Original Article

Caregivers' Burdens and Barriers in Accessing Healthcare Services for Dependent Elders in Thailand

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Background: Elders report poor health status and a greater need for healthcare services; however, in Thailand there are barriers in accessing healthcare services for these individuals.

Objective: To study the health status of dependent elders in Thailand, the barriers in accessing health services for them, the impact resulting from these barriers, and the impact on caregivers when taking care of dependent elders.

Materials and Methods: The study was conducted in 4 provinces in Thailand: Nonthaburi, Pathumthani, Ayutthaya, and Lopburi. Data were collected from 243 home-bound and bed-bound elders and 124 caregivers. The research tools both qualitative and quantitative parts were used to interview dependent elders and their primary caregivers.

Results: The study found that 96.5% of the dependent elders had chronic disease comorbidity with non-communicable. The barriers in accessing health services included long waits for healthcare services, transportation expenses to these services, medical expenses, no mobility support or body assist tools, no accessibility to information, unawareness of their rights in terms of medical treatment, and caregiver issues. These barriers affected the dependent elders regarding their physical and mental health and financial issues. Moreover, taking care of dependent elders had the impact on caregivers in terms of physical and mental health, family relationships, social participation, and financial issues.

Conclusion: There are still barriers in accessing health services for dependent elders. Furthermore, taking care of them is caregivers' burden. Therefore, caregivers should be supported.

Keywords: Caregivers' burden, Barriers in accessing healthcare services, Dependent elders

J Med Assoc Thai 2020;103(Suppl.4): 65-71
Website: http://www.jmatonline.com

As a result of the advancement in medical sciences, with increasing knowledge and awareness of healthcare, together with the behaviors regarding healthcare that have been improving, this has resulted in a rapidly-increasing number of elderly people. This trend is increasing consistently and has been expected that during 2025 to 2050 the elderly population will have increased by 17 percent, accounting for 27 percent of the total population, which Thailand will have completely transition into an aged society[1].

When entering into elderly age, all functions of all the different organs in the body will begin to deteriorate, and the body's immune functions will be less efficient. Sickness occurs more often during one's older age, especially chronic non-communicable illnesses, including heart disease, diabetes, cancer, cerebral ischemia, and respiratory diseases that are the cause of premature death. The trend of chronic illness among Thai elders has increased dramatically, resulting in a substantial loss of medical expenses. In 2013, medical expenses cost 280 billion THB. Physical deterioration, caused by chronic non-communicable diseases, force elderly people to encounter decreased ability to perform daily activities, disability, and dependency[2].

Dependent elders that are unable to rely on themselves, to take care of their own health independently, or to earn a living while having a chronic, non-communicable disease requiring long-term care must meet with doctors periodically, leading to greater expenses for medical treatment and travel. This affects the family's financial situation and positions primary caregiver to be responsible for the cost of medical treatment, leading to elders becoming stressful and anxious. In addition, weak physical conditions, lack of energy, disability, and difficulty making physical movements prevent the elderly from participating in many social activities, reducing their roles and importance in society. As a result, the elderly might feel that they are burden for their children or grandchildren and eventually feel self-worthless.

Difficulties in travelling to access healthcare services, especially for dependent elders that are poor, undereducated, or living in rural areas with no caregivers, or when caregivers are not available to take them to medical facilities, have resulted in several severe consequences. This places elders at risk for complications related to orthopedic,

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How to cite this article: Srisatidnarakul B, Bunthumporn N. Caregivers' Burdens and Barriers in Accessing Healthcare Services for Dependent Elders in Thailand. J Med Assoc Thai 2020;103(Suppl.4): 65-71.

respiratory, skin, and urinary systems. While their health status worsens, their living conditions shift from being ordinary elders normally living in a house to elderly people living on a bed or at the end stage of life.

Dependent elderly, therefore, need caregivers. Taking care of dependent elders with chronic non-communicable diseases is difficult work which requires continuous caregiving. Most of the caregivers are females, or people in their late adulthood and those that are old serving many complicated roles while solely taking responsibility for the medical treatment costs of their dependent elders. Such extreme responsibilities make the caregivers tired and stressed, and then they will miss the opportunity participate in social activities and eventually encounter financial problems.

Objective

1) To study the health status of dependent elderly people in Thailand.

2) To study the barriers in accessing health services among dependent elderly people.

3) To study the impact resulting from the barriers to accessing health services among dependent elderly people.

4) To study the impact on caregivers in taking care of dependent elderly people.

Scope of the research

In terms of the location of the study, it was conducted at the primary healthcare facilities in health region 4 in Thailand, governed by the Ministry of Public Health in 8 provinces, namely, Nonthaburi, Pathumthani, Phranakhon Si Ayutthaya, Ang Thong, Singburi, Nakhon Nayok, Lopburi and Saraburi.

The scope, in terms of the demographics and sample population used in this study, covered home-bound and bed-bound dependent elderly people aged 60 years old and over, both male and female, and dependent elderly caregivers.

Materials and Methods

Population

There were two groups in the study, each characterized as follows:

1) Home-bound and bed-bound dependent elderly people aged 60 and over, male and female.

2) Elderly caregivers, responsible for providing primary care for the elderly with experience of at least 3 months, living in the same home with the elderly and being able to speak Thai.

Sample size and sampling method

Dependent elders

With regard to defining the sample size, according to survey research, the Krejcie and Morgan (1970) sample size table was used, with the confidence level of 95%, which is appropriate for exploratory research. The sample size was 384 dependent elderly people.

In sampling the dependent elders, the following random method was used.

The number of provinces to be examined was calculated using 50% of health region 4, which included the 8 provinces named above.

The samples were selected from the districts in each province, with two districts being randomly selected. This process was conducted by coordinating with the healthcare office of the selected districts in order to request permission to collect the required information in the area.

The dependent elders were selected from the elderly list collected by the health promotion hospital using the following inclusion criteria:

1) The dependent elders included elderly with scores of complete, excessive, and moderate levels of dependency. The overall score in performing daily activities assessed using the Barthel ADL Index was 0 to 11 points.

2) Thai nationality.

3) If the dependent elder provided the information himself or herself, he or she could not have dementia and had to be able to hear and speak.

Elderly caregivers

The data for this sample group were qualitative, with a sample size of 50 persons. The samples were purposively selected using the following inclusion criteria:

1) Primary caregiver responsible for taking care of the elderly for at least 3 months.

2) Those related by relatives, daughters-in-law, sons-in-law, excluding hired caregivers.

3) Living in the same house with the elderly.

4) Able to speak Thai.

Research tools

The tools used to collect the data included:

1) A survey form on the living conditions of dependent elders.

2) A survey form on the chronic diseases of dependent elders.

3) An assessment form on the ability of dependent elders to perform daily activities (the Barthel ADL Index).

4) An interview form on the barriers to accessing health services (elderly clinic/servicing unit).

5) An interview form on the impact of the barriers to accessing healthcare services.

6) An interview form on the impact on the primary caregiver in giving care to dependent elders.

Testing the quality of the tools

All of the tools used were validated by 3 experts and tested with 41 dependent elders living in Norasing Sub-district in Ang Thong province, Thailand. The reliability of the assessment tools used to evaluate the ability of the elderly in performing their daily activities was 0.78.

Protecting the rights of human subjects

This research has been approved by the Ethical

Review Sub-committee Board for Human Research Involving Sciences, Thammasat University, No. 3, COA No. 233/2560.

Data collection

The data related to the dependent elderly in terms of health status, barriers in accessing healthcare services, the impact of the barriers in accessing healthcare services, and alternatives in dealing with barriers in accessing healthcare services were collected by interviewing the dependent elders. In the case that the dependent elderly individuals could not provide information by themselves, all of the required information was collected from the primary caregivers at their homes via face-to-face interviews, including observation of their daily life activities at home.

In order to study the impact of the primary caregivers taking care of the elderly, the qualitative data were collected from the primary caregivers through individual interviews until data saturation.

Data collection was conducted from November 2017 to July 2018.

Data analysis

Quantitative information was analyzed for frequency, mean, and standard deviation values using a software package by selecting 367 sets of complete questionnaires. In order to obtain qualitative information, content analysis was used.

Results

Personal information and general information

Number and percentage of participants

Among the 367 participants in this study, 243 (66.20%) were dependent elders that were able to provide information by themselves (66.20%) and 124 (33.80%) caregivers. Among these, 105 (28.60%) lived in Lopburi, 93 (25.30%) lived in Phra Nakhon Si Ayutthaya, 86 (23.40) lived in Nonthaburi, and 83 (22.60%) lived in Pathumthani province.

Demographic characteristic of the dependent elders

Of the 243 subjects (66.20%) that were able to provide information by themselves, 105 (28.60%) lived in Lop Buri, 93 (25.30%) lived in Phra Nakhon Si Ayutthaya, 86 (23.40%) lived in Nonthaburi, and 83 (22.60%) lived in Pathumthani. Eighty-six point five percent were female, 50.4% were divorced, 98.6% were Buddhist, 72.2% were primary school graduates, 89.6% were unemployed, 19.9% had 2 children, and 33.4% were aged 71 to 80 years, followed by 31.3% aged 81 to 90 years.

Most of the dependent elders lived with their children (35.4%), lived with a spouse and children (33.2%), lived with a spouse (18.5%), lived with others (8.2%), and lived alone (4.6%).

Residence: 60.8% of the elderly lived in two-storey house, 33.4% lived in a one-storey house, 80.9% mostly lived on the first floor, 66.6% slept on a bed, and 32.6% slept on the floor.

Eighteen point six percent of the dependent elders slept on the upper floor, where they were required to use stairs, and this led to the risk of falling, serious injury, disability and infirmity.

The toilets that the elderly used consisted of sitting toilets (71.3%) and squatting toilets (27.9%).

The types of toilets used consisted of indoor toilets (85.5%) and outdoor toilets (14.5%).

Demographic characteristic of the primary caregivers

There were 124 primary caregiver informants, consisting of daughters of the elders (56.2%) followed by spouses, including husbands (13.9%) and wives (11.7%), those with health problems (35%), those over 60 year of age (34%), those having occupations and working outside the home (9%), and those taking care of more than one elder (2%).

Health status of dependent elderly people

The six chronic illnesses of the dependent elders consisted of hypertension (73.3%), heart disease (45.0%), stroke (34.1%), diabetes (30.5%), osteoarthritis (29.2%), and amnesia (16.9%).

Ninety-six point five percent of the dependent elders were chronically ill with comorbidity of chronic diseases, namely, 2 chronic diseases (33.0%), 3 chronic diseases (25.1%), 4 chronic diseases (11.7%), and 5 chronic diseases (6.8%).

The five comorbid chronic diseases included: hypertension (28.6%), stroke (13.3%), diabetes (11.9%), osteoarthritis (11.4%), and herniated disc (10.5%).

As for the sources of medical expense support for the dependent elders, it came from: universal health coverage (40.9%), support of their children (18.8%), and social health insurance (13.5%).

The dependent elders consisted of 2 groups, the home-bound elderly group (55.7%) and the bed-bound elderly group (44.3%).

The daily routine activities that the dependent elders could perform by themselves rather than relying on the caregivers included: face washing, combing their hair, tooth brushing, shaving, and eating prepared meals.

The daily routine activities that the dependent elders relied on the caregivers the most included: activities that required force of arms or legs or good balance, such as going up and down stairs one step at a time, moving inside a room or house, and getting up from a mattress or bed to a chair.

As for the ability of the elders to hold their defecation, about 38% of them could not hold their feces some of the time, and 29.0% could not hold their feces or required an enema. Regarding the ability of the participants to hold their urine, about 40.4% of them could not hold it some of the time and 32.2% could not hold it or needed urinary catheterization.

Barriers to accessing healthcare services of dependent elders

The study found that the barriers to accessing the healthcare services of the dependent elderly were the following:

Long waits for healthcare services have been a chronic problem of public hospitals and healthcare offices, where the elderly felt tired and did not want to receive such services, especially those in community and general hospitals where there were many patients waiting. This affected particularly the elderly living in rural areas where convenient transportation was not available. Since traveling from a rural area to meet a doctor at a city hospital took many hours, the elders needed to arrive early to pick up a queue card before seeing the doctor just for a few minutes despite their weak health conditions, illness, and fatigue. This was a major reason why the elderly did not wish to receive medical care as scheduled or when they became ill.

The expense of travelling to healthcare services

The dependent elders usually relied on the universal health coverage (Gold Card) services, where they could apply for health services only at public hospitals, not at private hospitals or clinics. If the elderly needed to access health services at private hospitals or clinics if the caregivers were not able to take leave to take them to the healthcare services at public hospitals, or when the elderly were seriously ill requiring urgent treatment, or if they had to pay large expenses for healthcare, these circumstances might require them to ask for a loan for medical treatment, thus putting them in debt.

Medical expenses

Inconvenient transportation systems that did not facilitate the travel and the lack of public transport vehicles and buses, especially in rural areas, made the elders living in rural areas spend more of their money on traveling to healthcare services than those living in urban areas. For community healthcare services, there was the expense of hiring a transport car at 400 to 500 THB each time, and the expense of lunch at 200 to 300 THB. In addition, if the elderly person lived too far away from the hospital, the cost of hiring a transport car was about 1,000 THB, which was a significant barrier in accessing healthcare services, especially for elders and caregivers with poor economic status.

No mobility support or body assist tools for some dependent elders in this study faced difficulty with physical movement, for example being unable to walk alone, being unable to take the stairs or get out of a car, and being unable to stand or stabilize themselves, especially for bed-bound elders that had to rely on the health caregivers for mobility. Where there was no mobility support or body assist equipment, such as walking sticks (canes), walking frames (Zimmer frame), or wheelchairs, it was a major obstacle for them in terms of travelling to healthcare services.

No accessibility to information, unawareness of the right to medical treatment

The majority of the dependent elders (72.2%) in the present study were primary school graduates, while 18.8 percent of them were uneducated people, which leads to a lack of opportunity in accessing health information, the lack of knowledge about their right to have medical treatment, the lack of information about the welfare fund, the lack of channels for accessing health insurance, and the lack of knowledge about healthcare and control of chronic diseases, including the lack of knowledge about the roles and responsibilities of home elderly care volunteers (ECV) regarding the provision of care for the elderly, and the inability to take care of themselves.

No caregivers, the health status of caregivers, and the caregiver being poor

In the present study, 18.5% of the dependent elders lived with their spouses, while 8.2% lived with relatives. Additionally, some of the dependent elders (4.6%) lived alone without caregivers. Normally, they relied on their neighbors and elderly care volunteers. Additionally, these groups of elders were poor, having no money to hire a caregiver to take them to healthcare services at the hospital. Therefore, the lack of caregivers among the dependent elderly people that live alone and are poor leads to a significant barrier in terms of their accessing healthcare services.

Health status of caregivers

The study found that if the caregivers were elders with health problems, such as back pain, knee pain, osteoarthritis, and if their family members had no children of work-force age that were able to assist the caregivers with lifting and moving the elderly, it would lead to difficulties for the elders in accessing health services.

Economic status of caregivers and their occupation

The study found that caregivers performing "4" or complex duties usually helped and took responsibility for the expenses for daily life, expenses for traveling to access healthcare services, and expenses for medical treatment. They were paid less for their work and had no money left over for savings. In addition, the caregivers that worked in an office often could not take leave to take the elderly to see the doctor at the hospital.

Alternatives in dealing with barriers in accessing healthcare services

The present study found that the alternatives for solving the barriers in accessing the district healthcare services included: 1) buying medication without prescriptions; 2) using herbs; 3) using a religious doctor and holy water; 4) not receiving continuous treatment; 5) receiving services from private hospitals and clinics; 6) assigning children, grandchildren or relatives to obtain medication from the hospital instead of going to the hospital; and 7) other actions,

such as calling to obtain consultancy from a doctor and buying prescription medicines as the doctor suggested, hiring a local masseur to relieve the pain, discontinuing medicine without the recommendation from the doctor, and taking locally-arranged medications provided by the local pharmacy.

Impact on the dependent elderly from the barriers in accessing healthcare services

The study also found that the impacts on the dependent elders from the barriers in accessing healthcare services included: 1) impacts on physical health: symptoms and severity of the illness increase causing the risk of complications of the disease and harm to life; 2) impacts on mental health: emotions, anxiety, stress, depression, desolation, grieving, discouragement, loss of self-esteem, and self-infliction as burdens for children, including feelings of unwillingness to live; and 3) economic impacts: in the case that the illness was serious or urgent and the patient had to use a private hospital or local clinic because of the difficulty in travelling to a public hospital, the medical expenses could be costly, leading to loan requests and putting patients in debt.

Impact on primary caregivers from taking care of dependent elders

From interviewing the 40 primary caregivers that were selected from the 124 primary caregivers, the results of the analysis indicated the following.

Impact on physical health:

If the caregivers took care of the elders by themselves and the caregivers were also elders with no family members to replace their duties, the caregivers faced rest deprivation, dizziness, exhaustion, fatigue, weakness, muscle aches, back pain, lumbar pain and neck pain.

Impact on mental health and emotions:

If the elderly person was urgently ill or if the symptoms of his or her disease worsened while the caregiver provided care for the elders alone without a family member to assist in finding solutions and solving the problems, this made the caregiver stressed and more anxious. Moreover, when the dependent elder required urgent medical attention but he or she could not be taken to the hospital and could not be helped in time due to several obstacles and limitations, such as the caretaker having no energy for lifting the elderly person and there not being any personal car support, these situations could lead to greater tension and anxiety, including the feeling of guilt on the part of the caregiver.

In the case that the caregivers performed complex roles, for example in addition to taking care of the elderly person, they also needed to take care of other people, especially in their own families, or they needed to work outside the home to earn a living for the family, including expenses for taking care of the elders, and these complex roles made the caregivers become stressed and discouraged about taking care of the elderly. In addition, taking care dependent elders was difficult and arduous work. Moreover, taking care of dependent elders in the long-term certainly made the caregivers feel tired.

Impact on family relationship:

When the caregivers performed complex duties (sandwich roles) such as the role of housewife, wife, mother craft, or breadwinner by working outside the home, while other family members could not help alleviate these burdens or the cost of caring for the elderly, the caregivers could no longer bear these burdens, thus affecting the family relationships and leading to arguments and quarrels among the family members.

Impact on social participation:

If the caregivers were taking care of the elderly that could not help themselves or helped themselves very little and there were no other family members to replace the duties of caregiving and there were no other people offering help to alleviate such burdens, the caregivers lacked the opportunity to participate in social activities with social groups.

Economic impact:

If the caregivers had to take a leave or close their shops for example, resulting in no income and loss of trading opportunities and if they had no savings and were not supported by their family members, this made the caregivers request loans and they eventually found themselves in debt. However, taking care of the elderly is a good cultural value of Thai society that has been cultivated and inherited for a long time. Moreover, social values in terms of gratitude toward one's parents and the role model of one's ancestors in terms of their taking care of their parents, aid in the provision of care for one's parents. This makes the caregivers feel proud and happy that they have the opportunity to take care of and repay their parents, who taught them and gave them an education and fostered them since their childhood.

Discussion

Basically, the daily routine activities for which most of the dependent elders required caregivers included those that required force of arms and legs for mobility, such as going up steps, mobility within the room or house, getting up from a mattress or from a bed to chairs. If no caregivers offered this support, it could lead to the risk of falling or bone breaking. In addition, appropriate home environments for health should be created. Equipment to facilitate lifting and body mobility should be provided, so that caregivers and healthcare team members can promote and help rehabilitate the health of bed-bound elders to become home-bound elders, while eventually promoting and rehabilitating the health of home-bound elderly people, turning them into society-bound elderly groups.

The number of elderly is increasing continuously and this is forcing all countries to face chronic non-communicable diseases among the elderly, especially in developing countries. The study found that chronic non-

communicable diseases among the elderly are a major cause of death and disability[3]. The findings from the present study revealed that non-communicable chronic illnesses among elders in rural areas in Thailand included hypertension, heart disease, stroke, diabetes, mental illness, respiratory diseases, and cancer, and this appears to be congruent with the chronic non-communicable disease situation of all countries[4].

Normally, elderly people with chronic illness need to get medical care from a healthcare provider, especially for long-term treatment. However, the present study found that many elders with chronic diseases face many difficulties in accessing healthcare services, especially the underprivileged, such as the poor, poorly-educated elders, those living in rural areas, those with disabilities, infirmities, and those that have no caregivers. The lack of caregivers may be the result of changes in the family structure. According to a report on the elderly situation in Thailand, the family structure is becoming the nuclear family rather than the extended family system, a steadily growing trend. In addition, the decrease in the size of the family and the relocation of the young workforce from rural to urban areas have brought about the lack of caregivers for elders. Some households have elderly people living alone, thus leading to higher chances of dependent elders being abandoned or not being taken care of by their children[5].

The finding of the present study is that taking care of dependent elderly people with chronic non-communicable diseases is a heavy burden requiring care giving almost at all times, and this has a strong effect on the caregivers in terms of physical, mental, economic, and societal aspects. This finding is consistent with a study of Ghazali et al (2015), which indicated that the caregiving of elderly people with chronic illness is a heavy burden; if elders are only able to rely slightly on themselves, it requires more than 14 hours a day for caring. This increased the burden for caregivers, worsening their health with depression, anxiety and stress, as well as other social impacts including the impacts on the lives of their family members. Therefore, healthcare personnel or family care teams should provide care for caregivers along with taking care of the dependent elderly. However, a report on the aging situation in Thailand revealed that most elderly caregivers are informal caregivers and are family members living in the same family as the elder, such as daughters, wives, or daughters-in-law[5]. In addition, a study found that taking care of elderly people was a cultural and a Buddhist way of cultivating gratitude for parents. Therefore, the caregiver felt proud and happy to have the opportunity to repay the grace of their parents and grandparents, who had fostered them since an early age[6]. As the belief of Thai people that taking care of their parents and grandparents is a way to show their gratitude toward them, this may help to extenuate the burden of taking care of them.

Conclusion

The need for healthcare services for dependent elders tends to increase as one's health deteriorates. However, there are still limitations regarding accessibility to health services that affect the individual's physical and mental health. In addition, taking care of these elders is a burden for the caregivers. Therefore, health policies should be concerned not only with dependent elders but also their caregivers.

What is already known on this topic?

1) Elders, especially dependent elders have poor health status and need more healthcare services than other aged groups.

2) Difficulties in travelling to access healthcare services, especially for dependent elders that are poor, undereducated, or living in rural areas with no caregivers, or when caregivers are not available to take them to medical facilities, have resulted in several severe consequences.

3) Taking care of dependent elders is a burden for caregivers.

What this study adds?

1) Almost 100% of the dependent elders in this study had chronic disease comorbidity with the most common chronic diseases being non-communicable.

2) The barriers in accessing health services for dependent elders consisted of long waits for healthcare services; transportation expenses to these services, medical expenses, no mobility support or body assist tools, no accessibility to information, unawareness of their rights in terms of medical treatment, and caregiver issues.

3) The dependent elders and caregivers have alternatives to solve the barriers in accessing the healthcare services such as buying medication without prescriptions, using herbs, using a religious doctor and holy water, not receiving continuous treatment, receiving services from private hospitals and clinics, and assigning children, grandchildren or relatives to obtain medication from the hospital.

4) In terms of caregivers, the impact of taking care of dependent elders affects their physical and mental health, family relationships, social participation, and financial issues.

Funding

The present study was supported by National Research Council of Thailand.

Potential conflicts of interest

The authors declare no conflict of interest.

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ภาระของผู้ดูแลและอุปสรรคการเข้าถึงบริการสุขภาพของผู้สูงอายุที่มีภาวะพึ่งพิงในประเทศไทย

บุญใจ ศรีสถิตย์นรากูร, นุชนาถ บรรทุมพร

ภูมิหลัง: มีปรากฏให้เห็นว่าผู้สูงอายุมีภาวะสุขภาพที่ไม่ดีและมีความต้องการการบริการทางด้านสุขภาพเพิ่มขึ้น แต่อย่างไรก็ตาม ในประเทศไทยยังคงมีอุปสรรคบางอย่างในการเข้าถึงบริการทางด้านสุขภาพสำหรับผู้สูงอายุเหล่านี้

วัตถุประสงค์: เพื่อศึกษาภาวะสุขภาพของผู้สูงอายุที่มีภาวะพึ่งพิงในประเทศไทย อุปสรรคในการเข้าถึงบริการทางด้านสุขภาพสำหรับผู้สูงอายุกลุ่มนี้ ผลกระทบที่เกิดขึ้นจากอุปสรรคเหล่านี้ และผลกระทบต่อผู้ดูแลในการดูแลผู้สูงอายุที่มีภาวะพึ่งพิง

วัสดุและวิธีการ: การศึกษาครั้งนี้ดำเนินการศึกษาใน 4 จังหวัดของประเทศไทย ซึ่งประกอบด้วย นนทบุรี ปทุมธานี อยุธยา และลพบุรี โดยเก็บรวบรวมข้อมูลจากผู้สูงอายุที่ติดบ้านและติดเตียงจำนวน 243 คน และผู้ดูแลจำนวน 124 คน ซึ่งในการศึกษานี้ประกอบด้วยทั้งการศึกษาทั้งเชิงคุณภาพและเชิงปริมาณ โดยรวบรวมข้อมูลจากทั้งผู้สูงอายุที่มีภาวะพึ่งพิง และผู้ดูแลหลัก

ผลการศึกษา: จากการศึกษาพบว่า 96.5% ของผู้สูงอายุที่มีภาวะพึ่งพิง จะมีโรคเรื้อรังร่วมด้วย ซึ่งโรคเรื้อรังส่วนมากเป็นโรคที่ไม่ติดต่อ อุปสรรค ต่างๆในการเข้าถึงบริการทางด้านสุขภาพ ประกอบด้วย การรอคิวนานเพื่อรับบริการ ค่าใช้จ่ายในการเดินทางเพื่อไปรับบริการทางด้านสุขภาพ ค่าใช้จ่ายในการรักษาพยาบาล การไม่มีอุปกรณ์ช่วยเคลื่อนไหวร่างกายและอุปกรณ์ช่วยพยุงตัว การไม่สามารถเข้าถึงข้อมูลข่าวสาร การไม่ทราบสิทธิการรักษาพยาบาล และประเด็นปัญหาของผู้ดูแล ซึ่งอุปสรรคเหล่านี้ส่งผลต่อผู้สูงอายุที่มีภาวะพึ่งพิงทั้งด้านสุขภาพร่างกายและสุขภาพจิต และทางด้านเศรษฐกิจ ส่วนผลกระทบต่อผู้ดูแลในการดูแลผู้สูงอายุที่มีภาวะพึ่งพิงประกอบด้วย ผลกระทบต่อสุขภาพร่างกายและจิตใจ สัมพันธภาพในครอบครัว การเข้าร่วมกิจกรรมทางสังคม และด้านเศรษฐกิจ

สรุป: จะเห็นได้ว่ายังมีอุปสรรคในการเข้าถึงบริการทางด้านสุขภาพสำหรับผู้สูงอายุที่มีภาวะพึ่งพิง นอกจากนี้ ในการดูแลผู้สูงอายุเหล่ายังเป็นภาระสำหรับผู้ดูแลอีกด้วย ดังนั้นผู้ดูแลผู้สูงอายุในกลุ่มนี้ก็ควรได้รับการดูแลช่วยเหลือด้วยเช่นกัน