body of literature recognized the good heterogeneity among individual at every stage of life and factor that determine individuals' behaviour, including consumption of care, which are beyond the control of his own. These important factors that influence how ageing perceived in their social context. Within the developed world, the age and milestones usually mark life stages. Where as in many developing countries, adulthood taken into account to determine the active contribution to society. However, it is not any longer possible and replaced with other social roles and assignments.

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