Age Associated Disease Burden in Old Age Home and Residential Home in 21st Century-A Comparative Study

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Abstract

To map out disease burden among elderly people. In this study we see the pathological condition of the elderly who live in old age home and community home, that's who is promoting to another. Whole information was collected by interviewing method. Also assessing the disease condition of the older person with the help of pathological report. Food consumption pattern were assessed by the nature of diet and timing of that person. New area for exploring in the field of research among old age people was that who belong to their residential home but neglible in terms of health approach and their identification. Beside that old age home he/she facilitate and maintain their record for disease condition. This overview kept in mind new paradigm is seen in quality of life found in old age home. This raises a question among society people; old age home is better for elderly people. It safe old people inside their home to reduce the data of disease burden .Lastly but not least ,a danger sign for untold focus who lived there.

Keywords: Disease burden, pre and post condition.

Introduction

The World Health Organization (WHO) estimates that presently nearly 600 million people are living with disabilities worldwide. The world population is ageing. Over the course of the next fifty years, the share of the elderly (defined as those aged 65 years and above) is expected to climb from 6.9 percent in of the total population to 15.6 percent In countries that are considered "more developed" as per the UN definition, this share is expected to climb from 14.3 percent to 26.8 percent over the same period. The share of the elderly is expected to grow even more rapidly in the less developed countries of the world, rising from only about 5.1 percent of population in 2000 to 14.0 percent in 2050 as per projections of the United Nations[1]. The primary reason for the increase in the proportions of the elderly is the combination of ageing of the "baby-boom" generation that emerged from a demographic transition characterized by a decline in mortality rates (and subsequent declines in fertility rates) and increased survival rates at higher ages. Mortality rates have been continuously declining, so that life expectancy at birth in less developed countries increased from 41 years in the early 1950s to 62 years in the early 1990s. Even this is forecast to increase to 75 years by the year 2050 (United Nations 2001, p.10). One consequence of these trends is that we can expect a growing proportion of the "oldest-old" (85 years and above) in less developed country populations as well.

Among people ages 65 and older, minority and socioeconomically disadvantaged populations are much more likely than other groups to experience disability and the physical, cognitive, and sensory limitations that underlie it.

Disability prevalence increases rapidly with age, and women and those who are unmarried have much higher prevalence rates. The burden of disability clearly falls disproportionately on less advantaged groups[2].

The Global Burden of Disease Project combined information about death and illness to assess the total loss of healthy years of life due to disease and injury. Estimates from this project indicate that among people of all ages, non-communicable diseases account for a large share—85 percent—of the number of years spent in ill health in high-income areas including the United States and Western Europe.

Among people ages 60 and older, heart disease, cancer, and other chronic illnesses already account for over 87 percent of health problems globally. Chronic diseases associated with lifestyle and environment may progress into disability, but it is not clear that as we live longer more people will live with disabilities. In the next 10 to 15 years, heart disease, cancer, diabetes, and other chronic illnesses will produce greater declines in health and take more lives than infectious and parasitic diseases. This is a major shift in the pattern of causes and transmission of diseases[3]. The aging of the world's population is partly responsible for these changes. Many more people survive into adulthood and into old age, long enough for health behaviors such as

Poor diet or smoking, and environmental factors such as indoor pollution and stress, to take their toll.

Health improvements declines in age-specific mortality rates—would lead to fewer deaths globally. Health improvements related to infectious diseases, malnutrition, chronic diseases, and injuries are projected to reduce mortality globally. (HIV/AIDS is the exception to this pattern).

If the number of people over age 60 increases and mortality rates for this group remain the same, then the number of deaths will increase due to population aging. For most communicable diseases and for maternal, prenatal, and nutritional conditions, population aging should decrease the number of deaths globally. This change will occur largely because children tend to be most at risk of dying from these conditions. HIV/AIDS is again the major exception. Both population growth and aging are projected to add to the number of deaths from HIV/AIDS[4].

In response to the need for a universal definition and classification system for disability, the WHO published the International Classification of Functioning, Disability and Health (ICF) in 2001.10 the guide is an attempt "to provide a coherent view of different perspectives of health from a biological, individual and social perspective". Although the "burden" of a disease can be defined in a variety of senses, the consensus definition, particularly from the WHO, is a fairly specific one. GBD is defined by the WHO as a comprehensive regional and global assessment of mortality and disability from 136 diseases and injuries and 19 risk factors. It accounts for the morbidity and mortality to an individual that is caused by a specific disease. This information is aggregated into country level data to form the ''burden'', which can be viewed as the gap between current health status and an ideal situation in which everyone lives to old age free of disease and disability[5].

With the above view, the present study was conducted with the objective to assess the burden of disease among elderly, so as to check their health status with the disease which is highly stigmatized in our human population.

Objective of the study: To map out disease burden among elderly people.

Material and Methods

The desire sample size for this study was based on cohort study (purposive study). The required sample size drawn from a particular exposed factor though to be related to disease occurrence in old age. Beside another group consider for study was not exposed to that particular factor .Both above criteria determents the frequency of diseases among old age where consider to select as a sample study.

In the present study the study subject was 120. The consist of 60 +60 in number correspondely from old age home and residential home. To followed the study 60 years and above age group till before their aged was consider for the study purpose. Where used with those old people, she/he suffer from disease but not had any medical record because disease burden was measured only by one month back prescribed medical report only.

The present study is based on community survey that is field area work, the above sited have of cohort study now in the field area known as prospective study. They have distinguished feature to fulfill required sample size as a study purpose.

Results and Discussion

Here mention the diseases which were founded with the help of pathological record. As per register case in hospital were consider for disease. Which was included by doctor prescription and therapy, record (previous month of data only?)

In this table higher raise condition in gout was nineteenth (15.85%) out of 120, in that find out the major strength was in residential home. Similar ratio of disease find out between piles (1.67%), nephritis and cancer, especially in men respectively. A minor disease find out only in cirrhosis one (0.85%) especially female who live in old age home.

Table-1.1
Distribution as per Life Style Disease in respondents

Life Style Disease	Old Age Home (60)				Residential Home (60)				Total	
	Male (35)		Female (25)		Male (48)		Female (12)		120	%
	N	%	N	%	N	%	N	%		
Alzheimer's	0	0.00	0	0.00	0	0.00	01	0.85	01	0.85
Arteriosclerosis	02	1.65	05	04.16	04	3.35	01	0.85	12	10.00
Cancer	01	0.85	0	0.00	01	0.85	0	0.00	02	01.67
Liver Disease	0	0.00	05	04.16	02	1.65	03	02.05	10	08.35
Cirrhosis	0	0.00	01	0.85	0	0.00	0	0.00	01	0.85
COPD	0	0.00	0	0.00	03	2.05	0	0.00	03	02.05
Hypertension	0	0.00	01	0.85	08	6.65	04	03.35	13	10.85
Diabetes	02	01.65	02	01.65	06	05.00	02	01.65	12	10.00
Nephritis	0	0.00	02	01.65	0	0.00	0	0.00	02	01.67
Stroke	02	01.65	01	01.65	03	02.05	0	0.00	06	05.00
Gout	01	0.85	01	01.65	09	07.05	08	06.65	19	15.85
Piles	0	0.00	0	0.00	02	01.65	0	0.00	02	01.67

Table-1.2
Distribution of Mental Related Disease of respondents

Mental Disease	Old Age Home (60)				Residential Home (60)				Total	
	Male (35)		Female (25)		Male (48)		Female (12)		120	%
	N	%	N	%	N	%	N	%		
Dementia	01	0.85	02	01.65	07	05.85	06	5.00	16	13.35
Depression	0	0.00	0	0.00	09	07.05	04	3.35	13	10.85
Anxiety	0	0.00	0	0.00	09	07.05	06	5.00	15	12.05
Schizophrenia	0	0.00	04	03.35	01	0.85	01	0.85	06	05.00

NOTE- None of the study subjects find out in the Alzheimer disease.

Majority find out in dementia which was sixteenth (13.35%) out of 120 study subjects. In this the common ratio has find out in male and female. In this out of 120 study subjects only six (5%) suffering from schizophrenia.

Disease burden among study subjects: Disease burden of the study subjects was assess by clinical examination (pathological record-previous one month) by which diagnose the eject condition of the person. It generated comprehensive and internally consistent estimates of mortality and morbidity by age, sex and region. Drawing on extensive databases and information provided by Member States, the World Health Organization (WHO) prepared updated burden of disease assessments for the years 2000–2002, the most recent version being published in the World health report 2004. In (1.1) most of life style disease especially porn in gout, hypertension and arteriosclerosis. Among people ages 65 and older, minority and socioeconomically disadvantaged populations are much more likely than other groups to experience disability and the physical, cognitive, and sensory limitations that underlie it Disability prevalence increases rapidly with age, and women and those who are unmarried have much higher prevalence rates. The burden of disability clearly falls disproportionately on less advantaged groups[6].

Figure-1.1
Show the prevalence of life style disease

In the 1980s research claimed that population health and disability were worsening. Subsequent research questioned that conclusion, and studies of the elderly in particular began to find significant reductions in disability. Based on a stream of research on the topic starting in the late 1990s, the current evidence suggests that old-age disability has declined by roughly 1.5 percent per year during the past two decades. Declines of this magnitude have wide-ranging implications for individuals and society, including the potential for substantial savings in health and long-term care spending.
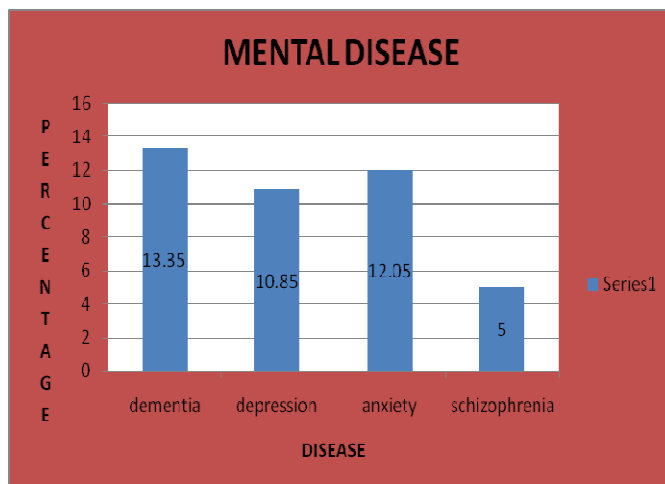

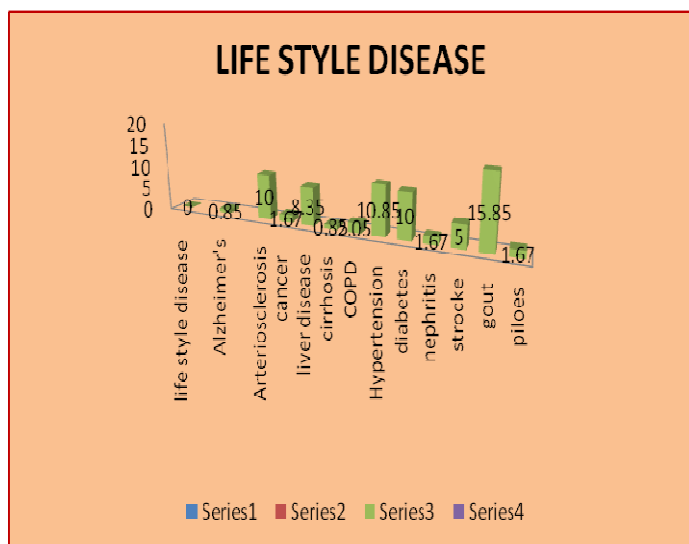**Figure-1.2**
Show the prevalence of mental disease

Conclusion

Ageing involves many physical and mental changes and there is huge variation between individuals. Some variance is genetically determined but much can be attributed to differences in social factors, for example lifestyles. Thus, the 1990 Global Burden of Disease (GBD) study examined the sensitivity of the ranking of causes of the burden of disease globally when discount rates and age weights were varied across a range of possible values[7]. Health state valuations, which link mortality information with information on nonfatal health outcomes in summary measures of population health, fit somewhat more ambiguously within the framework of uncertainty analysis[8]. If we conceptualize a health state in terms of levels in multiple

domains of health, health state valuation involves the weighting of these domains to arrive at an overall assessment of the health level associated with the state. This is mirrored by a decrease in the disease burden attributable to the risk factors for diseases that affect adults, because the total burden of the chronic diseases affected by these risks is reduced[9,10]. So, old people are important members of a given society.

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